Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP.
Telephone 01572 722577 Facsimile 01572 758307 DX28340 Oakham

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 April, 2016** commencing at 7.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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A G E N D A

APOLOGIES FOR ABSENCE

1) MINUTES

To confirm the minutes of the Audit and Risk Committee held on 26 January 2016.

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) AUDIT COMMITTEE EFFECTIVENESS AND ANNUAL REPORT

To receive a verbal update from the Chair.

5) EXTERNAL PLACEMENTS AUDIT PROGRESS REPORT

To receive Report No. 95/2016 from the Director for People.
(Pages 5 - 18)

6) INTERNAL AUDIT ANNUAL REPORT 2015/16

To receive Report No. 96/2016 from the Head of Internal Audit.
(Pages 19 - 62)

7) INTERNAL AUDIT PLAN 2016/17

To receive Report No. 92/2016 from the Head of Internal Audit.
(Pages 63 - 78)

8) EXCLUSION OF PRESS AND PUBLIC

The Committee is recommended to determine whether the public and press be excluded from the meeting in accordance with Section 100(A)(4) of the Local Government Act 1972,as amended, and in accordance with the Access to Information provisions of Procedure Rule 239, as the following item of business contains exempt information as defined in Paragraph 7, Part 1 of Schedule 12A of the Act.

Paragraph 7: Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

9) FRAUD RISK REGISTER

To receive Report No. 89 /2016 from the Director for Resources.
(Pages 79 - 98)

10) RISK MANAGEMENT UPDATE

To receive Report No. 101/2016 from the Director for Resources
Report to follow

11) EXTERNAL AUDIT PLAN

To receive Report No. 86/2016 from the Director for Resources.
(Pages 99 - 116)

12) REGULATION OF INVESTIGATORY POWERS ACT 2000 QUARTERLY UPDATES

To receive Report No. 98/2016 from the Director for Resources
(Pages 117 - 144)

13) ANY OTHER URGENT BUSINESS

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

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DISTRIBUTION
MEMBERS OF THE AUDIT AND RISK COMMITTEE:

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

OTHER MEMBERS FOR INFORMATION

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Report No: 95/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 2016

EXTERNAL PLACEMENTS AUDIT PROGRESS REPORT

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Karen Kibblewhite, Head of Commissioning	01572 758127 kkibblewhite@rutland.gov.uk
	Mark Andrews, Deputy Director for People	01572 758339 mandrews@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the update on progress made following the External Placements Audit report. 2. Endorses the request for a follow-up audit in January 2017.

1 PURPOSE OF THE REPORT

1.1 This report sets out the actions taken and progress made following the internal audit undertaken of External Placements.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The People Directorate makes a range of external placements for individual service users to meet their needs. Over the past 12 months, a total of 48 providers have been used: 34 for residential placements for older people, learning disabilities, physical disabilities, and mental health; and a further 14 providers for Special Educational needs (SEN) placements. The average annual cost of these placements is c£2m for all residential placements and c£1.4m for the SEN placements.

2.2 The People Directorate requested Welland Internal Audit Consortium undertake an audit of the external placements: officers had identified risks with the process as it

was, and were keen to ensure that all risks had been identified and that the plans to address would suitably mitigate these.

2.3 The audit was undertaken in August 2015 and the final report issued in October 2015. It showed Limited Assurance with 16 recommendations. It covered placements made for adults and children and young people with Special Educational Needs (SEN). Children's Social Care placements were not included.

3 ACTION TAKEN & PROGRESS

3.1 A number of issues were identified by the audit. These are grouped into themes and set out below along with actions taken. Appendix A sets out the full list of recommendations made.

3.2 Formal Commissioning Strategy

3.2.1 The Audit noted that there is currently no formal commissioning strategy in place for the Directorate. A Commissioning Strategy is currently being developed, and this strategy will form the basis for macro-commissioning: that which is how we commission provision types; rather than micro-commissioning: that which is how we support individual service users.

3.2.2 The overarching Commissioning Strategy will be across the People Directorate, covering children and adults. It will follow the principles for commissioning already set out in the Adult Social Care Market Position Statement, of utilising framework agreements; continuation of block contracts where there is sufficient demand; and agreeing pricing structures with providers based on the needs of the person using the services and using competitive tendering where possible.

3.2.3 The level of demand for placements in Rutland and the need to ensure that each is suitable for an individual's specific needs, mean that for most placement types – other than older people's residential – block contracts are not appropriate. Instead best use will be made of framework agreements, such as the East Midlands Regional Children's Framework to support commissioning from providers of both quality and value for money.

3.3 Individual Placement Policy

3.3.1 The Policy for Individual Placements had been drawn up in 2013 and remained in draft, having never been formally approved. There was an expectation that staff were working to it and the policy was available to all staff.

3.3.2 The Policy had remained in draft for two reasons: the staff who had lead responsibility had left the organisation and the incoming staff were not initially aware the policy had not been formally adopted; and the legislation behind the procedures for Adults had changed with the Care Act 2014.

3.3.3 The practice of staff had changed in line with legislation, but the policy itself was not updated.

3.3.4 The draft Policy has now been replaced with a Standard Operating Procedure which sets out clear steps that need to be undertaken for placements to be made, along with the relevant checklist and forms which need to be completed.

3.3.5 The SOP has been signed off by People DMT and will be reviewed annually. It has been transferred from a Policy to a SOP to ensure that it can be reviewed and updated by People DMT immediately and as frequently as necessary to maintain the procedures in line with legislative and national guidance changes.

3.3.6 All staff are aware of the revised procedures and are now working to them. Spot-checks will be undertaken on a periodic basis to ensure that placements continue to be made in line with the procedures.

3.4 Identifying and Negotiating Placements

3.4.1 The audit noted that it was not always clear how placements were identified for service users. This has been addressed through the revised paperwork to ensure that there is clarity on why a particular placement has been chosen, and the options considered. Justification also has to be provided where a placement has been made outside of an existing contract or framework.

3.4.2 Placement rates are set for some placements, including: in-county older people's residential; out of county older people's residential (usually set by the host Local Authority); those providers on existing regional or local authority frameworks. For other placements, usually learning or physical disability, or Special Educational Needs, placement costs are negotiated dependent on the individual's package and level of care and interventions required.

3.4.3 In many authorities, there are specific teams whose role it is to identify potential placements and negotiate the placement package and cost on behalf of the social workers. Rutland does not have sufficient placements to warrant this. However, staff turnover has left the Council in a position where staff do not have the experience of negotiating placements and care packages for individuals. In order to address this, support is currently being sought through an invest to save piece of work. This will:

- Review all existing external placements, to seek to renegotiate costs (and realise savings);
- Provide support to staff and lessons learned so that they feel more confident in undertaking these negotiations themselves in future.

3.4.4 This work will also provide a further assurance that the correct contractual paperwork and monitoring is in place for each individual placement.

3.4.5 Where placements are not already covered by pre-agreed rates, the negotiation of placement costs will be undertaken by the social/education worker with support from the Procurement Officers. Work is being undertaken to upskill officers to do this.

3.5 Quality Standards and Pre-Placement Checks

3.5.1 The audit noted that from the case files and contract paperwork it was not always clear whether these had taken place. Officers are confident that these are - and had been - taking place, the issue was one of recording. This has been resolved by implementing a checklist which requires recording of the checks before the placement is signed off.

3.5.2 It is also important to note that there has been no suggestion that any placements which have been made have put individual service users at risk. The audit found clear procedures for safeguarding and information sharing (though it notes that this was beyond the scope of the audit and only touched on).

3.6 The social/education worker ensures that when discussing potential placements with service users, only those which are registered (CQC or Ofsted) and meet quality standards are offered. The P&CM Team will undertake the financial checks and contact host local authorities for quality assurance and any safeguarding information.

3.7 A Financial Due Diligence process is being drafted currently by the P&CM Team and overseen by the Assistant Director for Finance, this will be used with all providers going forward to help monitor financial stability and risk. A piece of concurrent work is being undertaken regionally via the East Midlands Commissioning Leads group, which will ensure that work undertaken in Rutland to identify risk is consistent with processes used across the region.

3.8 Where it was suggested from the sample testing that contracts did not appear to be in place, work has been undertaken to ensure there are current contracts for all placements. It should be noted that at the point the audit was undertaken, a new set of contractual Terms and Conditions were being negotiated and agreed with older people's residential providers and this accounts for half of the placements where it was noted that a current contract was not in place. The new Terms and Conditions were being brought in to ensure contracts reflected the change in legislation following the Care Act.

3.9 Contract Monitoring

3.9.1 The audit suggested that the responsibility for contract monitoring was not necessary clear from the cases tested. The responsibility is in line with Contract Procedure Rules and has been made explicit to staff: the Procurements and Contracts Management (P&CM) Team undertake the annual contract compliance with providers; the individual case workers within the operational teams (whether in Education or Social Care) undertake the placement reviews according to the minimum statutory requirements for review.

3.9.2 The restructure within both Adult Social Care and the Procurement and Contracts Management Team which was undertaken at the end of 2015 has increased capacity in both teams:

3.9.2.1 Adult Social Care now have additional 2fte staff to undertake reviews and ensure assessments are kept up-to-date. This enables packages to be altered in light of service users' changing needs and ensures a placement remains the most appropriate intervention.

3.9.2.2 P&CM Team have recently recruited to a dedicated Quality Assurance Officer post to provide expertise on contract compliance for placements. This post will take over the monitoring of registered care providers in-county and develop the links with other local authorities where placements are made. This work was previously undertaken by the Senior Procurement Officers.

3.9.2.3 Since the Audit was undertaken, there has been regional work to establish

information sharing on quality and contract compliance of registered providers, via the Placement and Contracts Teams across the East Midlands. This information sharing covers: quality of provision; risks; and financial stability. This is in addition, to the existing structures for quality assuring and information sharing via the Care Quality Commission (adults) which Rutland participate in.

3.9.3 It was also identified that workforce training for providers had been previously withdrawn. This was reinstated last Autumn for providers, however this is only applicable for in-county providers and is not always practical for smaller providers to access or attend. Instead, work is being undertaken via the Adult Social Care Provider Forum to identify alternative ways to support providers with workforce development.

4 CONSULTATION

4.1 The relevant officers have been consulted to ensure the revised processes are fit for purpose.

5 ALTERNATIVE OPTIONS

5.1 There are no alternative options. The actions taken were to address the risks and issues identified.

6 FINANCIAL IMPLICATIONS

6.1 There are no direct financial implications of undertaking the actions to address the risks and issues within the audit.

6.2 The additional capacity created within Adult Social Care and within the P&CM Team were within the existing staffing budgets.

6.3 The external review of all placements noted in Section 3.4.3 should result in savings on the overall placement spend of between 2% and 5%, and should provide a basis on which to negotiate future placement spend going forward.

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 The placement process is in line with legislative requirements and national guidance for each placement type.

7.2 The Standard Operating Procedure will be reviewed at least annually to ensure to remains in line with these requirements.

8 EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment (EqIA) has not been completed as this report updates the actions taken following the audit. The placements themselves take account of individual service users' needs when choosing a suitable provider.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 The council is required by Section 17 of the Crime & Disorder Act 1998 to take into account community safety implications. Quality care placements contribute to the safety and reduction of risk of vulnerable people.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 Appropriate placements of individuals in quality services will support the good health and well-being of Rutland residents.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The audit identified a range of issues with the (then) current placement processes. There were no additional issues identified by the audit that Senior Officers had not already identified and started to address, however this does not suggest that officers were not greatly concerned about the potential impact of the issues identified.

11.2 Significant work has been undertaken over the past six months to ensure that placement decisions are both rigorous and the appropriate audit trails to support decisions are in place. Work continues across the Directorate to monitor placements and undertake spot-checks to ensure all staff are following the correct procedures.

11.3 In order to ensure that this more robust process addresses the issues raised and to provide further assurance, it is recommended that a follow-up audit is taken towards the end of this financial year. This would allow the Invest to Save work reviewing all external placements to be completed first and for officers to implement any lessons learned from that.

12 BACKGROUND PAPERS

12.1 Welland Internal Audit Consortium External Placements Audit 2015-16

13 APPENDICES

13.1 Appendix A. Audit Recommendations

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

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

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
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
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

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
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
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

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
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
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

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Report No: 96/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 2016

INTERNAL AUDIT ANNUAL REPORT 2015/16

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 review and approve the Annual Internal Audit Report and Assurance Opinion for 2015/16.

1 PURPOSE OF THE REPORT

1.1 To provide the Committee with the Head of Internal Audit's Assurance Opinion for 2015/16 and the Annual Report detailing the basis for this opinion, for review and approval.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Internal Audit Annual Report

The Internal Audit Plan sets out the Annual Assurance Opinion over the Council's system of internal controls based upon the work conducted during 2015/16. A copy of the full report is provided in Appendix A.

2.2 The report details the work of the Internal Audit team during 2015/16 and the findings from the various assignments delivered. An analysis of the assurance opinions provided during the year, compared with 2014/15, highlights an increase in the proportion of Substantial Assurance opinions given. Whilst three reports have been issued with an opinion of Limited Assurance, based upon the actions taken by management to address the findings and the findings from the remaining reviews, the overall annual assurance opinion remains at Sufficient Assurance.

This is consistent with 2014/15.

2.3 The findings of all reports have been presented to the Committee throughout the year. The Committee should note that the following reports have been finalised since the last Committee or are awaiting finalisation (details are provided in Appendix A):

- Creditors (Substantial Assurance)
- Debtors (Substantial Assurance)
- Local Taxation (Substantial Assurance)
- Benefits (Sufficient Assurance)
- Fraud Risk Review (Sufficient Assurance)
- Contract Procedure Rule Compliance (Sufficient Assurance)
- Care Act Implementation (Sufficient Assurance) – issued as draft report
- Better Care Fund Monitoring (Sufficient Assurance) – issued as final draft report

2.4 Performance of the Internal Audit service

2.5 The Annual Report provides details on the performance of the Internal Audit team against the service's performance indicators and the value added during 2015/16. This highlights that the service has successfully delivered against its delivery targets (in relation to days delivered and assignments completed).

2.6 The Head of Internal Audit has undertaken an annual self-assessment against the Public Sector Internal Audit Standards (PSIAS). This has concluded that the team is operating in general conformance with the Standards and a full copy of the assessment is provided in Appendix A.

3 CONSULTATION

3.1 No external consultation is required.

4 ALTERNATIVE OPTIONS

4.1 If Members are not satisfied that the Annual Report reflects the assurances provided during the year then it can provide feedback to the Head of Internal Audit who may consider whether to issue a revised opinion.

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 satisfying itself that the conclusions reached in the annual audit report are reasonable in light of the work undertaken although the opinion itself remains the responsibility of the Head of Internal Audit. 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 Annual Internal Audit Report and Assurance Opinion for 2015/16 are provided for the Committee's review and approval.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

12.1 Appendix A: Internal Audit Annual Report 2015/16

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

Appendix A

RUTLAND COUNTY COUNCIL

INTERNAL AUDIT ANNUAL REPORT

2015/16

Date: 26th April 2016

1. Background

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

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

2. Head of Internal Audit Opinion 2015/16

2.1 This report provides a summary of the work carried out by the Internal Audit service during the financial year 2015/16 and the results of these assignments. Based upon the work undertaken by Internal Audit during the year, the Head of Internal Audit's overall opinion on the Council's system of internal control is that:

Sufficient Assurance can be given that there is generally a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. The level of assurance, therefore, remains at a consistent level from 2014/15.

Controls relating to key financial systems for payroll, debtors, creditors and local taxation which were reviewed during the year were concluded to be at a level of Substantial Assurance.

The overall proportion of audit reports giving Limited Assurance has remained approximately consistent with 2014/15, as shown in Table 1. The proportion of Substantial Assurance reports is higher than in 2014/15.

The implementation of audit recommendations during the year has been strong, with 92% of those actions from 2015/16 audit reports which were agreed and due for implementation being completed during the year.

No systems of controls can provide absolute assurance against material misstatement or loss, nor can Internal Audit give that assurance.

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

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

Table 1 – Summary of Audit Opinions 2015/16:

Area	Substantial	Sufficient	Limited	No
Financial Systems	4	1	0	0
IT	0	0	1	0
Governance & Counter Fraud	0	1	0	0
Customer Facing	0	8	2	0
Total	**4**	**10**	**3**	**0**
Summary with 2014/15 Comparison	**24% (14%)**	**59% (68%)**	**17% (18%)**	**0% (0%)**

3. Review of Audit Coverage

3.1 Audit Opinion on Individual Audits

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

Table 2 – Assurance Categories:

Level of Assurance	Definition
Substantial	There is a robust framework of controls making it likely that service objectives will be delivered. Controls are applied continuously and consistently with only infrequent minor lapses.
Sufficient	The control framework includes key controls that promote the delivery of service objectives. Controls are applied but there are lapses and/or inconsistencies.
Limited	There is a risk that objectives will not be achieved due to the absence of key internal controls. There have been

Level of Assurance	Definition
	significant and extensive breakdowns in the application of key controls.
No	There is an absence of basic controls resulting in inability to deliver service objectives. Fundamental controls are not being operated or complied with.

Audit reports issued in 2015/16, other than those relating to consultancy support, resulted in the provision of one of the above assurance opinions. All individual reports represented in this Annual Report, with the exception of Better Care Fund Monitoring and Care Act Implementation, are final reports and, as such, the findings have been agreed with management, together with the accompanying action plans.

3.2 Summary of Audit Work

3.2.1 Table 3 details the assurance levels resulting from all audits undertaken in 2015/16 and the date of the Committee meeting at which a summary of the report was presented.

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

Table 3 – Summary of Audit Opinions 2015/16:

Audit Area	Audit Opinion	Committee Date
Financial		
Creditors	Substantial	April 2016
Debtors	Substantial	April 2016
Local Taxation	Substantial	April 2016
Benefits	Sufficient	April 2016
Payroll	Substantial	January 2016
IT		
IT Systems Administration	Limited	January 2016

Audit Area	Audit Opinion	Committee Date
Governance & Fraud Risks		
Fraud Risk Review	Sufficient	April 2016
Service Delivery		
Better Care Fund Monitoring *	Sufficient	April 2016
Care Act Implementation *	Sufficient	April 2016
Recruitment of Interims and Agency Staff	Sufficient	September 2015
Contract Procedure Rules Compliance	Sufficient	April 2016
Capital Allocations Programme Board	Sufficient	September 2015
Kerbside Collections	Sufficient	September 2015
Oakham Enterprise Park	Limited	January 2016
Demand Led Budgets	Sufficient	January 2016
External Care Placements	Limited	January 2016
Public Health Budgets	Sufficient	January 2016

* reports issued as draft and awaiting management responses before finalising.

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

3.2.3 At each Audit and Risk Committee meeting, full copies of any reports issued giving a Limited Assurance opinion are provided to Members. Details of actions taken by management to date to address the findings within these reports are provided in Appendix 1.

3.2.4 The Internal Audit Plan for 2016/17 includes 12 days for further review of all areas receiving Limited Assurance opinions during 2015/16 to provide assurance that actions have been taken and risks are being suitably managed.

3.3 Implementation of Internal Audit Recommendations

3.3.1 Internal Audit follow up on progress made against all recommendations arising from completed assignments to ensure these have been fully and promptly implemented. The Head of Internal Audit provides a summary at each Audit and Risk Committee on progress made and actions outstanding. Table 4 provides details of the implementation of recommendations made during 2015/16.

Table 4 - Implementation of Audit Recommendations 2015/16:

	Category 'High' recs	Category 'Medium' recs	Category 'Low' recs	Total
Agreed and implemented	10	34	17	61 **(72%)**
Not agreed (*risk accepted*)	0	1	4	5 **(6%)**
Agreed and not yet due for implementation	0	8	6	14 **(16%)**
Agreed and due within last 3 months, but not implemented	0	4	0	4 **(5%)**
Agreed and due over 3 months ago, but not implemented	0	0	1	1 **(1%)**
TOTAL	**10**	**47**	**28**	**85**

3.3.2 In addition to those actions which remain outstanding from the 2015/16 audit reports, a further four actions remain outstanding and overdue from 2013/14 and 2014/15 audit reports. A summary of all overdue recommendations is shown in Table 5:

Table 5 - Summary of Overdue Recommendations as at 31st March 2016

		High		Medium		Low	
Audit Title	**Audit year**	**Over 3 months**	**Under 3 months**	**Over 3 months**	**Under 3 months**	**Over 3 months**	**Under 3 months**
IT Service Desk, Asset Register & Licences	13/14	-	-	-	-	1	-
Disaster Recovery & Business Continuity	13/14	-	-	1	-	-	-
Agresso	14/15	1	-	-	-	-	-
Benefits	14/15	1	-	-	-	-	-
Kerbside Collections	15/16	-	-	1	-	-	-
Capital Allocations Programme Board	15/16	-	-	-	4	-	-
Totals		**2**	**-**	**2**	**4**	**1**	**-**

3.3.3 The level of implementation is reported to the Audit and Risk Committee throughout the year. Since April 2015, the Committee has also been provided with further details on the analysis of implementation and any high or medium priority actions which have been overdue for more than 3 months.

3.4 Internal Audit Contribution

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

3.4.2 Delivery of 2015/16 Audit Plan

The Council commissioned 370 days from the Internal Audit Consortium to deliver the 2015/16 Audit Plan.

The team delivered a total of **381** days to Rutland County Council during 2015/16. This involved delivery of the Audit Plan, client liaison, support, reporting, management and attendance at the Audit and Risk Committee.

By 5th April 2016, the team had delivered **100%** of the assignments within the 2015/16 Audit Plan to at least draft report stage. This excludes the review of Digital Broadband, for which it was agreed with senior management and the Chair of the Audit and Risk Committee, that there would be more value in issuing the report during 2016/17 as there has not been an opportunity during 2015/16 to review a number of the key controls such as the milestone to cash process, due to the stage of the project.

3.4.3 Internal Audit Contribution in Wider Areas

Key additional areas of Internal Audit contribution to the Council in 2015/16 are set out in Table 6:

Table 6 – Internal Audit Contribution

Area of Activity	Benefit to the Council
Membership of Governance Group and attendance at meetings.	To provide insight into governance arrangements and independent assurance, and to raise the profile of Internal Audit and governance in the organisation.
Audits of two schools against the Schools Financial Value Standard.	To provide assurance to the S151 Officer and Members on the adequacy and effectiveness of financial management in schools.
Independent verification of claims and ongoing support for the DCLG's Troubled Families Programme.	Assurance over the claims for outcomes achieved and the sharing of good practice on recording and assessing baselines and outcomes for the programme.
Maintaining good working relationships with External Audit so that Internal Audit work can be relied upon for the purposes of assisting them in forming their opinion on the Annual Accounts.	Reduce audit burden, saving costs.

4. Performance Indicators

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

Table 7 – Internal Audit KPIs 2015/16

Indicator description	Target	Actual
Delivery of the agreed annual Internal Audit Plan – Audit Days	370	381
Delivery of the agreed annual Internal Audit Plan to at least draft report stage by 31st March 2016	90%	95% (100% by 5th April 2016)
Customer Feedback – rating on a scale of 1 to 4 (average) Whereby: 1 = Poor, 2 = Satisfactory, 3 = Good and 4 = Outstanding	3.6	3.3

5. Professional Standards

5.1 The Public Sector Internal Audit Standards (PSIAS) were introduced in April 2013 and are intended to promote further improvement in the professionalism, quality, consistency and effectiveness of Internal Audit across the public sector.

5.2 The objectives of the PSIAS are to:

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

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

Appendix 1: Summary of Internal Audit Work Undertaken for 2015/16

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
Financial Systems			
Creditors	Substantial	To provide assurance that adequate controls exist to mitigate the key risks to the Council of the Creditor payment processes. Including: System access, segregation of duties between key tasks, setting up new suppliers, purchase requisitions, purchase order approval, goods receipting, invoice processing, compliance with policies, BACS/Cheque payments, urgent payments, aged creditor reviews and creditor control account reconciliations.	Sample testing of the purchase invoice process, credit notes, urgent payments, BACS payments, aged creditor reports and reconciliations all provided evidence of efficient, effective procedures and consistent compliance with key controls and Council policy. It was highlighted that 100% of invoices reviewed in sample testing were matched to a purchase order which had been approved on the Agresso system before the invoice date, a notable improvement on previous years. Improvements to the BACS payment process were also identified which have enforced a segregation of duties in the payment process, as recommended in the 2014/15 Creditors Audit report. Audit testing confirmed that detective controls were in place to identify unauthorised, fraudulent or inaccurate changes to supplier data and the preventative controls were being consistently applied. In sample testing, 100% of the changes to existing supplier bank details had been verified and evidenced in accordance with Council procedures. Testing confirmed that all purchase orders must be approved in accordance with the approval limits set on the Agresso system. It was highlighted, however, that four officers held approval limits on the Agresso system which were in excess of the authorisation limits delegated to them in the Financial Procedure Rules. This has since been addressed and there was no evidence that any orders had been approved by these officers in

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			2015/16 beyond their formally approved authorisation limits. A draft Agresso Disaster Recovery Plan was available for review dated 15th June 2014. This was incomplete and had not been updated to reflect changes in the staffing structure. The new Agresso recovery plan is expected to be developed as part of the Agresso system upgrade in 2016.
Debtors	Substantial	To assess whether the procedures for invoicing, receiving sundry income and collecting debt are adequately controlled and fit for purpose.	Internal Audit testing confirmed that sufficient guidance notes/procedures were in place to ensure the debtors function operated effectively. Sample testing of debtor invoices, credit notes, changes/new additions to customer standing data, debt recovery, cash allocation and reconciliations to the general ledger all demonstrated proficient, effective procedures and consistent compliance with Council policy. Bad debt write offs were also found to be compliant with established policy and delegations. Furthermore, records of all debt recovery actions taken to date – including actions regarding deferred debt agreements and suspense account payments - were easily located and suitably maintained. Two areas for improvement were identified in relation to Agresso user access and exception reporting. A review of users with 'create, update or delete' access to the debtors module within Agresso highlighted a number of segregation of duty conflicts which could potentially expose the Council to the risk of fraudulent activities. The risk of fraudulent activity taking place is however reduced as controls within the Debtors module require changes to invoices to be approved and the 'create, update or delete' access does not give the approval rights. Internal Audit

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			did not find any instances of misuse of access, non-compliance or fraudulent activity during testing but a recommendation was made to address this potential risk area. It was also noted that there was no practice of formally scrutinising changes to customer standing data. Under existing arrangements, data input onto the debtors system was not regularly reviewed for misapplications or human error. Further assurance could be gained from reviews of exception reports which could be produced directly from the Agresso system.
Local Taxation	Substantial	To provide assurance that the material risks associated with the collection and management of local taxes are sufficiently mitigated. Areas reviewed: System access controls Discounts and exemptions Recovery & enforcement proceedings Refunds & write-offs Performance management (i.e. collection rates)	Based on testing undertaken, the controls in respect of council tax collection and recovery were found to be sound, with well-established processes in place. Sample testing on the application of council tax discounts and exemptions confirmed that all were fully evidenced, accurately calculated and subject to review. Business rates controls were also operating effectively to ensure recovery of monies due. Sample testing of refunds and write-offs for both council tax and business rates debts found that all had been correctly processed and approved. It was highlighted that there was scope to further strengthen arrangements in respect of cases where council tax recovery action has been suspended; including ensuring charging orders are processed by legal services in a timely manner. System access controls could be further strengthened by ensuring that the manual record of system access rights, if retained as a key control, is periodically checked for consistency with the Civica system. Development of the interface and working relationship with the Customer Service Team is ongoing with plans in place

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			to improve supporting guidance, protocols and feedback mechanisms.
Benefits	Sufficient	To provide assurance that the controls surrounding the processing and payment of benefits are sound. The audit covered the following key control areas: System parameters Processing new claims Quality assurance Review of ongoing benefit BACS payments Reconciliations Identification & recovery of overpayments	Internal Audit found there to be clear and well established procedures for processing of claims and recovery of overpayments. Staff within the Revenues and Benefits Team are highly experienced and knowledgeable. Sample testing provided assurance that claims were complete, supported by appropriate evidence and accurately input onto the benefits system, with only minor immaterial exceptions. All reconciliations were completed in a timely and accurate manner. It was highlighted that arrangements for the management and evidencing of periodic review of ongoing claims could be strengthened and there was scope to improve record keeping in some areas. Lack of separation of duties in relation to the processing of BACS payments was raised in the 2014/15 audit and progress had recently been made in addressing the technical constraints. From February 2016, an appropriate segregation of duties should be enforced for the BACS payments and the implementation of this control is subject to follow up review by Internal Audit.
Payroll	Substantial	To provide assurance over the key internal controls operating to ensure: Payroll payments to employees are accurate, timely and secure and an appropriate audit trail is available;	A full review of user accounts and permissions on the payroll system was underway at the time of testing. Whilst the Internal Audit testing of payroll system user access highlighted examples of temporary Payroll staff for whom access rights had not been revoked, all issues highlighted were promptly addressed by management and the full review should ensure that all permissions remain up-to-date and appropriate.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		Payments to HMRC are timely and accurate to avoid penalties; Payroll data recorded in the financial system is correct so that the Council's financial accounts are accurate and reliable; and Access to payroll data is appropriately restricted to avoid inappropriate access and potentially exposing the Council to fraudulent activities.	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. 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.
Financial Governance and Transparency	N/A	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 followed when publishing information on budget setting, budget monitoring and financial	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

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		performance. This was a joint benchmarking review which was delivered concurrently to Rutland County Council, Melton Borough Council and East Northamptonshire District Council. The data published by the five Welland authorities, plus an additional five authorities, was reviewed to provide meaningful comparative information.	were found to be easily accessible and up to date. For these reasons, Internal Audit assessed the Council as providing a **High** level of transparency relating to its budget setting and monitoring. The Council demonstrated **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.
Community Care Finance – Deputyships & Court of Protection - Limited Assurance Follow Up	N/A	To assess how far management have implemented agreed actions from the Limited Assurance report issued in 2014/15, and validate this through a review of evidence, as appropriate. To gain assurance that risks associated with the internal control issues are being addressed.	Documented procedure notes for the management and administration of client finances are almost complete. There are now three individuals within the Council that have the knowledge to perform the deputyship role allowing for appropriate cover in case of staff absences. All payments require signatures of two of these officers, which ensures that any payments proposed are subject to a secondary check. A standard electronic indexing system has been developed to enable the retention and retrieval of clients' financial documentation. Each client file holds scanned copies of bank

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			statements, a cash book recording all income and expenditure and a number of folders containing scanned receipts and/or invoices as evidence to support transactions. Money can be issued from the clients' accounts to carers and care homes to cover the costs of the service users' daily living needs. Such expenditure is of low value and the Council would typically issue cheques up to a maximum of £200 at a time. Home carers are now required to provide an itemisation and copies of receipts to support all service user expenditure, however care homes have not consistently provided a breakdown of spend with copies of receipts/invoices and further work is planned to ensure this takes place and spot checks are carried out. For Deputyship arrangements where a client is able to spend their own money, changes have been made so that clients no longer hold cheque books. These clients now have two bank accounts, one for bills and one for personal spending. The client only has a debit card for the personal spending account (i.e. food / clothes shopping) and a set amount of cash is transferred to this account by standing order on a weekly basis. This change allows to client have independence but controls the amount that is being spent and allows the Council to easily track client expenditure and ensure that all required bills are paid.
IT			

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
ICT Systems Administration	Limited	To provide assurance that the Council has put in place controls to ensure that it has an effective IT 'system administration' function for both the network and the business critical / sensitive applications.	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 was also in place to notify the IT team of leavers so access could be promptly revoked. Some controls were highlighted which required 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 were 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 who still had live access to the Council's network resulting in a risk that Council records could be reviewed and altered from remote locations. At the time of testing, the Council did not have an IT Change Management methodology and event logs of actions by network

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			administrators were not available. Network performance was also not recorded, monitored or reported. Testing of three Council systems determined that System Administrators were aware of their responsibilities and that they had 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 were not notified of leavers from the Council resulting in a risk that access was 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 were promptly revoked. **Update - all actions arising from this audit report have since been implemented. Including:** • **introduction of a Change Control policy and procedure;** • **the procurement of software to enable audit reports to be produced detailing any changes to the Active Directory;** • **comparison of the HR staff list and the IT directory of users was undertaken 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;** • **remote access list was reviewed to ensure all with**

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			remote access rights are valid employees; • **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; and** • **where possible, the performance of the network will be monitored on an ongoing basis.**
Governance and Fraud Risks			
Fraud Risk Review	Sufficient	To provide assurance that the Council is identifying areas vulnerable to fraud and that mitigating actions are being taken to effectively manage the Council's exposure to these risks.	The process followed to develop the fraud risk register included reference to national guidance and trends, was conducted by professionally qualified and experienced senior officers and resulted in the identification and recording of 32 key risks affecting various council services and including frauds which could be committed internally and externally. The process included consultation with the senior management team and each risk was given an 'owner' and the controls operating to mitigate each risk were identified and further actions required to address the risks were recorded. In order to provide assurance over the management of the identified risks, a sample of these have been reviewed to confirm that the stated controls are operating consistently and effectively and that any actions agreed on the register have been implemented. A number of areas of good practice were identified including robust controls to mitigate the risk of recruitment fraud and fraudulent changes to supplier bank account details. It was highlighted that, whilst a number of key fraud risks have been recorded on the fraud risk register and suitable controls

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			and innovative further actions have been identified, the register has not been subject to regular review to confirm that these remain complete and up-to-date and that actions have been implemented. The Register is on the Audit and Risk Committee forward plan for formal, annual review in April 2016 but, in order to maximise the value of the fraud risk register, this should be subject to more regular management review and updates to reflect any new and emerging risks/national trends. It was noted that some of the actions recorded on the fraud risk register were yet to be implemented and some further areas for improvement to ensure the existing controls are fit for purpose have been highlighted during audit testing.
Service Delivery			
Better Care Fund (BCF) Monitoring	Sufficient * Issued as Final Draft report	To provide assurance that the Council's overall governance arrangements for managing the Better Care Fund (BCF) programme are sound and to verify the reported performance and spend for a sample of projects.	Testing confirmed that there were clearly established governance structures, roles and responsibilities for management and control of the BCF programme. A formally approved plan was in place together with detailed business cases for each project and a comprehensive pooled budget (section 75) agreement. Overall performance metrics had been clearly specified and RAG (Red/Amber/Green) rated performance 'dashboards' provided an informative picture of overall progress and performance at programme level. There was potential to further strengthen the existing governance arrangements by incorporating a more detailed timeline and milestones for the overall programme and individual projects together with regular monitoring and reporting of key risks. Arrangements for the management of individual projects were

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			generally sound. Each scheme had a nominated lead officer and progress and performance was being reported on a monthly basis. Testing of a sample of projects identified some inconsistencies between the outcomes and metrics in the original project documentation and the project 'highlight' reports. Financial management arrangements were clearly set out in the section 75 agreement and costs and forecasts are regularly reported to the partnership board. Testing confirmed that reported costs were consistent with the underlying records although arrangements for verifying costs incurred by East Leicestershire and Rutland Clinical Commissioning Group (EL&R CCG) have not yet been formalised.
Care Act Implementation	Sufficient * Issued as Draft Report	To review the implementation and embedding of the revised policies and procedures following the introduction of the Care Act in April 2015.	Council policies and procedures for adult social care have been reviewed and updated to ensure compliance with the Care Act. They have been designed well and the Council has processes in place to ensure that up to date information and guidance is available to staff and the public. Generally, Internal Audit review and testing confirmed Care Act compliant processes to be fully embedded into day to day operations, including personalisation of assessments, service user eligibility and ensuring continuity of care when an individual moves between areas. Some areas were highlighted where audit trails and documentary evidence could be strengthened to ensure consistency, particularly in relation to needs assessments and care and support plans. Providing refresher training to staff on Care Act compliant procedures was also highlighted as an area for improvement as well as setting out clear timescales,

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			milestones and activities on how the Council intends to shape the market place for adult social care.
Recruitment of Interims and Agency Staff	Sufficient	To review how the Council's revised procedures for recruitment of Interims and Agency staff were being applied to ensure that all employment regulations were complied with and value for money is achieved. Included review of: Policies and procedures; Recruitment approvals; Pre-recruitment checks; Interim/Agency Staff records; and Management reporting.	The Council's Senior Management Team (SMT) had agreed standard protocols and processes for recruiting interims and agency staff to ensure that all appropriate checks have been undertaken. Internal Audit sample testing highlighted, however, that these processes had not been consistently applied. Whilst line managers were able to provide reasonable justification for recruiting interim staff, the Council was unable to demonstrate a suitable audit trail to confirm this. The introduction of a formal 'Approval to Recruit' form would ensure that justification is documented, clear accountability can be evidenced and the Council is provided with sufficient data to carry out a root cause analysis to determine why temporary agency cover is required. For recruitment to permanent posts, the Council policy requires the Chief Executive to approve all posts before advertising. It is noted that there is a different employment relationship between the Council and interim/agency staff compared to substantive posts. The Council uses software (Agresso HR) for recording agency/interim worker details, however testing highlighted potential scope to further develop this system into a database for recording and retaining all correspondence and documentation in a secure central location.
Contract Procedure Rules Compliance	Sufficient	The audit focused on compliance with CPRs across all departments and specifically	The current Contract Procedure Rules (CPRs), guidance, tools and templates were confirmed as all available and accessible from a single intranet page and training on the revised rules was

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		contracts let since the implementation of the 2015 regulations. Review of contract management arrangements focused on the Resources Directorate only as other directorates had been subject to recent audit of contract management arrangements. The audit did not review whether Contract Procedure rules/related guidance notes and documentation were fit for purpose as work was already ongoing in this area led by the Team Manager (Procurement & Contract Management) and supported by a governance sub-group.	provided to key officers in July 2015. The Council publishes its departmental contract registers on a quarterly basis listing all contracts over £5,000. However, comparison of the contract registers with the published list of expenditure over £500 indicated that the contract registers may be incomplete. Moreover, testing of contracts selected from both sources identified non-compliance with certain aspects of contract procedure rules in each case, which ranged from basic poor record keeping to non-compliance with advertising requirements. It should be noted that in all non-exempt cases there was evidence of some form of competition and no evidence of fraud or corruption was identified. The Council must ensure, however, that these procedures are consistently applied to minimise the risk of challenge on the fair and transparent procurement of goods and services. An audit on wider compliance with CPRs has been included in the draft Internal Audit Plan for 2016/17 to provide assurance over this risk. Review of compliance with the contract management aspects of contract procedure rules within the Resources directorate found full compliance with all requirements.
Kerbside Collections (TEEP Compliance)	Sufficient	Internal Audit has reviewed controls in respect of the following key risks: the methodology applied in assessing compliance with the new TEEP regulations is flawed or not sufficiently robust to avoid challenge; and evidence and	The Council had undertaken an assessment of its current waste collection methodology and concluded that the existing comingled collection system was compliant with the regulations. The Council's initial assessment was conducted prior to the publication of detailed guidance and was developed based on officers' interpretation of the regulations. The assessment was reviewed and considered to be rational and proportionate and

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		information used as part of the assessment is unclear, inaccurate or insufficiently robust to support the overall conclusion.	covered all key aspects of the TEEP requirements. The assessment could have been strengthened further with the inclusion of more evidence regarding the quality of recycled materials and ensuring a full and detailed audit trail to all supporting information and data.
Oakham Enterprise Park	Limited	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.	Since opening for business, the demand for this site has exceeded expectations with existing local businesses and new businesses to Rutland requiring units. 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. Internal Audit recognised that the Council had taken positive steps to improve the controls over the tenancy application process for prospective tenants. Tenants' credit, trade reference, age (to ensure they are over 18 and thus legally entitled to hold a lease) and citizenship checks had 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. A 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

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			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 occupied 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 was being recovered in a structured, timely manner and payments plans had been put into place where required. However, on occasions it was noted that cash payments had been 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 was promptly addressed and rent is only accepted by cheque or BACS with most tenants now paying by standing order. **Update – All actions due for implementation have been completed. Only one low risk recommendation due 31st March 2016 remains open.** **Completed actions include:**

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			- **Cash payments for rent have now ceased.** - **Lease agreements are independently reviewed by the Estates Surveyor prior to signing to ensure there are no errors and they are commercially viable.** - **Copies of all Heads of Terms are saved in the appropriate unit folder on the shared network for reference and ID verification is now in place for all tenants. A copy of official photo ID is taken, scanned and saved electronically.** - **A signed lease agreement is on file for all currently let units within the Oakham Enterprise Park.** - **All leases are accompanied by a rent deposit deed prepared by Legal Services and rent reviews are explicitly detailed within the lease template.** - **A commercial tenancy selection policy has been agreed and documented.** - **Training on fraud, bribery and money laundering has been arranged by Corporate Services and is scheduled for 11th May 2016. This will be attended by a number of staff from OEP and Property Services.**
Demand Led Budgets	Sufficient	To provide assurance that appropriate controls are in place to ensure that the Council is doing all it reasonably can to control, monitor and predict demand led social care	Based upon a review of 20 areas of expenditure, there was a high level of compliance with the Council's established budget monitoring procedures. There were clear communication channels in place to highlight emerging pressures. Quarterly finance reports were submitted to Cabinet and provided appropriate commentary on emerging issues related to demand

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		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.	led budgets. Commitment records were in place for a number of the services examined. The Council was also developing processes to ensure correlation between the services provided, commitment records and budgets. 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 could be made to improve the reliability of demand led budget setting and expenditure forecasting. There were some inaccuracies within expenditure commitment records, particularly in Adult Social Care, whereby the forecast expenditure was not consistent with the latest approved care package. Furthermore, there was scope to improve the budget setting process by adopting a 'zero based' approach. It was acknowledged that management had already initiated actions to address some of these issues.
External Care Placements	Limited	To review the Council's procedures for purchasing external social care placements. To provide assurance over the processes in place to ensure value for money is achieved, and subject to ongoing assessment, and that contract management is robust.	At the time of audit, a Head of Commissioning had been appointed and tasked with developing a strategic approach to all commissioning activity within the department. 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 had been drafted at the time of review but was yet to be finalised, formally adopted and fully implemented. The draft policy included a requirement for specialist procurement input into the commissioning process

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		Audit testing focused on the following areas: SEN; Disabled children residential care; Learning disability residential care; and Older people residential care.	which, if implemented, would help to ensure value for money and provide additional safeguards through separation of duties. Evidence to demonstrate the achievement of value for money (VFM) needed 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 needed to be clarified and strengthened, particularly in relation to out-of-county and educational placements. It was highlighted that there were 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. **Update – the Deputy Director (People) is due to provide details on progress made in addressing the findings at the Audit and Risk Committee meeting in April 2016.**
Public Health Budgets	Sufficient	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 highlighted a number of examples of good governance. Contracts for provision of Public Health services were entered into only on approval of RCC. A Public Health Steering Group was in place, attended by representatives of RCC and the LCC Public Health department, and LCC Public Health representatives attended RCC People Directorate Departmental Management Team (DMT) meetings. Appropriate contract and performance management frameworks were found to be in place. Sample testing of 20 Public Health transactions confirmed that in 19 cases the expenditure was in accordance

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			with the Public Health grant terms and conditions. The remaining case was discussed with officers and resolved. The audit review also identified a number of areas in which further improvements could be made to ensure that future commissioning activity meets the needs of Rutland. Furthermore, there was 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.
Safe Driving at Work – Limited Assurance Follow Up	N/A	To assess how far management have implemented agreed actions from the Limited Assurance report issued in 2014/15, and validate this through a review of evidence, as appropriate. To gain assurance that risks associated with the internal control issues are being addressed.	Proposed safety standards for driving and riding at work were presented to the Joint Safety Committee (JSC) with a view to incorporation into the corporate Health & Safety policy framework. At the time of Internal Audit's follow-up the safety standards had not yet been formally adopted and were not easily accessible on the intranet. A corporate safe driving procedure was approved by Senior Management Team (SMT) in July 2015 and JSC in October 2015. It has been decided not to adopt the procedure as a formal corporate policy but to incorporate it into section 17 (Health & Safety) of the staff Code of Conduct with a cross reference to the safety standards referred to above. The procedure is due to be finalised and a separate section of the intranet has been created ready to go 'live' when the procedure is launched. The procedure will be presented at two policy briefings for Managers – 14th May and 17th May. An all staff email will be sent after the manager briefings and an article put in One Council.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			The need for driver training has been considered with the associated costs being balanced against risks. Management have concluded that driver training is only required in a small number of cases where service users are being transported. A driving at work risk assessment is to be provided to line managers for completion to identify drivers who regularly transport service users and appropriate training will be organised commensurate with risk.

Appendix 2: Self-Assessment against the Public Sector Internal Audit Standards (PSIAS) April 2016

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

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						All audit planning records are approved by the Head of Internal Audit before work commences.
	1230	Continuing Professional Development	✓			Staff attendance at training and development opportunities. All Audit Managers must satisfy professional body CPD requirements.
1300 – Quality Assurance & Improvement Programme	1310	Requirements of the Quality Assurance and Improvement Programme	✓			External assessment completed in 2013 and annual internal self-assessment conducted by Head of Internal Audit, which is included in the Annual Report.
	1311	Internal Assessments	✓			Ongoing monitoring of performance at monthly individual supervision meetings, team meetings and post audit completion discussions. Customer Satisfaction Questionnaires (CSQs) requested from clients for each assignment and responses summarised for Audit Committees. Head of Internal Audit meets with senior management on regular basis and seeks feedback on value of the Internal Audit service and areas for development.
	1312	External Assessments	✓			External assessment conducted in 2013 by independent, professional company to assess against compliance with PSIAS. No further external assessment due until 2018.
	1320	Reporting on Quality Assurance and Improvement Programme	✓			The outcome of the external assessment and progress against the resulting improvement plan were reported to the Welland Board (where all Welland S151 officers are members) and to Audit Committees. All actions from the improvement plan were signed off by the Welland Board. Annual self-assessment against PSIAS included

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						within Head of Internal Audit's Annual Report – to be presented to the Welland Board and Audit Committees.
	1321	Use of 'Conforms with the International Standards for the Professional Practice of Internal Auditing'	✓			Based upon completion of improvement plan and ongoing assessment and quality assurance processes, results support compliance with Standards and Code of Ethics.
	1322	Disclosure of Non-conformance	✓			Instances of non-conformance identified in 2013 were reported to the Board and Committees following the external assessment. Progress against the improvement plan to address all areas of non-conformance was reported to Committees and management until all actions were signed off.
2000 – Managing the Internal Audit Activity	2010	Planning	✓			Process for development of risk based audit plans was presented to each Audit Committee for approval. Plans were developed with input from senior management and Committee members. Audit planning process is documented in Internal Audit Charter.
	2020	Communication and Approval	✓			Any changes to the approved Audit Plans during the financial year are communicated to the Audit Committee and subject to agreed approval mechanisms in accordance with the delegated decision making arrangements.
	2030	Resource Management	✓			Resources reviewed on an ongoing basis to ensure these are appropriate, sufficient and effectively deployed. Team includes four professionally qualified, experienced Audit Mangers. Any concerns on adverse impact on provision of the audit opinion would be raised by the Head of Internal Audit in Annual Report.

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
	2040	Policies and Procedures	✓			Audit manual, charter and practice notes revised as part of improvement plan to ensure compliance with Standards.
	2050	Coordination	✓			Other sources of assurance are considered and reviewed as part of the Audit Planning process to avoid any duplication with other assurance providers.
	2060	Reporting to Senior Management and the Board	✓			The Head of Internal Audit attends meetings with senior management and Audit Committees on a regular basis. Progress reports are presented at every Audit Committee meeting and details of assurance levels are provided with focus upon those of Limited Assurance opinions. The content of the progress reports was reviewed during 2015 and the Audit & Risk Committee now receives a detailed breakdown of the implementation of audit actions and full details of all actions which have been overdue for more than three months and classed as 'high' or 'medium' priority. The Committee also now receives the full Executive Summary of all audit reports finalised during the period and full audit reports for any assignments receiving a rating of Limited or No Assurance.
2100 – Nature of Work	2110	Governance	✓			Audit team provides independent advice on drafting of governance related policies and attends governance groups, where applicable. Audit findings on risks and controls are presented to the Audit Committee and senior management with recommendations on areas for improvement. As appropriate, the Internal Audit team contributes to

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						the development of the Annual Governance Statement. IT Governance reviews included in rolling IT Audit plan.
	2120	Risk Management	✓			Internal Audit refer to the organisation's risk registers during Annual Planning exercises and provide training to committee members on risk management and the 'three lines of defence' to support effective review. Risks relating to the organisation's governance, operations and information systems, as well as fraud risks, form part of individual audit assignments, as stated in the audit planning records and audit reports. The Internal Audit planning process for 2016/17 included review of risk management systems and procedures and as stated in the PSIAS 'Internal Audit gather the information to support this assessment during multiple engagements The results of these engagements, when viewed together, provide an understanding of the organisation's risk management processes and their effectiveness'. As such, the outcome of the various risk based assignments within the Audit Plans provide an understanding of the effectiveness of the Council's risk management procedures which can be raised with senior management and the Committee. Auditors are alert to other significant risks when undertaking any consulting engagements and give

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

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

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

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						Committee members by requesting from the Head of Internal Audit or Section 151 Officer. Copies are provided to the Chair of the Audit Committee where agreed with the specific committee. The progress reports presented at each committee meeting include the outcome of each assignment, in relation to the assurance rating and the key matters arising.
	2450	Overall Opinions	✓			The Head of Internal Audit provides an annual Internal Audit opinion which can be used to inform the Council's governance statement. This report includes an opinion, a summary of work that supports that opinion and a statement on conformance with PSIAS.
	2500	Monitoring Progress	✓			There is an established process in place at each of the councils within the Consortium for the follow-up of progress made by management in implementing the agreed actions arising from audit reports. Internal Audit monitor and report to the Committee on the progress made. The content of the progress reports was reviewed during 2015 and the Audit & Risk Committee now receives a detailed breakdown of the implementation of audit actions and full details of all actions which have been overdue for more than three months and classed as 'high' or 'medium' priority. The Committee also now receives the full Executive Summary of all audit reports finalised during the period and full audit reports for any assignments

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						receiving a rating of Limited or No Assurance.
	2600	Communicating the Acceptance of Risks	✓			Where an identified risk is accepted by management this is reflected in the audit report. Where the risk is subsequently accepted because the agreed action is no longer feasible this would be discussed with senior management and details and context would be reported to the Committee. If the Head of Internal Audit had concerns about the level of risk accepted by management this would be reported to the Committee.

Conclusion

Based upon the self-assessment completed by the Head of Internal Audit on 4th April 2016, the Welland Internal Audit Consortium is operating in general conformance with the Public Sector Internal Audit Standards (PSIAS).

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Report No: 92/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 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 review and approve the Internal Audit Plan for 2016/17. 2. That Members give authority to the Assistant Director – Finance to make changes to the Audit Plan 2016/17 in consultation with the Chair of the Audit & Risk Committee. 3. That Members review and approve the Internal Audit Charter.

1 PURPOSE OF THE REPORT

1.1 To seek the Committee's approval of the Internal Audit Plan for 2016/17 and the Internal Audit Charter, in line with the Public Sector Internal Audit Standards.

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

Audit Plan.

2.3 Appendix A provides details on the process followed to develop the Internal Audit Plan for 2016/17 and a copy of the draft Plan is provided in Table 1.

2.4 At the January 2016 meeting, Members of the Audit and Risk Committee were invited to highlight any areas where assurance from Internal Audit is sought during 2016/17 for inclusion and prioritisation in the development of the Audit Plan. The areas raised by the Committee have been considered and risk assessed in the development of the Plan and all have been included with the exception of Blue Badge fraud which was assessed as lower risk than the other assignments at this time. The Plan will remain subject to ongoing review during the year and amendments to reflect any changes in the risk environment can be made accordingly.

2.5 To ensure that the Internal Audit activities are consistently focused upon the Council's key risks, the plan will remain subject to ongoing review by the Head of Internal Audit throughout the year and will be subject to regular consultation with senior management. To enable the Internal Audit team to be responsive and amend the planned activities to address any new or emerging risk areas as required, it is recommended that a mechanism be agreed to allow for changes to the Audit Plan between Audit and Risk Committee meetings. Any such amendments could be subject to formal approval by the Assistant Director - Finance and the Chair of the Audit and Risk Committee and would be reported at the subsequent Audit and Risk Committee meeting.

2.6 **Internal Audit Charter**

The Public Sector Internal Audit Standards (PSIAS), define the internal audit charter as 'a formal document that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the chief audit executive's functional monitoring relationship with the board; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities'.

2.7 The Head of the Welland Internal Audit Consortium has undertaken an annual review of the Charter for the new financial year to confirm that this remains fit for purpose and compliant with good practice and the Public Sector Internal Audit Standards. No material changes have been made to the document or the audit approach following this review. The only minor changes proposed are:

- To include a mission statement for the Internal Audit service – 'to enhance and protect Rutland County Council's organisational value by providing risk-based and objective assurance, advice and insight'; and
- To amend the reference to the Audit Manager discharging some of the responsibilities of the chief audit executive, to reflect that these will usually be undertaken by the Head of Internal Audit but can be undertaken by the Audit Manager if required.

2.8 A copy of the updated Charter is provided in Appendix B. All proposed amendments are shown as tracked changes.

3 CONSULTATION

3.1 No external consultation is required but, as noted above, senior management and the Audit and Risk Committee have been involved in developing audit proposals for 2016/17.

4 ALTERNATIVE OPTIONS

4.1 Members are able to approve the plan as presented in Appendix A or approve it with amendments.

5 FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising from this report. The Audit Plan has been 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 draft Internal Audit Plan for 2016/17 has been developed following a risk based approach, with input from Senior Management and the Audit and Risk Committee. The Plan is presented to the Audit and Risk Committee for final refinement and formal approval.

10.2 The Internal Audit Charter is presented to Members for review and approval.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

12.1 Appendix A: Draft Internal Audit Plan 2016/17

12.2 Appendix B: Internal Audit Charter

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

Appendix A: Internal Audit Plan 2016/17

the Welland Internal Audit Consortium

Internal Audit Plan

2016 / 17

RUTLAND COUNTY COUNCIL

Head of Internal Audit: Rachel Ashley-Caunt

INTERNAL AUDIT PLAN 2016/17

1. Introduction

1.1 This report sets out the proposed work of Internal Audit at Rutland County Council for 2016/17 for review and approval by the Audit and Risk Committee.

1.2 Internal Audit provides independent assurance designed to add value and support the Council in achieving its priorities and objectives. To deliver this, Rutland County Council commissions 370 days from the Welland Internal Audit Consortium on an annual basis.

1.3 The provision of assurance services is the primary role for Internal Audit in the UK public sector. This role requires the Head of Internal Audit to provide an annual Internal Audit opinion based on an objective assessment of the framework of governance, risk management and control.

1.4 Internal Audit also provide consultancy services which are advisory in nature and are generally performed at the specific request of the organisation, with the aim of improving governance, risk management and control and contributing to the overall opinion.

1.5 In setting the annual Audit Plan, the Public Sector Internal Audit Standards require:

- The audit plan should be developed taking into account the organisation's risk management framework and based upon a risk assessment process undertaken with senior management and the Audit Committee;
- The audit plan should be reviewed and approved by an effective and engaged Audit Committee to confirm that the plan addresses their assurance requirements for the year ahead; and
- The Head of Internal Audit should consider accepting proposed consulting engagements based on the engagement's potential to improve management of risks, add value and improve the organisation's operations. Accepted engagements must be included in the plan.

2. The Audit Plan

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

- An assessment of the design and operation of the underpinning Governance, Assurance and Risk Frameworks and supporting processes; and
- An assessment of the range of individual opinions arising from the risk based assignments, which will be reported throughout the year.

2.2 Other Sources of Assurance

In forming this opinion, the Head of Internal Audit can also consider other appropriate sources of assurance available. Other independent assurance

providers also produce reports that provide assurance over key service areas and risks. These may include external bodies such as OFSTED, external audit, Care Quality Commission, peer reviews, Information Commissioner's Office, RIPA compliance inspections and HMRC. Furthermore, there are internal sources of assurance provided by senior management including quarterly finance and performance reporting.

As such, in developing the Audit Plan, any other potential sources of assurance in relation to the identified risks have been considered and work will be aligned with these other assurance providers to ensure the Internal Audit resource is focused upon areas where value can be added and the use of all assurances is maximised.

3. Planning Process

2.3 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 has identified and prioritised the areas for coverage by:

- Reviewing the Council's Risk Registers and corporate objectives;
- Analysing coverage of Internal Audit reviews over the last four years and the assurance opinions provided following each review, to identify any assurance gaps or areas where follow up work would be of value;
- 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 and where work could be aligned with other assurance providers;
- Identifying any areas of the Audit Universe (a list of potential areas for audit review across the Council) which have not been subject to Internal Audit review during the last four years;
- Consultation with the Audit and Risk Committee at the January 2016 meeting to discuss the planning process and areas where Members require assurances from Internal Audit during 2016/17; and
- Meetings with each member of Senior Management Team to discuss key risks and emerging risk areas for the year ahead and any areas where Internal Audit support would be beneficial either in an assurance or consultancy role.

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

2.5 Following this consultation and review, a Draft Internal Audit Plan has been compiled and is provided in Table 1.

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

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

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

2.7 In order to ensure the Audit Plan addresses the Council's key risks and that the service is able to respond to any in year changes to the organisation's business, risks, operations, programs or systems, it is vital that the content of the Plan be subject to ongoing review throughout the financial year. To enable the service to be responsive and ensure all audit resources are used effectively and add maximum value, it is recommended that arrangements be agreed to allow changes to the Plan to be made between Audit and Risk Committee meetings, involving consultation between the Head of Internal Audit, the S151 Officer and the Chair of the Committee.

3 Resources

3.1 The Welland Internal Audit Consortium provides the Internal Audit function for five local authorities (Corby Borough Council, Harborough District Council, East Northamptonshire Council, Melton Borough Council and Rutland County Council).

3.2 Since August 2014, the Head of Internal Audit has been provided by LGSS (Local Government Shared Services) under a management arrangement with the Consortium. This provides the Consortium with additional resilience and the benefit of shared practice and experience from the wider LGSS client base. This arrangement is formally agreed until 31st March 2017.

3.3 The audit assignments for all of the Welland authorities are delivered by a team of audit staff including a mix of highly regarded professional qualifications (including ACCA, CIPFA and IIA) and extensive experience in the public and private sector. In the last twelve months the Consortium has established a Trainee Auditor post to develop and train new audit staff and a new trainee joined the team on 4th April 2016. One existing member of the team is also due to undertake final stage exams in 2016 for the Institute of Internal Auditors (IIA).

3.4 Absences and resource gaps/vacancies are currently filled by buying in external resources, mostly through the Consortium's connections with LGSS. The current vacancies will be reviewed during 2016/17 and the most cost effective and reliable option for filling these will be discussed with the Consortium Board.

3.5 Efforts are constantly made to ensure all clients benefit from the shared service arrangement. This includes achieving efficiencies in delivering assignments, sharing of knowledge and experience and opportunities to deliver cross-cutting reviews.

3.6 On an annual basis, the Head of Internal Audit completes a self-assessment of the Internal Audit service against the Public Sector Internal Audit Standards. In doing so, the Head of Internal Audit must consider whether the resource base and mix is adequate and would highlight to the S151 officer and Members if there were any concerns that the resources in place could not provide the required coverage to inform the annual Assurance Opinion.

Table 1: Draft Internal Audit Plan 2016/17

Assurance Area	Audit Assignment and Potential Coverage	Proposed days	Planned Quarter	Strategic Risk Ref
Finance	**Key Financial Controls:**			
	Debtors	**14**	**3 or 4**	
	Creditors	**14**	**3 or 4**	
	Payroll	**15**	**3 or 4**	
	Main Accounting	**12**	**3 or 4**	
	Local Taxation	**15**	**3 or 4**	
	Benefits	**15**	**3 or 4**	
	Financial System upgrade:			
	Consultancy support in design phase - to ensure controls are suitably enforced in new system, changes to access rights are appropriate and identify potential flaws before sign off.	**15**	**As required**	
	Systems Administration - to provide assurance over the administration of the Agresso system following the upgrade.	**12**	**3**	**Risk 11**
Counter Fraud	**Council Tax and NDR Fraud** To provide assurance that effective and proportionate controls are operating to prevent and detect Council Tax and NDR Fraud and that these are being consistently applied.	**12**	**3**	**Risk 11**
Service Delivery	**Highways Maintenance Contract** To provide assurance over the effective management of this key, £3 million contract. Potential to undertake an open book review, if possible.	**20**	**1**	**Risk 11**
	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 compliance with good practice and relevant legislation.	**15**	**2**	**Risk 4**
	Contract Procedure Rules (CPR) compliance To provide assurance over compliance with the Council's procurement rules across the organisation through sample testing	**10**	**3**	**Risk 11**
	Taxi Licensing To provide assurance that licences are granted to applicants that satisfy the relevant conditions and in accordance with Council policy and procedures.	**15**	**1**	**Risk 4** **Risk 11**

Assurance Area	Audit Assignment and Potential Coverage	Proposed days	Planned Quarter	Strategic Risk Ref
Service Delivery	**Section 106 Agreements** To provide assurance over the controls in place for collection of income, legal agreements, monitoring of existing agreements and clawbacks.	**15**	**2**	**Risk 7**
	Safeguarding Policies and Procedures and Compliance To provide assurance that controls are being exercised consistently and in accordance with Council procedures, including case audits, escalation processes and awareness of safeguarding procedures.	**20**	**3**	**Risk 4** **Risk 5**
	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.	**15**	**2**	**Risk 7**
	Data Management To provide assurance over the Council's procedures and controls to ensure data is held and disposed of securely and in compliance with the Data Protection Act.	**15**	**2**	**Risk 11**
	LiquidLogic To provide assurance over the new social care system including its administration and to conduct a post implementation review of the project.	**15**	**TBA**	**Risk 4** **Risk 5**
	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.	**5**	**1**	**Risk 11**
	Limited Assurance Reports There were a number of audits in 2015/16 which resulted in 'Limited' opinions. In all cases action plans were agreed to resolve issues raised. This review will report on the updated status of those action plans.	**12**	**4**	**Risk 11**
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.	**12**	**3**	**Risk 11**
	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.	**10**	**4**	**Risk 11** **Risk 3**

Assurance Area	Audit Assignment and Potential Coverage	Proposed days	Planned Quarter	Strategic Risk Ref
Support	**Support to Rutland County Council** - to include Committee meeting preparation and attendance, Committee liaison and development, senior management support and engagement, Annual Report, work with External Auditors, queries and ad-hoc support, support on National Fraud Initiative and Annual Governance Statement, strategic management, development of the annual Audit Plan.	**33**	**-**	
	Management of the Welland Internal Audit Consortium – to include Joint Committee work and attendance, Consortium Board reporting and attendance, development and training of the Internal Audit team, staff supervision and appraisals, budget monitoring.	**34**	**-**	
	Total Days Commissioned	**370**		

Appendix B: Internal Audit Charter

Internal Audit Charter

Purpose

This Charter formally defines the purpose, mission, authority and responsibility of the Welland Internal Audit Consortium (the Consortium) within Rutland County Council and outlines the scope of the Consortium's internal audit work.

The Audit Charter complies with the mandatory requirements of the Public Sector Internal Audit Standards (The Standards).

Definitions

The Standards set out the requirements of a 'Board' and of 'senior management'. For the purposes of the internal audit activity within Rutland County Council, the role of the Board within the Standards is taken by the Council's Audit & Risk Committee and senior management is the Council's Senior Management Team

Role

Internal Audit is a statutory service in the context of The Accounts and Audit (England) Regulations 2011, which state:

> *6.—(1) A relevant body must undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control.*

Also, The Local Government Act 1972, Section 151, requires every local authority to designate an officer to be responsible for the proper administration of its financial affairs. In Rutland County Council, the Assistant Director - Finance is the 'Section 151 Officer'. One of the ways in which this duty is discharged is by maintaining an 'adequate and effective internal audit service'.

Internal Audit is defined by the Public Sector Internal Audit Standards as:

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

Mission

The Welland Internal Audit Consortium's mission is to enhance and protect Rutland County Council's organisational value by providing risk-based and objective assurance, advice and insight.

Professionalism

The Consortium will govern itself by adherence to the mandatory guidance published by Chartered Institute of Public Finance Accountants (CIPFA) and the Chartered Institute of Internal Auditors' (IIA) including the Definition of Internal Auditing, the Code of Ethics, and the Public Sector Internal Audit Standards. This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of internal auditing within the public sector and for evaluating the effectiveness of the Consortium's performance.

The IIA's Practice Advisories, Practice Guides, and Position Papers and any corresponding publications from CIPFA will also be adhered to as applicable to guide operations.

In addition, the Consortium will adhere to Rutland County Council's relevant policies and procedures and the Internal Audit Manual.

Authority

The Consortium's Auditors, with strict accountability for confidentiality and safeguarding records and information, are authorised full, free, and unrestricted access to any and all of the Council's records, physical properties, and personnel pertinent to carrying out any assignment.

All employees are requested and required to assist the Consortium in fulfilling its roles and responsibilities. This is enforced in the Accounts and Audit (England) Regulations 2011 section 6(2) which state that:

> *'Any officer or member of a relevant body must, if the body requires:*
> *(a) make available such documents and records as appear to that body to be necessary for the purposes of the audit; and*
> *(b) supply the body with such information and explanation as that body considers necessary for that purpose'.*

For the purposes of internal audit activity, the Consortium's Audit Managers will also have free and unrestricted access to the Council's Strategic Management Team and Audit & Risk Committee.

Organisation

The Head of Consortium reports functionally to the Audit & Risk Committee on items such as:

- Approving the Internal Audit Charter;
- Approving the risk-based Internal Audit Annual Plan;
- The Consortium's performance against the Plan and other matters;
- Approving the Head of Consortium's Annual Report;
- Approving the review of the effectiveness of the system of Internal Audit.

The Head of Consortium has direct access to the Chair of Audit & Risk Committee and has the opportunity to meet with the Audit & Risk Committee in private.

The Council's Section 151 Officer will be Client Officer for the Consortium with responsibility for monitoring performance; ensuring adequacy of Internal Audit resources; and ensuring the Head of Consortium's independence. Responsibility for line management of the Head of Consortium is vested in the Section 151 Officer of the Consortium's employing organisation – Rutland County Council.

The Welland Internal Audit Board – comprising the clients' Section 151 Officers - is responsible for oversight of the Consortium's performance in delivering the agreed level and quality of service commissioned by individual clients.

Independence, integrity and objectivity

In respect of its internal audit activities, the Consortium will remain free from interference by any element in the Council, including matters of audit selection, scope, procedures, frequency, timing, or report content, to permit maintenance of a necessary independent and objective mental attitude.

Auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair an Auditor's judgment.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments. To achieve that outcome, the Head of Consortium will ensure that, where an Auditor is recruited from a client local authority, they will not audit the area that they moved from for at least a period of one year. Auditors will also be required to state any possible conflicts of interest at the start of each audit assignment to their manager to ensure a completely independent and unbiased audit is carried out.

The Head of Consortium will confirm to the Audit & Risk Committee, at least annually, the organisational independence of the Consortium in respect of all internal audit activity.

Responsibility

The scope of internal audit encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of the Council's governance, risk management, and internal control processes in relation to the Council's defined goals and objectives.

The Consortium is responsible for evaluating all processes (not just financial) of the Council including governance and risk management processes. It also assists the Audit & Risk Committee in evaluating the quality of performance of external auditors and ensures that there is a proper degree of co-ordination between the Consortium and the Council's External Auditors.

The Consortium may perform consulting and advisory services related to governance, risk management and control as appropriate for the Council. Approval must be sought from the Audit & Risk Committee for any significant additional consulting services not already

included in the Annual Internal Audit Plan. The Consortium may also evaluate specific operations at the request of the Audit & Risk Committee or management, as appropriate: where requests from management have the potential to impact on the delivery of planned work, approval of the Audit & Risk will be required.

Based on its activity, the Consortium is responsible for reporting significant risk exposures and control issues identified to the Audit & Risk Committee and to senior management, including fraud risks, governance issues, and other matters requested by the Audit & Risk Committee.

Internal audit plan and resources

The Head of Consortium will submit to the Audit & Risk Committee, annually, a risk-based Internal Audit Annual Plan for review and approval. The report to Committee will include budget and resource requirements for the next financial year necessary for the delivery of the Plan. The Head of Consortium will communicate the impact of resource limitations and of significant interim changes to senior management and the Audit & Risk Committee.

The Internal Audit Annual Plan will be developed using a risk-based process that has been approved by the Audit & Risk Committee. The process will include input of senior management and the Audit & Risk Committee. Any significant deviation from the approved Internal Audit Annual Plan will be communicated through the periodic activity reporting process.

The Head of Consortium will carry out a continuous review of the development and training needs of all of the Consortium's personnel as part of the Consortium's Quality Assurance and Improvement Programme, and will arrange appropriate training.

Reporting and monitoring

A written report will be prepared and issued by the Head of Consortium or designee following the conclusion of each audit assignment and will be distributed in line with the Council's reporting processes. The outcome of each assignment will also be communicated to the Audit & Risk Committee in the manner determined by the Committee.

The Internal Audit reports will include management's response and a record of corrective action taken or to be taken in regard to the specific findings and recommendations. Management's response will include a timetable for anticipated completion of agreed action to be taken and an explanation for decision not to take action to address a control weakness identified in the report.

The Consortium will be responsible for monitoring the timely implementation of agreed audit recommendations and will report to the Council's Senior Management Team and the Audit & Risk Committee on progress achieved.

The Head of Consortium will produce an annual Internal Audit Opinion on the adequacy and effectiveness of the Council's framework of governance, risk management and control. The Head of Consortium Opinion will contribute to the Council's review of the effectiveness of its control environment as required under the Accounts and Audit (England) Regulations 2011.

Periodic assessment

The Head of Consortium is responsible also for providing a periodic self-assessment on the Internal Audit activity as regards its consistency with the Audit Charter (purpose, authority, responsibility) and performance relative to its Plan.

In addition, the Head of Consortium will communicate to senior management and the Audit & Risk Committee on the Consortium's Quality Assurance and Improvement Program, including results of on-going internal assessments and external assessments conducted at least every five years as required by the Standards.

Approval

The Head of Consortium will be responsible for the annual review of the Charter for subsequent approval by the Council's Audit & Risk Committee.

Approved by Audit and Risk Committee: 26th April 2016

Next review and approval due: April 2017

Report No: 89/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 2016

FRAUD RISK REGISTER

Report of the Director for Resources

Strategic Aim:	All	
Exempt Information	Appendix A of this report contains exempt information and is not for publication in accordance with paragraph 7 Part 1 of Schedule 12A of the Local Government Act 1972.	
Cabinet Member(s) Responsible:	Mr O Hemsley, Portfolio Holder for Resources (excluding Finance), Culture, Sport & Recreation, Tourism and Housing	
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		

DECISION RECOMMENDATIONS
That the Audit and Risk Committee: 1. Notes the report and attached Fraud Risk Register at Appendix A, which provides an update on the Council's management of fraud risks.

1 PURPOSE OF THE REPORT

1.1 To present an update on the Council's Fraud Risk Register ("the Register") following its implementation in January 2015.

2 BACKGROUND

2.1 In order to deliver good governance the Council must ensure that effective counter fraud arrangements are in place and operating appropriately. The Council has developed a Counter Fraud Strategy, which has been communicated to and is reviewed by, the Audit and Risk Committee. The Strategy involves the Council assessing those areas must vulnerable to the risk of fraud and ensuring the appropriate measures are in place to protect the Council and its assets.

2.2 To this end, the Register (attached at Appendix A) was developed and

implemented in 2015. The Register contains a list of areas where officers believe the Council is susceptible to fraud, and in turn, has enabled the Council to focus on suitable controls to mitigate any risks associated with fraud.

3 MONITORING AND REVIEW

3.1 The Resources Departmental Management Team (DMT) has had oversight of the Register since its implementation.

3.2 The Register was also reviewed by Internal Audit in 2015 as part of their review of the Council's counter fraud arrangements. The review sampled a number of identified risks to confirm that the stated controls were operating consistently and effectively and that any actions agreed had been implemented. A number of areas of good practice were identified during the review, including robust controls to mitigate the risk of recruitment fraud and fraudulent changes to supplier bank account details. Some suggested enhancements to existing risks were included in the Internal Audit review; these have now been incorporated into the Register

3.3 In addition to the above, the Governance Group now includes the Register as a standing agenda item to ensure it is discussed and if appropriate, updated on a quarterly basis.

4 NEW ADDITIONS AND UPDATES

4.1 One new risk has been added relating to the Council's role as a Deputy. A Deputy is a person appointed by the Court of Protection (COP) to manage the personal welfare or the property and affairs of another person, who lacks mental capacity to manage their own affairs. A relative usually acts as a Deputy, but it could be a close friend or other person. There is a potential risk that funds can be misappropriated and this has been added to the Register to show how this is managed.

4.2 Other finance risks have been reviewed and some actions noted in light of the planned upgrade of Agresso. The implementation of the new version gives an opportunity to strengthen controls in particular areas, for example:

- Introduce workflow (automated segregation of duties) on processes such as the set-up of new suppliers;

- Remove access rights from certain functions for staff who do not need it; Introduce a formal 'no purchase order no payment policy'.

4.3 The Register will also be updated during 2016 to ensure it is consistent with the Council's risk management strategy format.

5 CONSULTATION

5.1 The Governance Group comprises of representatives from service areas across the organisation; those representatives have been consulted as part of this review.

6 ALTERNATIVE OPTIONS

6.1 This report provides an opportunity for the Audit and Risk Committee to review the Register since its implementation in 2015 therefore there are no alternative

options.

7 FINANCIAL IMPLICATIONS

7.1 There are no direct financial implications arising as a result of this report.

8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 The Council operates through a governance framework; this framework brings together an underlying set of legislative requirements, governance principles and management processes. The Register is part of the Council's approach to good governance and demonstrates compliance with the principles of such.

9 EQUALITY IMPACT ASSESSMENT

9.1 An Equality Impact Assessment (EqIA) has not been completed as this report provides an update for the Audit and Risk Committee and does not have an equality impact.

10 COMMUNITY SAFETY IMPLICATIONS

10.1 Not applicable for the reasons set out above.

11 HEALTH AND WELLBEING IMPLICATIONS

11.1 Not applicable for the reasons set out above.

12 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

12.1 The Register is an integral tool in the Council's approach to countering fraudulent activities; the Audit and Risk Committee are asked to note the developments

13 BACKGROUND PAPERS

13.1 There are no additional background papers to the Report.

14 APPENDICES

14.1 Appendix A – Fraud Risk Register – exempt not for publication

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

Exempt Appendix – Appendix A is marked as "Not For Publication" because it contains exempt information as defined in paragraph 7 of Part 1 of Schedule 12A of the Local Government Act 1972, namely the information relates to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

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By virtue of paragraph(s) 7 of Part 1 of Schedule 12A
of the Local Government Act 1972.

Document is Restricted

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Report No: 86/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 2016

EXTERNAL AUDIT PLAN

Report of the Director for Resources

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Terry King, Leader and Portfolio Holder for Corporate Finance	
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 audit plan from the external auditors, KPMG LLP

1 PURPOSE OF THE REPORT

1.1 To ensure that the Committee is aware of and understands the approach to the external audit of the Statement of Accounts for 2015/16.

2 BACKGROUND AND MAIN CONSIDERATIONS

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

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

2.2 The plan for the 2015/16 audit is attached at Appendix A to this report. There are three key issues worth noting:

- The plan has been updated following planning work by the external auditors. There are no major risk issues identified by the auditors in their work to date which suggests that additional work will be needed;

- The fee has reduced from £87,308 to £65,481. This is a reduction of £21,827 (25%); and

- An omission or misstatement is regarded as material if it would reasonably influence the user of financial statements. Materiality for planning purposes has been set at £0.7m, which equates to a little over 1% of the previous year's gross expenditure. For specific accounts (i.e. debtors or creditors) the level is set at £0.5m. Any misstatement above this level would therefore need to be corrected. Below this level the s151 Officer will determine the approach and seek approval from the Committee. All misstatement in excess of £35k will be reported to Committee.

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 the Statement of Accounts.

7 EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EqIA) has not been completed for the following 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 approach of external audit to the audit of the Statement of Accounts.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

Appendix 1 – External Audit plan

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

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DRAFT External Audit Plan 2015/16

Rutland County Council

March 2016

Headlines

Financial Statement Audit

There are no significant changes to the Code of Practice on Local Authority Accounting in 2015/16 which impact on the authority's accounts, which provides stability in terms of the accounting standards the Authority need to comply with.

Materiality

Materiality for planning purposes has been based on last year's expenditure and set at £0.7m.

We are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance and this has been set at £35,000.

Significant risks

Our initial assessment has not identified any significant risks that are specific to the audit of the Authority's financial statements for 2015/16. We will revisit our assessment throughout the year and should any risks present themselves we will adjust our audit strategy as necessary.

See pages 3 to 4 for more details.

Value for Money Arrangements work

The National Audit Office has issued new guidance for the VFM audit which applies from the 2015/16 audit year. The approach is broadly similar in concept to the previous VFM audit regime, but there are some notable changes:

- There is a new overall criterion on which the auditor's VFM conclusion is based; and
- This overall criterion is supported by three new sub-criteria.

Our risk assessment is ongoing and we will report VFM significant risks during our audit

See pages 5 to 7 for more details.

Logistics

Our team is:

- Tony Crawley – Director
- Mike Norman – Manager
- David Schofield – Assistant Manager

More details are on **page 10.**

Our work will be completed in four phases from December to September and our key deliverables are this Audit Plan and a Report to those charged with Governance as outlined on **page 9.**

The scale fee for the audit is £65,481 (£87,308 2014/2015) see **page 8.**

Introduction

Background and Statutory responsibilities

This document supplements our Audit Fee Letter 2015/16 presented to you in April 2015, which also sets out details of our appointment by Public Sector Audit Appointments Ltd (PSAA).

Our statutory responsibilities and powers are set out in the Local Audit and Accountability Act 2014 and the National Audit Office's Code of Audit Practice.

Our audit has two key objectives, requiring us to audit/review and report on your:

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

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

Acknowledgements

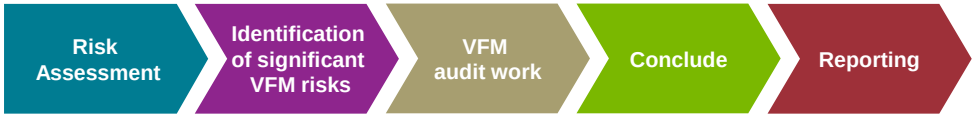
We would like to take this opportunity to thank officers and Members for their continuing help and co-operation throughout our audit work.

Financial Statements Audit

Our financial statements audit work follows a four stage audit process which is identified below. Appendix 1 provides more detail on the activities that this includes. This report concentrates on the Financial Statements Audit Planning stage of the Financial Statements Audit.

Value for Money Arrangements Work

Our Value for Money (VFM) Arrangements Work follows a five stage process which is identified below. Page 6 provides more detail on the activities that this includes. This report concentrates on explaining the VFM approach for the 2015/16 [and the findings of our VFM risk assessment].



Financial statements audit planning

Financial Statements Audit Planning

Our planning work takes place during January to March 2015. This involves the following key aspects:

- Risk assessment;
- Determining our materiality level; and
- Issuing this audit plan to communicate our audit strategy.

Risk assessment

The diagram opposite identifies a range of areas considered by our audit approach.

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

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

Our initial assessment has not identified any significant risks that are specific to the audit of the Authority's financial statements for 2015/16. We will revisit our assessment throughout the year and should any risks present themselves we will adjust our audit strategy as necessary.

Other areas of audit focus are those risks with less likelihood of giving rise to a material error but which are nevertheless worthy of audit understanding. We will review and discuss with officers the changes to the accounts required by this year's CIPFA Code of Accounting Practice, which include changes to the valuation of surplus assets and the replacement of the Explanatory Foreword with the Narrative Statement. We will also review the disclosure and accounting arrangements for the Better Care Fund, which the Authority hosts. We will update the Audit Committee during the year if any new issues emerge.

Financial statements audit planning (cont.)

Materiality

We are required to plan our audit to determine with reasonable confidence whether or not the financial statements are free from material misstatement. An omission or misstatement is regarded as material if it would reasonably influence the user of financial statements. This therefore involves an assessment of the qualitative and quantitative nature of omissions and misstatements.

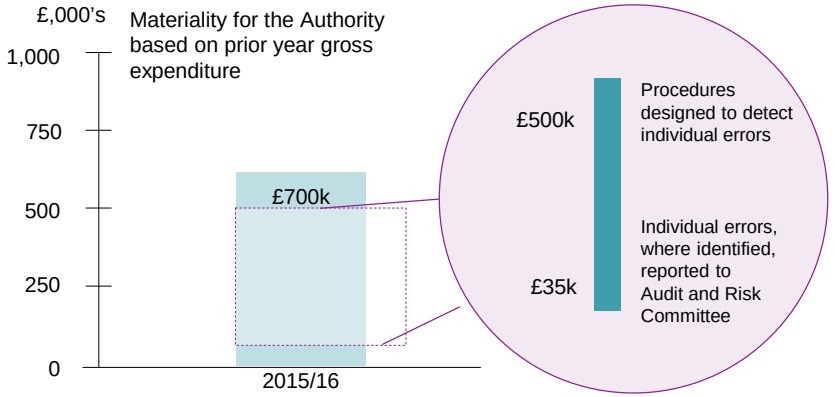
Generally, we would not consider differences in opinion in respect of areas of judgement to represent 'misstatements' unless the application of that judgement results in a financial amount falling outside of a range which we consider to be acceptable.

Materiality for planning purposes has been set at £0.7m, which equates to a little over 1% of the previous year's gross expenditure.

We design our procedures to detect errors in specific accounts at a lower level of precision. For planning purposes this level has been set at £0.5m.

Reporting to the Audit and Risk Committee

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



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

In the context of the Authority, we propose that an individual difference could normally be considered to be clearly trivial if it is less than £35,000.

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

Value for money arrangements work

Background to approach to VFM work

The Local Audit and Accountability Act 2014 requires auditors of local government bodies to be satisfied that the authority 'has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources'.

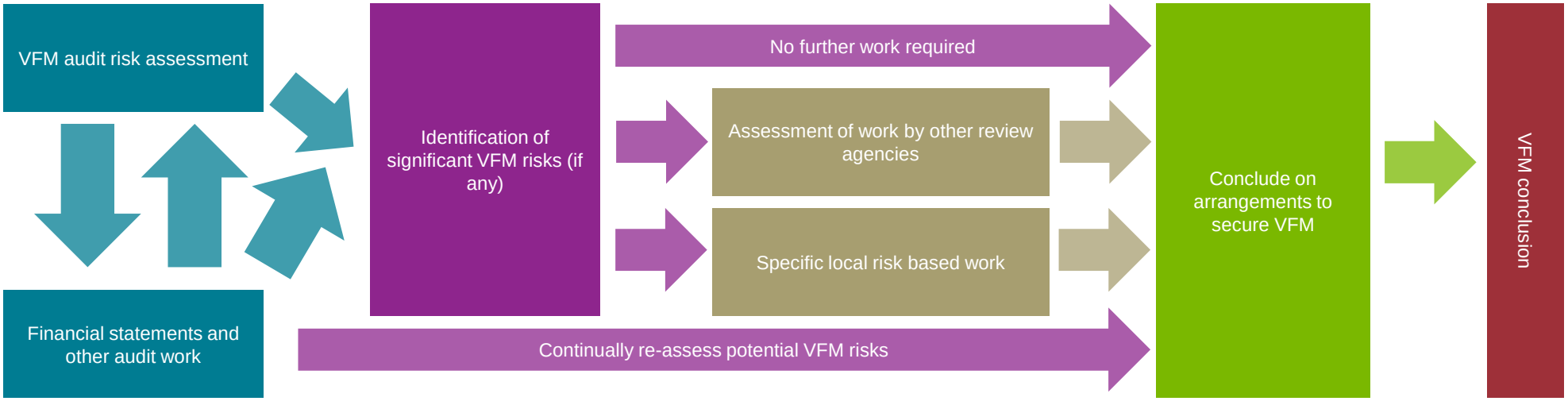
This is supported by the Code of Audit Practice, published by the NAO in April 2015, which requires auditors to 'take into account their knowledge of the relevant local sector as a whole, and the audited body specifically, to identify any risks that, in the auditor's judgement, have the potential to cause the auditor to reach an inappropriate conclusion on the audited body's arrangements.'

The VFM approach is fundamentally unchanged from that adopted in 2014/2015 and the process is shown in the diagram below. However, the previous two specified reporting criteria (financial resilience and economy, efficiency and effectiveness) have been replaced with a single criteria supported by three sub-criteria. These sub-criteria provide a focus to our VFM work at the Authority. The diagram to the right shows the details of this criteria.

Overall criterion

In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

- Informed decision making
- Sustainable resource deployment
- Working with partners and third parties



Value for money arrangements work (cont.)

VFM audit stage	Audit approach
VFM audit risk assessment	We consider the relevance and significance of the potential business risks faced by all local authorities, and other risks that apply specifically to the Authority. These are the significant operational and financial risks in achieving statutory functions and objectives, which are relevant to auditors' responsibilities under the *Code of Audit Practice.* In doing so we consider: ■ The Authority's own assessment of the risks it faces, and its arrangements to manage and address its risks; ■ Information from the Public Sector Auditor Appointments Limited VFM profile tool; ■ Evidence gained from previous audit work, including the response to that work; and ■ The work of other inspectorates and review agencies.
Linkages with financial statements and other audit work	There is a degree of overlap between the work we do as part of the VFM audit and our financial statements audit. For example, our financial statements audit includes an assessment and testing of the Authority's organisational control environment, including the Authority's financial management and governance arrangements, many aspects of which are relevant to our VFM audit responsibilities. We have always sought to avoid duplication of audit effort by integrating our financial statements and VFM work, and this will continue. We will therefore draw upon relevant aspects of our financial statements audit work to inform the VFM audit.
Identification of significant risks	The Code identifies a matter as significant *'if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects.'* If we identify significant VFM risks, then we will highlight the risk to the Authority and consider the most appropriate audit response in each case, including: ■ Considering the results of work by the Authority, inspectorates and other review agencies; and ■ Carrying out local risk-based work to form a view on the adequacy of the Authority's arrangements for securing economy, efficiency and effectiveness in its use of resources. Our risk assessment is in progress and our key areas of focus include your Medium Term Financial Planning arrangements. We are aware of the financial and operational pressures that you are dealing with and your need to have in place a balanced medium term financial plan. One of the factors you have been evaluating is the impact on your plans of the lower level of financial contribution to be received in respect of the Oakham North development, under the new Agreement signed in September 2015. The amount receivable is around £1.9m less than the maximum £6.9m contribution due under the previous Section 106 agreement. We will discuss with you your arrangements for establishing your updated medium term financial plan, including your assumptions and forecasts regard the impact of the final local government settlement on the funds available to you..

Value for money arrangements work (cont.)

VFM audit stage	Audit approach
Assessment of work by other review agencies and **Delivery of local risk based work**	Depending on the nature of the significant VFM risk identified, we may be able to draw on the work of other inspectorates, review agencies and other relevant bodies to provide us with the necessary evidence to reach our conclusion on the risk. If such evidence is not available, we will instead need to consider what additional work we will be required to undertake to satisfy ourselves that we have reasonable evidence to support the conclusion that we will draw. Such work may include: ■ Meeting with senior managers across the Authority; ■ Review of minutes and internal reports; ■ Examination of financial models for reasonableness, using our own experience and benchmarking data from within and without the sector.
Concluding on VFM arrangements	At the conclusion of the VFM audit we will consider the results of the work undertaken and assess the assurance obtained against each of the VFM themes regarding the adequacy of the Authority's arrangements for securing economy, efficiency and effectiveness in the use of resources. If any issues are identified that may be significant to this assessment, and in particular if there are issues that indicate we may need to consider qualifying our VFM conclusion, we will discuss these with management as soon as possible. Such issues will also be considered more widely as part of KPMG's quality control processes, to help ensure the consistency of auditors' decisions.
Reporting	We have completed our initial VFM risk assessment and have not identified any significant VFM risks. We will update our assessment throughout the year should any issues present themselves and report against these in our ISA260. We will report on the results of the VFM audit through our ISA 260 Report. This will summarise any specific matters arising, and the basis for our overall conclusion. The key output from the work will be the VFM conclusion (i.e. our opinion on the Authority's arrangements for securing VFM), which forms part of our audit report.

Other matters

Whole of government accounts (WGA)

We are required to review your WGA consolidation and undertake the work specified under the approach that is agreed with HM Treasury and the National Audit Office. Deadlines for production of the pack and the specified approach for 2015/16 have not yet been confirmed.

Elector challenge

The Local Audit and Accountability Act 2014 gives electors certain rights. These are:

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

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

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

Our audit team

Our audit team will again be led by Tony Crawley and will be supported by Mike Norman and David Schofield on a day to day level. Appendix 2 provides more details on specific roles and contact details of the team.

Reporting and communication

Reporting is a key part of the audit process, not only in communicating the audit findings for the year, but also in ensuring the audit team are accountable to you in addressing the issues identified as part of the audit strategy. Throughout the year we will communicate with you through meetings with The Finance Team and the Audit and Risk Committee. Our communication outputs are included in Appendix 1.

Independence and Objectivity

Auditors are also required to be independent and objective. Appendix 3 provides more details of our confirmation of independence and objectivity.

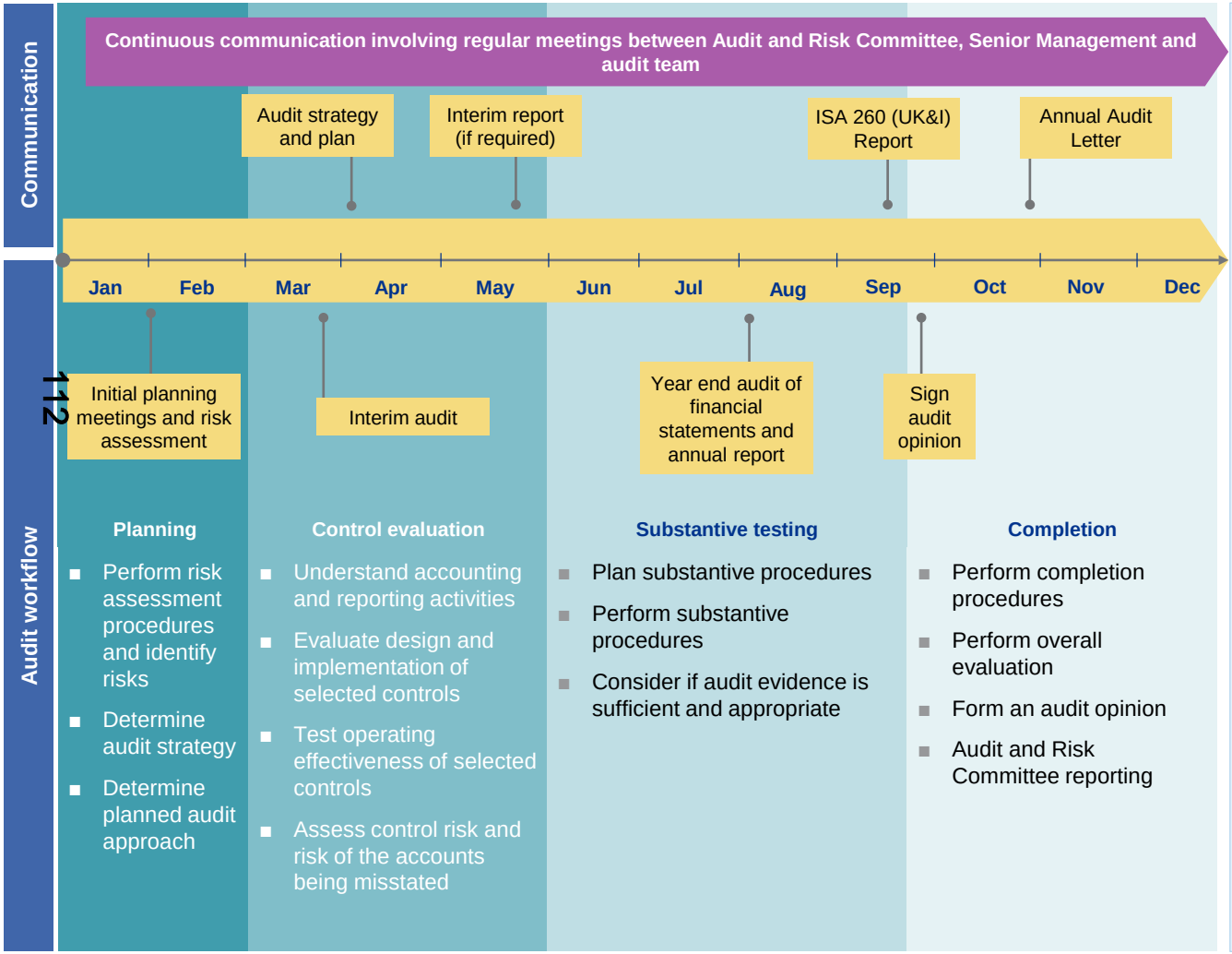
Audit fee

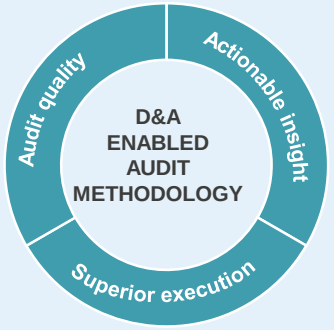
Our Audit Fee Letter 2015/2016 presented to you in April 2015 first set out our fee for the 2015/2016 audit. This letter also sets out our assumptions. We have not considered it necessary to make any changes to the planned fee at this stage.

The planned audit fee for 2015/16 is £65,481. This is a reduction in the scale audit fee, compared to 2014/2015, of £21,827 (25%).

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

Appendix 1: Key elements of our financial statements audit approach





Driving more value from the audit through data and analytics

Technology is embedded throughout our audit approach to deliver a high quality audit opinion. Use of Data and Analytics (D&A) to analyse large populations of transactions in order to identify key areas for our audit focus is just one element. We strive to deliver new quality insight into your operations that enhances our and your preparedness and improves your collective 'business intelligence.' Data and Analytics allows us to:

- Obtain greater understanding of your processes, to automatically extract control configurations and to obtain higher levels assurance.
- Focus manual procedures on key areas of risk and on transactional exceptions.
- Identify data patterns and the root cause of issues to increase forward-looking insight.

We anticipate using data and analytics in our work around key areas such as accounts payable and journals. We also expect to provide insights from our analysis of these tranches of data in our reporting to add further value from our audit.

Appendix 2: Audit team

Your audit team has been drawn from our specialist public sector assurance department. Our audit team were all part of the Rutland County Council audit last year.

Name	Tony Crawley
Position	Director
	'My role is to lead our team and ensure the delivery of a high quality, valued added external audit opinion. I will be the main point of contact for the Audit and Risk Committee and Executive Directors.

Tony Crawley
Director
0116 256 6067
tony.crawley@kpmg.co.uk

Name	Mike Norman
Position	Manager
	'I provide quality assurance for the audit work and specifically any technical accounting and risk areas. I will work closely with Tony Crawley to ensure we add value. I will liaise with the Finance Team and Internal Audit.

Mike Norman
Manager
0115 935 3544
michael.norman@kpmg.co.uk

Name	David Schofield
Position	Assistant Manager
	'I will be responsible for the on-site delivery of our work and will supervise the work of our audit assistants.'

David Schofield
Assistant Manager
0116 256 6074
david.schofield@kpmg.co.uk

Appendix 3: Independence and objectivity requirements

Independence and objectivity

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

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

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

Further to this auditors are required by the National Audit Office's Code of Audit Practice to:

- Carry out their work with integrity, independence and objectivity;
- Be transparent and report publicly as required;
- Be professional and proportional in conducting work;
- Be mindful of the activities of inspectorates to prevent duplication;
- Take a constructive and positive approach to their work;
- Comply with data statutory and other relevant requirements relating to the security, transfer, holding, disclosure and disposal of information.

PSAA's Terms of Appointment includes several references to arrangements designed to support and reinforce the requirements relating to independence, which auditors must comply with. These are as follows:

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

Confirmation statement

We confirm that as of March 2016 in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the Engagement Lead and audit team is not impaired.

This report is addressed to the Authority and has been prepared for the sole use of the Authority. We take no responsibility to any member of staff acting in their individual capacities, or to third parties. We draw your attention to the Statement of Responsibilities of auditors and audited bodies, which is available on Public Sector Audit Appointment's website (www.psaa.co.uk).

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

We are committed to providing you with a high quality service. If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Tony Crawley, the engagement lead to the Authority, who will try to resolve your complaint. If you are dissatisfied with your response please contact the national lead partner for all of KPMG's work under our contract with Public Sector Audit Appointments Limited, Andrew Sayers, by email to Andrew.Sayers@kpmg.co.uk After this, if you are still dissatisfied with how your complaint has been handled you can access PSAA's complaints procedure by emailing generalenquiries@psaa.co.uk by telephoning 020 7072 7445 or by writing to Public Sector Audit Appointments Limited, 3rd Floor, Local Government House, Smith Square, London, SW1P 3HZ.

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Report No: 98/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 April 2016

ANNUAL RIPA REPORT AND POLICY

Report of the Director for Resources

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr O Hemsley, Portfolio Holder for Resources (excluding Finance), Culture, Sport & Recreation, Tourism and Housing	
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. Notes the report and reviews the Regulation of Investigatory Powers Act 2000 (RIPA) Policy attached at Appendix A.

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 2015/2016.

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

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

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

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

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

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

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

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

2.5 The Council has an approved policy, which governs the use of RIPA. This was approved by Cabinet in 2014. Although there have not been any amendments to legislation, which affect the operation of RIPA, the Policy is attached at Appendix A to allow Audit and Risk Committee members to review the document and comment on any changes they feel may be necessary (please see 2.6 below).

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 USE OF RIPA

3.1 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 2015/2016 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 There is no requirement to consult as this report is to provide an update for Audit and Risk Committee and to allow them to comment on the associated Policy.

5 ALTERNATIVE OPTIONS

5.1 No applicable; 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 authorisation process.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 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 (MANDATORY)

12 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

13 BACKGROUND PAPERS

13.1 There are no background papers in respect of this report.

14 APPENDICES

14.1 Appendix A – Regulation of Investigatory Powers Act 2000 (RIPA) Policy

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

Rutland
County Council

REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA)

FOR THE USE OF COVERT SURVEILLANCE, COVERT HUMAN INTELLIGENCE SOURCES ("CHIS") and THE ACQUISITION AND DISCLOSURE OF COMMUNICATIONS DATA

Version & Policy Number	**Version 1**
Guardian	**Head Of Corporate Governance**
Date Produced	**November 2014**
Next Review Date	**November 2017**

Approved by Cabinet	**December 2014**

CONTENTS

BACKGROUND

The Human Rights Act 1998 (which became effective on the 2nd October 2000) incorporates into UK law the European Convention on Human Rights, the effect of which is to protect an individual's rights from unnecessary interference by the "State".

The relevant parts of the Regulation of Investigatory Powers Act 2000 (*RIPA*) are Part II which came into force on 25th September 2000 and regulates covert investigations and Part 1 Chapter II, the acquisition and disclosure of communications data which came into force on 5th January 2004. Further provisions came into effect through the Protection of Freedoms Act 2012. Chapter 2 of this Act amends RIPA 2000 in that it introduces the necessity for judicial approval for local authorities engaging RIPA. These provide a framework within which the "State" (the specified public bodies) can work to ensure that law enforcement and other important functions can effectively protect society as a whole.

The Public Bodies defined in *RIPA* include Local Authorities and, therefore, Rutland County Council District Council's activities are subject to the *RIPA* framework.

The purpose of this guidance is to:

- explain the scope of *RIPA* and the circumstances where it applies
- provide guidance on the authorisation procedures to be followed .

The Council has had regard to the Codes of Practice produced by the Home Office in preparing this guidance. These can be accessed via the following link:

https://www.gov.uk/government/collections/ripa-forms--2

1. RIPA - PART II COVERT SURVEILLANCE

INTRODUCTION

1.1 There are a number of investigation activities that are covered by *RIPA*. These are known as: Directed Surveillance; Intrusive Surveillance and the use of a Covert Human Intelligence Source (CHIS). These are explained later in this document and the flowcharts in the Appendix provide a straightforward approach to determining whether *RIPA* applies and, if so, which provisions apply.

The Chief Executive, Directors and Head of Corporate Governance are responsible for authorising applications for directed surveillance or the use of a CHIS. References to the "Authorising Officer" should be read as

referring to any of the above; applications for approval under *RIPA* should be submitted to an Authorising Officer for consideration.

RIPA specifies that directed surveillance or the use of a CHIS by Councils can only be undertaken for the following reason:

"for the purpose of preventing or detecting crime or of preventing disorder;"

Authorisation under *RIPA* gives lawful authority to carry out directed surveillance and to use a CHIS. Before approving applications, the Authorising Officer must have regard to the necessity and proportionality of the application. Proportionality means that the action taken must be appropriate, fair and sufficient and that a sledgehammer should not be used to crack a nut. In order for the Authorising Officer to be satisfied that proportionality has been addressed, the following elements should be considered:

- balancing the size and scope of the proposed activity against the gravity and extent of the perceived crime or offence;
- explaining how and why the methods to be adopted will cause the least possible intrusion on the subject and others;
- considering whether the activity is an appropriate use of the legislation and a reasonable way, having considered all reasonable le alternatives, of obtaining the necessary result;
- evidencing, as far as reasonably practicable, what other methods had been considered and why they were not implemented.

For example, if the evidence can be gained without surveillance then there should be no authorisation or, if sufficient evidence can be gained in one surveillance/visit then four must not be taken. But, once obtained, the authorisation helps to protect the Council and its officers from complaints of interference with the rights protected by Article 8 of the European Convention on Human Rights (the right to private and family life).

It should be noted that the Council **does not, *under any circumstances,*** have the power to undertake what is defined as "Intrusive Surveillance".

Staff should refer to the Home Office Codes of Conduct for supplementary guidance.

The Codes do not have the force of statute, but are admissible in evidence in any criminal and civil proceedings. As stated in the codes,

"If any provision of the code appears relevant to a question before any Court or tribunal considering any such proceedings, or to the tribunal established under *RIPA*, or to one of the commissioners responsible for overseeing the powers conferred by *RIPA*, it must be taken into account".

Deciding when authorisation is required involves making a judgement. Section 1.3 of this guidance gives some examples and Section 1.4 explains the authorisation process. If you are unclear about any aspect of the process, seek the advice of the Authorising Officer. If they are unable to answer your questions they must seek advice from the Head of Corporate Governance and/or the Council's Legal Services Team.

However, **IF YOU ARE IN ANY DOUBT** about whether a course of action requires an authorisation, **REFER IT FOR AUTHORISATION.** (If you are unable to secure an authorisation it is likely that your application does not comply with the law).

Teams of the Council that undertake surveillance that is covered by *RIPA* may wish to develop specific guidance on the applicability of RIPA to their particular circumstances. Such an approach is to be encouraged but the relevant Team Manager must ensure that any "local" guidance does not conflict with this corporate document.

1.2 DEFINITIONS

What is meant by:

Surveillance?

Surveillance includes:

a) monitoring, observing or listening to persons, their movements, their conversations or their other activities or communication and, for the purposes of *RIPA*, the term persons includes "any organisation and any association or combination of persons", this will include limited companies, partnerships, co-operatives etc;

b) recording anything monitored, observed or listened to in the course of surveillance;

c) surveillance by or with the assistance of a surveillance device.

Covert Surveillance?

Covert surveillance is that carried out in a manner calculated to ensure that persons subject to surveillance are unaware it is or may be taking place.

If activities are open and not hidden from the persons subject to surveillance, the *RIPA* framework does not apply.

Directed surveillance?

Surveillance is 'Directed' for the purposes of *RIPA* if it is covert, but not intrusive and is undertaken :

a) for the purposes of a specific investigation or a specific operation: and

b) in such a manner as is likely to result in the obtaining of private information about a person (whether or not one is specifically identified for the purposes of the investigation or operation); and

c) otherwise than by way of an immediate response to events or circumstances the nature of which is such that it would not be reasonably practicable for an authorisation to be sought for the carrying out of the surveillance.

Intrusive surveillance?

a) is carried out in relation to anything taking place on any "residential premises" or in any "private vehicle"; and

b) involves the presence of an individual on the premises or in the vehicle or is carried out by means of a surveillance device; or

c) is carried out by means of a surveillance device in relation to anything taking place on any residential premises or in any private vehicle but is carried out without that device being present on the premises or in the vehicle, where the device is such that it consistently provides information of the same quality and detail as might be expected to be obtained from a device actually present on the premises or in the vehicle.

Covert Human Intelligence Source (CHIS)

A person is a Covert Human Intelligence Source if:

a) the source establishes or maintains a personal or other relationship with a person for the covert purpose of facilitating the doing of anything falling within paragraph b) or c) below,

b) the source covertly uses such a relationship to obtain information or provide access to any information to another person; or

c) the source covertly discloses information obtained by the use of such a relationship or as a consequence of the existence of such a relationship.

Covert Purpose?

A purpose is covert, in relation to the establishment or maintenance of a personal or other relationship, **if and only if,** the relationship is conducted in a manner that is calculated to ensure that one of the parties to the relationship is unaware of the purpose behind the relationship.

It is not the Council's policy to use a CHIS. If any officer considers that a CHIS should be used in any particular case, they should discuss the matter with the Head of Corporate Governance before seeking authorisation.

Private Information?

Private information is any information relating to a person's (see the definition in surveillance part a above) private or family life.

For example, if part of an investigation is to observe a member of staff's home to determine their comings and goings then that surveillance would, almost certainly, gather private information, as would surveillance of an individual selling counterfeit goods as the surveillance may provide information about the earnings that the person made from the sales.

Confidential Material?

a) matters subject to legal privilege;
b) confidential personal information; or
c) confidential journalistic material.

- Matters subject to legal privilege includes both oral and written communications between a professional legal adviser and his/her client (or any person representing his/her client) made in connection with the giving of legal advice to the client or in contemplation of legal proceedings and for the purposes of such proceedings, as well as items enclosed with or referred to in such communications. Communications and items held with the intention of furthering a criminal purpose are not matters subject to legal privilege (see NB1 below)

- "Confidential Personal Information" is information held in confidence concerning an individual (whether living or dead) who can be identified from it, and relating:

  a) to his/her physical or mental health; or
  b) to spiritual counselling or other assistance given or to be given, and which a person has acquired or created in the course of any trade, business, profession or other occupation, or for the purposes of any paid or unpaid office (see NB2 below). It includes both oral and written information and also communications as a result of which personal information is acquired or created. Information is held in confidence if:
  c) it is held subject to an express or implied undertaking to hold it in confidence; or
  d) it is subject to a restriction on disclosure or an obligation of secrecy contained in existing or future legislation.

- "Confidential Journalistic Material" includes material acquired or created for the purposes of journalism and held subject to an undertaking to hold it in confidence, as well as communications resulting in information being acquired for the purposes of journalism and held subject to such an undertaking.

NB 1. Legally privileged communications will lose their protection if there is evidence, for example, that the professional legal adviser is intending to hold or

use them for a criminal purpose; privilege is not lost if a professional legal adviser is advising a person who is suspected of having committed a criminal offence. The concept of legal privilege shall apply to the provision of professional legal advice by any agency or organisation.

NB 2. Confidential personal information might, for example, include consultations between a health professional or a professional counsellor and a patient or client, or information from a patient's medical records.

1.3 DOES RIPA PART II APPLY TO MY SITUATION?

Is it for the purposes of a specific investigation or a specific operation?

The test is if the surveillance is directed at a known individual or group the provisions of RIPA will cover the investigation. In respect of other situations, such as CCTV cameras that are readily visible to anyone walking around the area, their use is not governed by RIPA. However, if the cameras are used as part of an operation to observe a known individual or group it is very likely that RIPA will apply and an appropriate authorisation will be required.

Is the surveillance likely to obtain private information about a person?

If it is likely that observations will result in the obtaining of private information about any person, then RIPA may apply.

If in doubt, it is safer to seek authorisation

Is the Surveillance Intrusive?

Directed surveillance turns into intrusive surveillance if it is carried out involving anything that occurs on residential premises or any private vehicle and involves the present of someone on the premises or in the vehicle or is carried out by means of a (high quality) surveillance device.

If the device is not on the premises or in the vehicle, it is only intrusive surveillance if it consistently produces information of the same quality as if it were.

Commercial premises and vehicles are therefore excluded from intrusive surveillance.

The Council is NOT authorised to carry out intrusive surveillance.

Is the surveillance an immediate response to event or circumstances where it is not reasonably practicable to get authorisation?

The Home Office guidance indicates that this is to take account of an immediate response to something happening during the course of an observer's work, which is unforeseeable. If this occurs, the surveillance will not require prior

authorisation. It should be noted that general observation forming part of an officer's normal activities, for example, planning enforcement, will not be within the scope of *RIPA*.

However, if, as a result of an immediate response, a specific investigation subsequently takes place that investigation will be within the scope of *RIPA.*

1.4 AUTHORISATIONS, RENEWALS AND DURATION UNDER RIPA PART II

1.4.1 The conditions for authorisation

Directed Surveillance

For directed surveillance no officer shall grant an authorisation for the carrying out of directed surveillance unless he believes:

a) that an authorisation is *necessary* that is, it has to be gained to be able to gather the information needed for the detection or prevention of crime. (Also, see the relevant Codes of Practice).
b) the authorised surveillance is *proportionate* to what is sought to be achieved by carrying it out and that a sledgehammer is not being used to crack a nut. Any surveillance that is carried out must be at the most appropriate level to achieve the objectives of the investigation. (Additional guidance is available in the relevant Codes of Practice).

An authorisation under *RIPA* will only be given if the work is:

"for the purpose of preventing or detecting crime or of preventing disorder;"

The onus is on the people authorising the surveillance activity to satisfy themselves that the action to be taken is necessary and proportionate.
In order to ensure that authorising officers have sufficient information to make an informed decision it is important that detailed records are maintained. An application form must be completed.

It is also sensible to make any authorisation sufficiently wide to cover all the means required as well as being able to provide effective monitoring of what was done against the actions that had been authorised.

See the flowchart in the Appendix, page 2.

Use of Covert Human Intelligence Sources

The same principles as Directed Surveillance apply (see paragraph 1.4.1 above). However, as it is the Council's policy not to use CHIS, further guidance is not included in this document. The Head of Corporate Governance must be contacted if an officer considers that the use of a CHIS is appropriate in any particular case.

1.4.2 Provisions of RIPA PART II

For *urgent* grants or renewals, oral authorisations are acceptable, but should be followed up with a written application as soon as possible thereafter. Urgent grants are those where authorisation would be needed but the circumstances are such that if a grant was waited for then the time for the gathering of the information would have passed and the opportunity missed. In all other cases, authorisations must be in writing.

Directed surveillance and the use of a CHIS will be applied for on the relevant forms, even if they relate to the same surveillance target.

Authorisations **must** be cancelled as soon as they are no longer required, and, in any event, on or before the expiry date of the authorisation.

Authorisations only last, if not renewed:

- Any authorisation granted or renewed orally, (or by a person whose authorisation was confirmed to urgent cases) expire after 72 hours, this period beginning with the time of the last grant or renewal;

- A written authorisation to use a CHIS expires after 12 months from the date of last renewal or

- in all other cases (i.e. directed surveillance) 3 months from the date of their grant or latest renewal.

Any person entitled to grant a new authorisation, as described above, can renew an existing authorisation, on the same terms as the original authorisation, at any time before the original ceases to have effect.

A CHIS application should not be renewed unless a thorough review has been carried out and the authorising officer has considered the results of the review when deciding whether to renew or not. A review must cover what use has been made of the source, the tasks given to them and information obtained.

The benefits of obtaining an authorisation are described in section 3 below.

1.4.3 Factors to Consider

General

Any person giving an authorisation must satisfy themselves, based on the information in the application and their knowledge of the service that:

- the authorisation is necessary
- the surveillance is proportionate to what it seeks to achieve.

Particular consideration should be given to intrusion on, or interference with, the privacy of persons other than the subject(s) of the application (**known as**

collateral intrusion). Such collateral intrusion or interference would be a matter of greater concern in cases where there are special sensitivities, for example in cases of premises used by lawyers or for any form of medical or professional counselling or therapy.

An application for an authorisation **must include an assessment of the risk of any collateral intrusion or interference.** The authorising officer will take this into account, particularly when considering the proportionality of the directed surveillance or the use of a CHIS.

Those carrying out the covert directed surveillance should inform the Authorising Officer if the operation/investigation unexpectedly interferes with the privacy of individuals who are not the original subjects of the investigation or covered by the authorisation in some other way. In some cases the original authorisation may not be sufficient and consideration should be given to whether a separate authorisation is required.

Any person giving an authorisation will also need to be aware of particular sensitivities in the local community where the directed surveillance is taking place or of similar activities being undertaken by other public authorities that could impact on the deployment of surveillance.

The keeper of the central register will inform the Investigating officers of the review time. **The Investigating officer is responsible for ensuring that approvals, reviews, renewals and recommendations for cancellation are made and timely.**

The fullest consideration should be given in cases where the subject of the surveillance might reasonably expect a high degree of privacy, for instance at his/her home, or where there are special sensitivities. Care must be exercised, particularly in relation to residential premises, to avoid carrying out any surveillance that may be deemed to fall under the definition of Intrusive Surveillance (because a local authority is not empowered to undertake intrusive surveillance).

Spiritual Counselling

No operations should be undertaken in circumstances where investigators believe that surveillance will lead to them intrude on spiritual counselling between a Minister and a member of his/her faith. In this respect, spiritual counselling is defined as conversations with a Minister of Religion acting in his/her official capacity where the person being counselled is seeking or the Minister is imparting forgiveness, or absolution of conscience.

Confidential Material

RIPA does not provide any special protection for confidential material (see the definition in the Appendix). Nevertheless, such material is particularly sensitive, and is subject to additional safeguard under this code. In cases where the likely consequence of the conduct of a source would be for any person to acquire

knowledge of confidential material, the deployment of the source should be subject to special authorisation by the Chief Executive.

In general, any application for an authorisation that is likely to result in the acquisition of confidential material should include an assessment of how likely it is that confidential material will be acquired. Special care should be taken where the target of the investigation is likely to be involved in handling confidential material. Such applications should only be considered in exceptional and compelling circumstances with full regard to the proportionality issues this raises.

The following general principles apply to confidential material acquired under authorisations:

- Those handling material from such operations should be alert to anything that may fall within the definition of confidential material. Where there is doubt as to whether the material is confidential, advice should be sought from the Head of Corporate Governance before further dissemination takes place;

- Confidential material should be disseminated only where an appropriate officer (having sought advice from the Head of Corporate Governance) is satisfied that it is necessary for a specific purpose

- The retention or dissemination of such information should be accompanied by a clear warning of its confidential nature. It should be safeguarded by taking reasonable steps to ensure that there is no possibility of it becoming available, or its content being known, to any person whose possession of it might prejudice any criminal or civil proceedings related to the information. Any material of this nature will be reviewed on a monthly basis by the Team Manager.

- Confidential material should be destroyed as soon as it is no longer necessary to retain it for a specified purpose.

Combined authorisations

A single authorisation may combine two or more different authorisations under RIPA (but cannot include an authorisation for intrusive surveillance activity).

In cases of joint working with other agencies on the same operation, the lead agency should be responsible for authorisations. Council officers should ensure that there is agreement between the agencies at the start of the operation as to which will be the lead agency for this purpose.

Handling and disclosure of the products of surveillance

Authorising Officers are reminded of the guidance relating to the retention and destruction of confidential material as described above.

The Authorising Officer should retain RIPA related documents for a period of three years. However, where it is believed that the records could be relevant to

pending or future criminal proceedings, they should be retained for a suitable further period, commensurate to any subsequent review.

Authorising officers must ensure compliance with the appropriate data protection requirements and the relevant codes of practice in the handling and storage of material. Where material obtained by surveillance is wholly unrelated to a criminal or other investigation, or to any person who is the subject of the investigation, and there is no reason to believe it will be relevant to future civil or criminal proceedings, it should be destroyed immediately. Consideration of whether or not unrelated material should be destroyed is the responsibility of the Authorising Officer.

Material obtained through the proper use of the RIPA authorisation procedures can be used for relevant Council purposes. However, the transfer of such information outside the Council, other than in pursuance of the grounds on which it was obtained, should be authorised only in the most exceptional circumstances and should always only occur following consideration of the appropriate Data Protection legislation.

The Use of Covert Human Intelligence Sources (CHIS)

It is not the Council's policy to seek, cultivate or develop a relationship with a potential external or professional source. If the use of a CHIS was to be considered in exceptional circumstances, a risk assessment of the safety and welfare of any employee potentially involved would be an essential pre-requisite of an authorisation.

Register of Authorisations

The Head of Corporate Governance is responsible for maintaining a central register of authorisations. The register will record the date of the authorisation, the name of the authorising officer and the location of the file where the authorised application will be retained. The Officer who has authorised the application must contact the Head of Corporate Governance to provide the specified information and to obtain a reference number for the authorisation. This must be done on the day that the application is authorised. The Authorising Officer must then ensure that the authorised application is filed in the location notified to the Head of Corporate Governance. The original will be kept in the Central register. A Director who is permitted to authorise applications under *RIPA* will ensure that their Team maintains appropriate files for all applications, approvals and cancellations. Cancellations must be attached to the relevant authorised applications.

2. RIPA PART I CHAPTER II – THE ACQUISITION AND DISCLOSURE OF COMMUNICATIONS DATA

2.1 INTRODUCTION

Part I Chapter II (sections 21 – 25 of RIPA) came into force on 5th January 2004. It regulates the acquisition and disclosure of communications data. It provides powers for the Council to gain communications information when carrying out investigations. It also regulates information previously gained without regulations, which now has to be authorised.

The process is similar to that of the authorisation of directed surveillance and CHIS, but has extra provisions and processes.

The purpose of the introduction is the same, that is, to protect people's human rights. The effect of not gaining authorisation when needed is the same. The Council leaves itself open to a challenge under the Human Rights Act 1998 and the evidence gained without authorisation may not be admissible in court.

RIPA specifies that the only purpose for which the Council can gather communication data is in the:

'Prevention and detection of crime or preventing disorder'

Staff should refer to the Home Office Codes of Conduct for supplementary guidance

The Codes do not have the force of statute but are admissible in evidence in any criminal and civil proceedings.

2.2 WHAT IS COMMUNICATIONS DATA?

The definition of communications data includes information relating to the use of a communications service but it does not include the contents of the communication itself. It is broadly split into three categories:

- Traffic data – where a communication was made from, to who and when
- Service data – the use made of a service by any person e.g. itemised telephone records
- Subscriber data – any other information held or obtained by an operator on a person they provided a service to.

This Council is restricted to subscriber and service use data and even then only for the purpose of preventing or detecting crime and disorder. For example a benefit fraud investigator may be able to get access to an alleged fraudster's mobile phone bills.

The word ‘data’ in relation to a postal item means anything written on the outside such as an address. Officers at the Council have previously been able to apply for the new address of a person that they were investigating, that is the re direction details. A request form was completed and the post office supplied the information. This activity is now regulated and authorisation needs to be gained.

THE CODE DOES NOT COVER THE INTERCEPTION OF COMMUNICATIONS (IE THE CONTENTS OF ANY COMMUNICATIONS INCLUDING THE CONTENT OF AN E-MAIL, OR INTERACTION WITH WEB SITES)

2.3 AUTHORISATIONS, NOTICES, RENEWALS AND DURATION

2.3.1 AUTHORISATIONS AND NOTICES

The Code states that a ‘designated person’, must decide whether authorisation is necessary and proportionate to the action to be taken. The designated person is in effect the Authorising Officer. The designated persons at this Council are the Chief Executive and Directors.

There are two ways to authorise access to communications data.

(a) Authorisation under 22(3). This allows the authority to collect the data itself. This may be appropriate where:

- The postal or telecommunications operator is not capable of collecting or retrieving the communications data;
- It is believed that the investigation may be prejudiced if the postal or telecommunications operator is asked to collect the data itself;
- There is a prior agreement in place between the relevant public authority and the postal or telecommunications operator as to the appropriate mechanisms for the disclosure of data.

(b) By a notice under section 22(4). A notice is given to a postal or telecommunications operator and requires that operator to collect or retrieve the data and provide it to the authority.
The designated person decides whether or not an authorisation should be granted.

The designated person must take account of the following points when deciding whether to authorise the application or not.

- Is the accessing of data for the prevention or detection of crime or disorder?
- Why is obtaining the data necessary for that purpose?
- Is obtaining access to the data by the conduct authorised proportionate to what is being sort to be achieved? That is what conduct are you authorising and is it proportionate?
- Is the accessing of the data likely to result in collateral intrusion? If so, is the access still justified?

- Is any urgent time scale justified?

  The designated person will make a decision whether to grant the authorisation based upon the application made. The application form should subsequently record whether or not the application was approved or not, by whom and the date. A copy of the application must be kept by the officer until it has been inspected by the Commissioner.

  If the application is authorised and the notice needs to be served, then only the notice is served upon the postal or telecommunications officer.

  The application form and the authorisation itself are not served upon the holder of the communications data. The authorisation and notice are in the standard form and are available on the Shared drive.

  The postal or telecommunications service can charge for providing the information.

2.3.2 PROVISIONS OF RIPA

Single Point of Contact (SPOC)

Notices and authorisations for communications data should be channelled through a SPOC. The Code states that this is to provide an effective system in that the SPOC will deal with the postal or telecommunications operator on a regular basis. The SPOC will advise the Authorising Officer/designated person on whether an authorisation and/ or notice is appropriate.

The SPOC should be in a position to:

- Where appropriate, assess whether access to communications data is reasonably practical for the postal or telecommunications operator;
- Advise applicants and designated persons on the practicalities of accessing different types of communications data from different postal or telecommunications operators;
- Advise applicants and designated persons on whether communications data falls under section 21(4)(a), (b) or (c) of the Act, that is traffic, service or subscriber data;
- Provide safeguards for authentication;
- Assess any cost and resource implications to both the public authority and the telecommunications operator.

The SPOC at this Council is the Head of Corporate Governance, who is formally accredited through the Home Office.

Oral Authority

An oral application and approval can only be made on an urgent basis for the purpose set out in section 22(2)(g) of the Act. That is

> "for the purpose, in emergency, of preventing death or injury or any damage to a person's physical or mental health, or of mitigating any injury or damage to a person's physical or mental health".

That is not a purpose under which the council is able to collect communications data and therefore oral authorisations are not possible.

Duration

Authorisations and notices will only be valid for one month beginning from the date when it was granted. If the information can be collected in a shorter time period then that should be specified. This would accord with the proportionality element of the decision making.

The postal or telecommunications operator need only comply with the request if it is reasonably practicable to do so.

Renewal

An authorisation or notice can be renewed at any point during the month that it is valid by following the same procedure as in obtaining a fresh authorisation.

Cancellations

The duty to cancel falls on the designated person who authorised it. The notice shall be cancelled as soon as it is no longer necessary or is no longer proportionate to what is being sort to be achieved.

Authorisations should also be cancelled. In the case of a section 22(4) notice, the postal or communications operator shall be informed of the cancellation.

Retention

Applications, authorisations and notices will be retained by the authority until they have been audited by the Commissioner. The authority should also keep a record of the dates that the notices and authorisations were started and cancelled. A copy of each form should be kept by the investigating Team and the originals kept in the Central Register. It shall be the responsibility of the designated person to ensure that the records are accurate and kept up to date.

Combined Authorisations

Applications for communications data may only be made by persons in the same authority as a designated person. There cannot, therefore, be any combined authorisations.

Errors

Where any errors have occurred in the granting of authorisations or the giving of notices, a record should be kept and a report and explanation sent to the Commissioner as soon as practical.

3. BENEFITS OF OBTAINING AUTHORISATIONS UNDER RIPA

Authorisation of surveillance, human intelligence sources and the acquisition and disclosure of communications data.

RIPA states that:

"If authorisation confers entitlement to engage in a certain conduct and the conduct is in accordance with the authorisation, then it shall be "lawful for all purposes".

However, the opposite is not true – i.e. if you do not obtain *RIPA* authorisation it does not make any conduct unlawful (e.g. use of intrusive surveillance by local authorities). It just means you cannot take advantage of any of the special RIPA benefits and you may have to justify infringing a person's Human Rights and any evidence you place before the courts may be subject to challenge in respect of the processes used to obtain the evidence (s78 Police and Criminal Evidence Act 1984).

RIPA states that a person shall not be subject to any civil liability in relation to any conduct of his which –

a) is incidental to any conduct that is lawful by virtue of an authorisation; and

b) is not itself conduct for which an authorisation is capable of being granted under a relevant enactment and might reasonably be expected to have been sought in the case in question.

However, **IF YOU ARE IN ANY DOUBT** about whether a course of action requires an authorisation, **REFER IT FOR AUTHORISATION**. (If you are unable to secure an authorisation it is likely that your application does not comply with the law).

4. SCRUTINY AND TRIBUNAL

As of 1 November 2012 the Council has to obtain an order from a Justice of the Peace approving the grant or renewal of any authorisation for the use of directed surveillance or CHIS before the authorisation can take effect and the activity be carried out. The Council can only challenge a decision of the Justice of the Peace on a point of law by way of judicial review.

Consideration must be given to 'Crime Threshold' which means that a Local Authority can now only grant an authorisation under RIPA for the use of directed

surveillance 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 relate to the underage sale of alcohol or tobacco.

The Chief Executive shall be the Senior Responsible Officer who will:

- ensure compliance with the Council's policy, relevant RIPA legislation and guidance;
- engage with Commissioners and inspectors when the Council's inspection is due (usually every three years);
- oversee any post-inspection action plans recommended or approved by a Commissioner.

This policy shall be reviewed, and where necessary amended, at least once a year. If requiring amendment, the revised policy shall be presented to and considered by the following:

- the Strategic Management Team
- the Audit and Risk Committee

The Senior Responsible Officer (or delegated representative) will report to the relevant Council committee, detailing the Council's use of RIPA powers, annually. The Council's elected members will not be involved in any decisions made on specific authorisations granted.

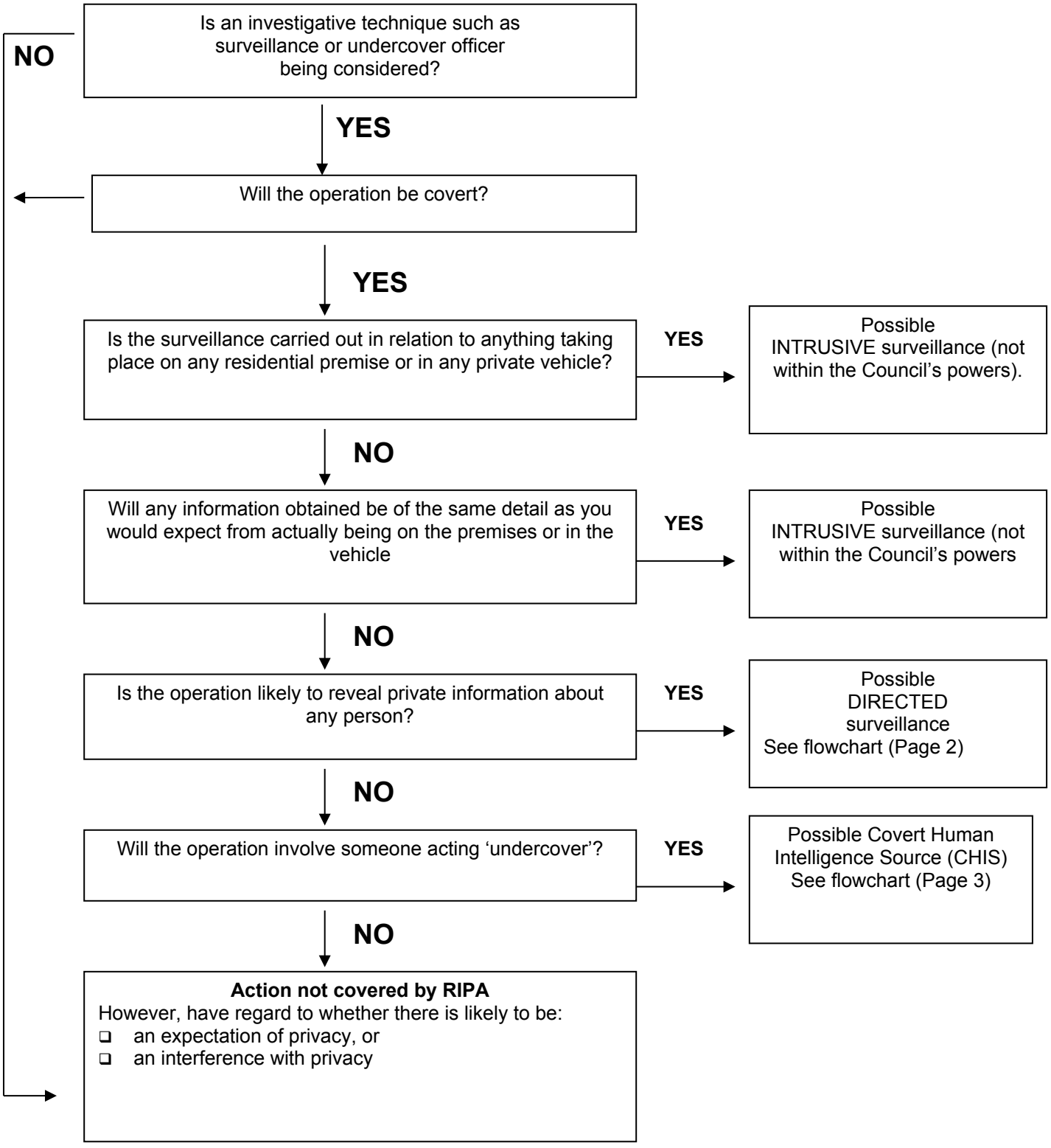
RIPA set up the Office of the Surveillance Commissioner to regulate the conduct of public bodies and to monitor their compliance with *RIPA*. The Chief Surveillance Commissioner will keep under review, among other things, the exercise and performance of duties, imposed in *RIPA* by the persons on whom those duties are conferred or imposed. This includes authorising directed surveillance and the use of covert human intelligence sources.

A tribunal has been established to consider and determine complaints made under *RIPA* if it is the appropriate forum. Persons aggrieved by conduct, e.g. directed surveillance, can make complaints. The forum hears application on a judicial review basis. Claims should be brought within one year unless it is just and equitable to extend that period.

The tribunal can order, among other things, the quashing or cancellation of any warrant or authorisation and can order destruction of any records or information obtained by using a warrant or authorisation, and records of information held by any public authority in relation to any person. The Council is, however, under a duty to disclose or provide to the tribunal all documents they require if:

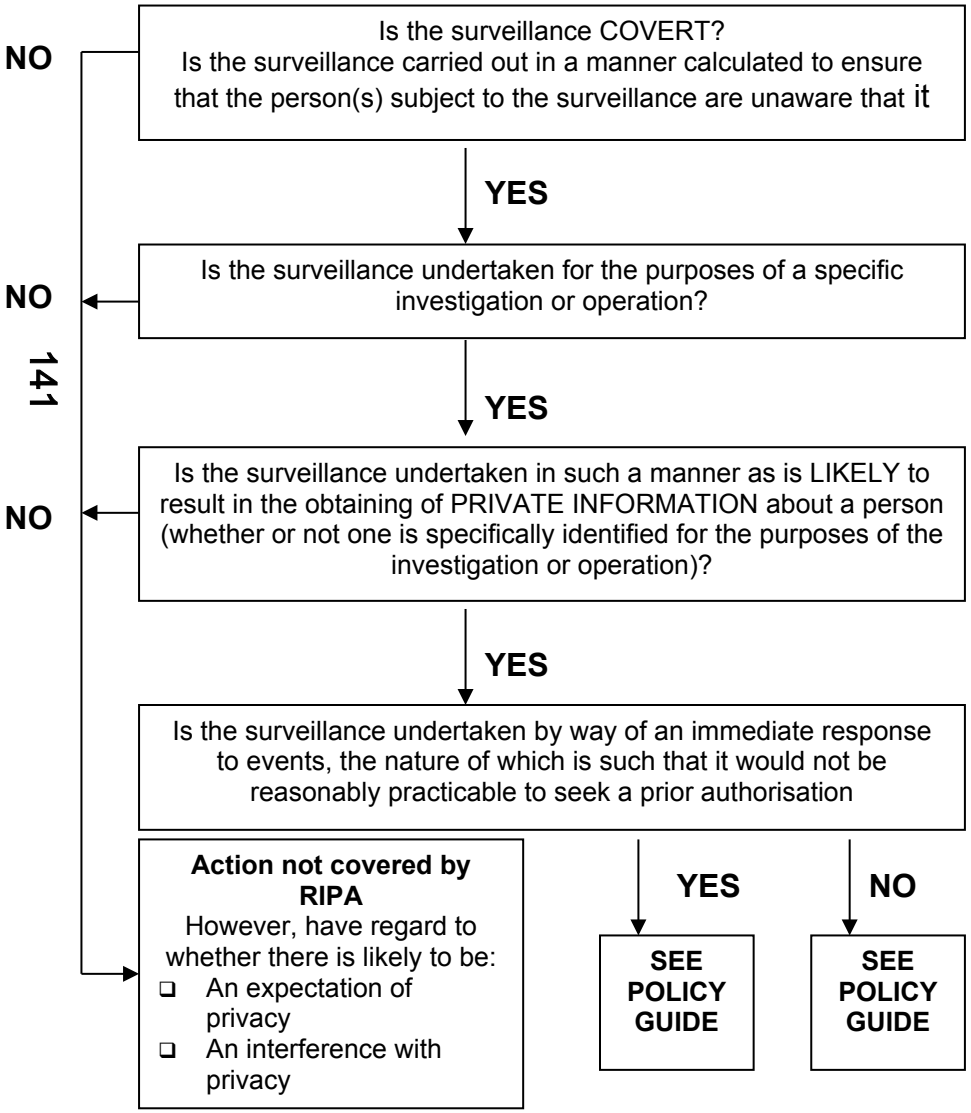
- A Council officer has granted any authorisation under RIPA.
- Council employees have engaged in any conduct as a result of such authorisation.
- A disclosure notice requirement is given.

SURVEILLANCE SUMMARY



PROCESS FLOWCHARTS

DIRECTED SURVEILLANCE



INTERPRETATION

COVERT see section 26(9) RIPA

SURVEILLANCE see Section 48(2) to 48(4) RIPA includes monitoring, observing or listening to persons, their movements, their conversations or their activities or communications.

DIRECTED SURVEILLANCE see Section 26(2) RIPA

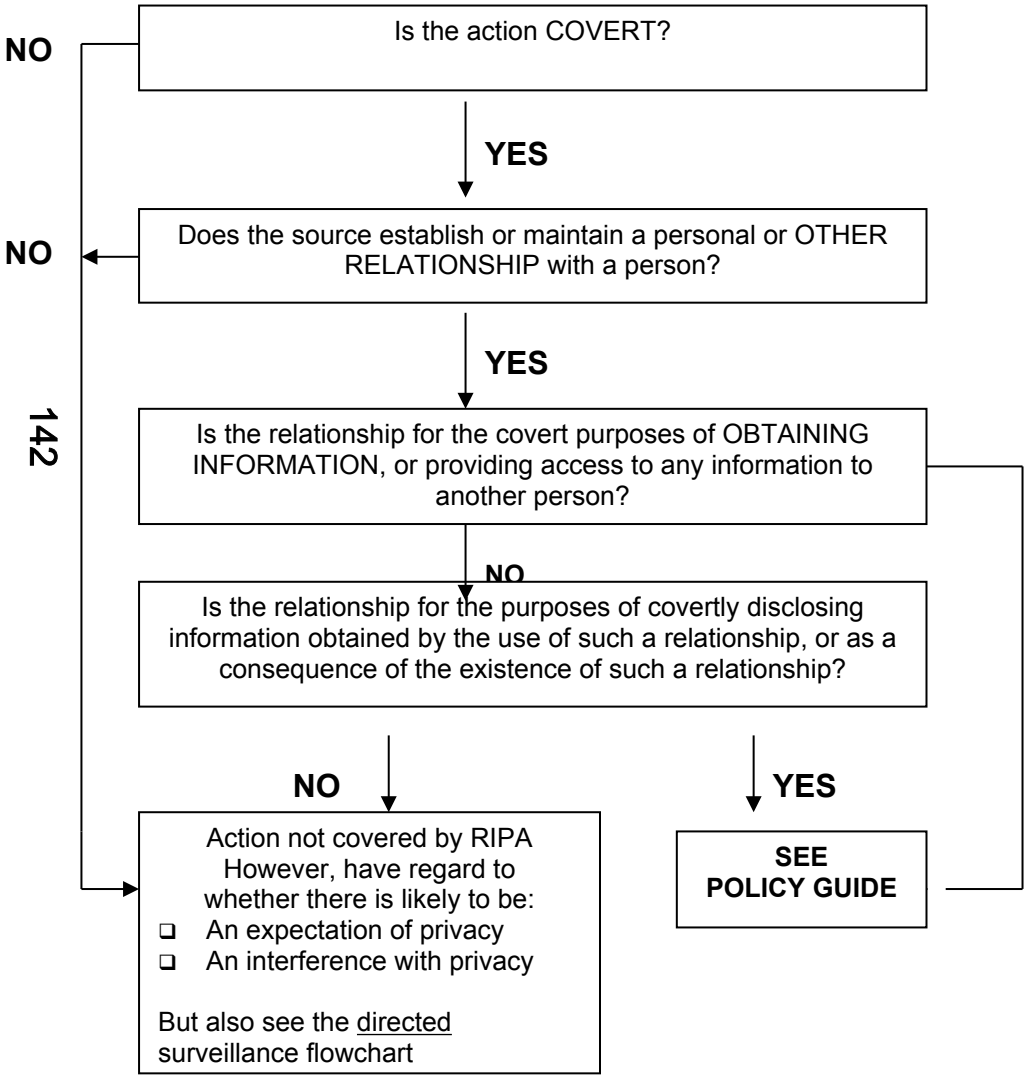
PERSON see Section 81(1) RIPA. Includes any organisation and any association or combination of persons

PRIVATE INFORMATION see Section 26(10) RIPA in relation to a person, includes any information relating to his private or family life.
'Private Information' should be given a wide interpretation and should not be restricted to what might be considered to be 'secret' or 'personal' information. Information that is in the open for all to see (for example: who is visiting a premise) may be deemed to be private information.

CONFIDENTIAL MATERIAL see paragraph 3 of the Code of Practice confidential information includes matters subject to legal privilege, confidential journalistic material and confidential personal information, for example medical records or religious material.

For further interpretation see Sections 48 & 81 RIPA, including Explanatory Notes to RIPA & Codes of Practice on Covert Surveillance & Use of a CHIS

COVERT HUMAN INTELLIGENCE SOURCE



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INTERPRETATION

COVERT see section 26(9) RIPA

COVERT PURPOSES. see Section 26(9)(b)&(c) RIPA

CHIS See Section 26(8) RIPA. The use of a CHIS is NOT surveillance. (see Section 48(3) RIPA)

PERSONAL OR OTHER RELATIONSHIP This is not defined, but a wide interpretation should be applied.

INFORMATION This is not defined but section talks about information in general and is not restricted to private information as is the case with directed surveillance

CONFIDENTIAL MATERIAL see paragraph 3 of the Code of Practice confidential information includes matters subject to legal privilege, confidential journalistic material and confidential personal information, for example medical records or religious material.

For further interpretation see Sections 48 & 81 RIPA, including Explanatory Notes to RIPA & Codes of Practice on Covert Surveillance & Use of a CHIS.

A large print version of this document is available on request

Rutland
County Council

Rutland County Council
Catmose, Oakham, Rutland LE15 6HP

01572 722 577
enquiries@rutland.gov.uk
www.rutland.gov.uk

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