AUDIT COMMITTEE

Date:- **Wednesday, 8th February 2017**

Venue:- **Town Hall, Moorgate Street, Rotherham. S60 2TH**

Time:- **4.00 p.m.**

AGENDA

1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Questions from Members of the Public or the Press.

4. Minutes of the previous meeting held on 23rd November, 2016 (herewith) (Pages 1 - 11)

5. Internal Audit Progress Report (Pages 12 - 34)

6. Internal Audit Assessment against PSIAS (Pages 35 - 101)

7. Local Code of Corporate Governance (Pages 102 - 127)

8. Risk Policy and Strategy Update (Pages 128 - 158)

9. Prudential Indicators and Treasury Management and Investment Strategy 2017/18-2019/20 (Pages 159 - 187)

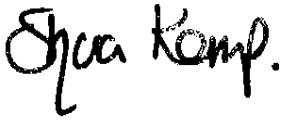
10. Procurement and Appointment of External Auditors - 2018/19 Onwards (Pages 188 - 194)

11. Exclusion of the Press and Public
    That under Section 100(A) 4 of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12(A) of such Act indicated, as now amended by the Local Government (Access to Information) (Variation) Order 2006 (information relates to finance and business affairs).

12. Risk Register Deep Dive - Assistant Chief Executive (Pages 195 - 204)

13. Items for Referral for Scrutiny

14. Date of Next Meeting
Wednesday, 19th April, 2017 at 4.00 p.m.



SHARON KEMP,
Chief Executive.

2016/17 Membership:-
Chair:- Councillor Wyatt
Vice-Chair:- Councillor Walsh
Councillors Allen, Cowles and Ellis
Independent Person:- Mr. Bernard Coleman

AUDIT COMMITTEE
23rd November, 2016

Present:- Councillor Wyatt (in the Chair); Councillors Allen and Walsh and Bernard Coleman (Independent Person).

Councillor Simpson was in attendance as an observer.

Mrs. D. Chamberlain (KPMG) was also present.

Councillor Roche, Cabinet Member for Adult Social Care and Health, and AnneMarie Lubanski, Strategic Director, Adult Care and Housing, were in attendance for Minute No. 40.

Apologies for absence:- Apologies were received from Councillor Cowles and Ellis.

30. QUESTIONS FROM MEMBERS OF THE PUBLIC OR THE PRESS

There were no members of the public or press present at the meeting.

31. MINUTES OF THE PREVIOUS MEETING HELD ON 21ST SEPTEMBER, 2016

Consideration was given to the minutes of the meeting held on 21st September, 2016.

Resolved:- That the minutes of the previous meeting be approved as a correct record for signature by the Chairman.

32. UPDATE ON THE USE AND OPERATION OF SURVEILLANCE AND ACQUISITION OF COMMUNICATIONS DATA POWERS

Neil Concannon, Legal Services, presented an update on the use of covert surveillance and covert human intelligence sources (CHIS) carried out by Council officers under the Regulation of Investigatory Powers Act 2000 (RIPA).

The Council was required to notify the Office of Surveillance Commissioners (OSC) of the number of directed surveillance/CHIS authorisations granted in each financial year. There had been no such authorisations this financial year so far.

The Council was also required to notify the Interception of Communications Commissioner's Office of the number of authorisations for the acquisition and disclosure of communications data granted each calendar year. There had been no such authorisations this calendar year so far.

The Council's Policies were last set in September, 2015; since that time there had been no amendments to the Home Office Codes of Practice. In July 2016 the OSC had issued an amended procedures and guidance document in relation to convert surveillance/CHIS but this did not require any amendments to be made to the Council's RIPA Policy.

The RIPA Policy had been amended to reflect an accurate list of the current authorising officers together with an additional paragraph clarifying that the Council's RIPA Senior Responsible Officer (the Assistant Director of Legal Services) would maintain an up-to-date list of the current authorising officers. This would be amended should there be any relevant personnel changes throughout the year.

Notification had been received that the Council would be inspected by the OSC in January 2017 to review its policies and procedures to comply with RIPA and the use it made of the directed surveillance/CHIS powers. Details of the outcome of the inspection would be reported to the Committee.

Resolved:- (1) That the Council's RIPA Policy and Acquisition and Disclosure of Communications Data Policy, as shown in Appendix A and B of the report submitted, be approved.

(2) That the update on the figures for the use of RIPA and Communications Data authorisations be noted.

(3) That it be noted that the Office of Surveillance Commissioners were due to carry out an inspection of the Council's use of powers for directed surveillance/CHIS and the policies and procedures it had in place for that purpose in January, 2017.

(4) That a report be submitted to the Audit Committee on the outcome of the aforementioned inspection.

(5) That further annual corporate training take place with regard to the use of RIPA and Communications Data powers on 4th January, 2017.

(6) That a further update be provided in 6 months' time.

33. MID-YEAR TREASURY MANAGEMENT AND PRUDENTIAL INDICATORS MONITORING REPORT 2016-17

Consideration was given to the report presented by the Assistant Director, Finance and Corporate Services, that outlined a mid-year treasury review.

The review, as set out in the Appendix submitted, highlighted the key changes to the Council's capital activity (the PIs) and the actual and proposed treasury management activity (borrowing and investment).

With regard to investments, the primary governing principle remained security over return and the criteria for selecting counterparties continued to reflect this.

Overall borrowing remained fairly constant over the period covered by the report. The Council would remain under-borrowed against the borrowing requirement due to the cost of carrying debt and new borrowing would only be taken up as debt matured. This was in line with financial assumptions.

The report showed that the underlying economic and financial environment remained difficult for the Council, foremost being the improving but still challenging concerns over investment counterparty risk. This background encouraged the Council to continue maintaining investments short term and with high quality counterparties. The downside of such a policy was that investment returns remained low. The governing principle remained security over return and the criteria for selecting counterparties continued to reflect this.

The 'call' account with the top-rated bank Handlesbanken who met the Council's highest investment criteria was being used in a prudent and cautious manner to improve the expected returns for the year.

To meet regulatory requirements the report would be submitted to the Cabinet and Commissioners' Decision Making meeting and to full Council.

Resolved:- (1) That the report be noted.

(2) That the report be referred to the Cabinet and Commissioners' Decision Making Meeting to consider recommending Council approve the changes to the 2016/17 Prudential Indicators.

34. INTERNAL AUDIT PROGRESS REPORT FOR THE TWO MONTHS ENDING 31ST OCTOBER, 2016

Consideration was given to a report presented by David Webster, Head of Internal Audit, which provided a summary of Internal Audit work completed during September and October, 2016, and the key issues that had arisen therefrom.

Performance against Key Indicators was generally positive although delivery of the planned programme of work remained behind schedule due mainly to vacancies and other Service priorities. The Assistant Director Audit, ICT and Procurement and the Chief Internal Auditor had both left the Authority during the period with 2 new staff having commenced in October including the new Head of Internal Audit.

Since the last meeting, the Plan had been the subject of a half year review with all Strategic Directors consulted to update it and match to the resources available whilst ensuring it provided sufficient coverage to enable the year end Internal Audit opinion to be reached.

Summary conclusions in all significant audit work concluded during September and October 2016 were set out in Appendix B of the report submitted together with the audits that were at draft report stage. All assurance opinions were substantial or adequate.

Allegations of fraud, corruption or other irregularity were also investigated with details of significant investigations completed in the period set out in Appendix C.

The report highlighted:-

- An Internal Audit Plan for 2016/17 had been produced in line with the UK Public Sector Internal Audit Standards
- The Plan had been reviewed and updated at the half year
- Although there was an overall reduction in audit days, it was still sufficient to give the required coverage
- Despite the challenges, Internal Audit was exceeding other key performance targets and feedback on several pieces of work completed demonstrated value added by the Service
- Management responses and action plans were in place for all recommendations made by Internal Audit during the period

Veritau Ltd. had been asked to review and provide independent comment on the progress reports. They had made a number of suggestions on presentation and highlighted areas for review but overall the report accurately reflected the work being undertaken by the Team.

Discussion ensued with the following issues raised/clarified:-

- The remaining vacant posts
- BDR waste disposal facility
- Responsive work and the impact on planned work
- Involvement of the independent partner, Veritau Ltd.

Resolved:- (1) That the performance of the Internal Audit Service during September and October, 2016, and the key issues that had arisen therefrom be noted.

(2) That the information contained regarding the performance of Internal Audit and the actions being taken by management in respect of the performance be noted.

(3) That the independent assurance provided by Veritau Ltd. on the report be noted.

35. ANNUAL AUDIT LETTER 2015-16

Debra Chamberlain, KPMG, presented the Annual Audit Letter (AAL) 2015/16 produced by KPMG summarising the external audit work in relation to the 2015/16 audit plan and highlighted the findings in relation to the following:

Value for Money Conclusion
Audit of Financial Statements
Any Other Matters the external auditor was required to communicate.

A copy of the AAL was attached to the report.

The main headlines from the AAL in relation to the accounts and other audit responsibilities were that:-

- As last year, the external auditor had issued a qualified Value for Money conclusion

- The Council's financial statements were produced to a good standard with only one minor presentational change being made. The financial statements were given an unqualified audit opinion on 26th September. The Narrative Report published alongside the financial statements was consistent with KPMG's understanding

- The Annual Governance Statement approved September's Audit Committee (Minute No. 19 refers), was consistent with KPMG understanding an compliant with the CIPFA/SOLACE framework in local government

- The Council's consolidation pack prepared to support the production of Whole of Government Accounts by HM Treasury was consistent with the audited financial statements

- There were no high priority recommendations or other matters that needed to be brought to the attention of the Audit Committee

Resolved:- That the final Annual Audit Letter 2015/16 presented to the Council by its external auditors, KPMG LLP, be noted and approved for publication on the Council's website.

36. IMPLEMENTATION OF RECOMMENDATIONS RESULTING FROM THE PWC REVIEW OF INTERNAL AUDIT

Further to Minute No. 22 of the meeting held on 21st September, David Webster, Head of Internal Audit, submitted the third progress report on the implementation of the recommendations made in the PWC review of Internal Audit.

Internal Audit had operated with a high vacancy level during most of 2016 to date. In addition there had been significant change since production of the PwC report including a refresh of procedures, a full service restructure and the subsequent recruitment to the Head of Internal Audit and a vacant senior auditor post.

Appendix 1 contained a full update of progress against the PwC recommendations with the key points being:-

Actions completed/certain to be completed as at October, 2016

- 19 actions, spread across 17 recommendations, 10 of which had been completed, 3 rated green (certain to be achieved) and 6 were amber rated (in progress/on target). There were no red rated actions

Key progress as at October

- 2015/16 audit plan successfully delivered (with 95% delivery achieved against the final plan)
- Completed service review and a restructure determined
- Audit structure and budget set up to provide for specialist audit resources to be engaged as required to carry out specified work in the audit plan
- Audit agreement between Rotherham and Doncaster Councils terminated on 30th September, 2016
- Improved consultation and engagement with senior management in audit planning and reviewing progress
- Recruitment to the new structure
- PDRs completed and a team development plan produced/implementation commenced
- Revised Audit Charter and Strategy
- Streamlined and improved audit review process
- New risk based style of audit report
- Evaluation of bids for an electronic audit system

Key actions in progress:-

- Production of plan to achieve full compliance with auditing standards, subject to regular review and reporting to Audit Committee
- Embedding of new audit scoping, reporting and performance monitoring and management processes
- Need for implementation of team development plan
- Implementation of electronic audit system, streamlining of administration and reduction of non-productive time
- Development of assurance mapping
- Development and reporting to Audit Committee of Quality Assurance and Improvement Programme to improve and maintain standards
- Full refresh of the Internal Audit Manual to reflect new PSIAS compliant, audit policies and procedures
- Establishment of programme to review the Council's Governance Arrangements set out in its Code of Governance

The Service would remain in transition until the Team reached full establishment. The procurement and implementation of an integrated audit management system would also facilitate consistency in the way in which audits were conducted and compliance with auditing standards.

It was required that an annual internal assessment be made of conformance with the Standards. This would be completed by the Head of Internal Audit and reported to the Audit Committee in February, 2017.

An external assessment was also required every 5 years by a qualified independent assessor. External assessments could be in the form of a full external assessment or a self-assessment with independent external validation. The CIIA had accepted that reviews within a peer group met the requirements for external assessments provided that the reviews were not reciprocal and were demonstrably independent, therefore, the review could be carried out by Veritau Ltd. or another South/West Yorkshire authority.

Progress against the action plan would be reported to the Audit Committee during 2016/17. Veritau Ltd. had been asked to comment on the progress reports and commented that it was a reasonable reflection of progress being made to implement the proposed actions.

Resolved:- That the progress made in implementing the recommendations included in the PwC review of Internal Audit be noted.

37. EXTERNAL AUDIT AND INSPECTION RECOMMENDATIONS

Further to Minute No. 22 of 27th April, 2016, Sue Wilson, Performance and Planning, presented a report detailing recent and current external audits and inspections including the details of arrangements that were in place regarding the accountability and governance for implementing any recommendations that arose.

The following update was given:-

Adult Social Care

- Treefields Close (Learning Disability Respite Service) – The outstanding recommendation regarding the Manager's registration had been completed and confirmed by the CQC in July, 2016
- Quarry Hill Road (Learning Disability Respite Service) –The jointly management arrangement with Treefields Close had been formally signed off and confirmed in July 2016 when the current Manager's registration was finalised
- Netherfield Court (intermediate care provider) - Closed in September 2016 with Lord Hardy Court and Davies Court taking on the role of providing residential intermediate care. Netherfield's last CQC inspection had resulted in it being awarded an overall rating of Good with 1 action recorded with respect to the way consent was obtained and recorded. Immediate action was taken to ensure client files

recorded this. Staff from Netherfield had been redeployed to Davies and Lord Hardy with both Managers being made aware of the actions taken by Netherfield with respect to the CQC requirements and had adopted them in their own services

- Park Hill (Learning Disability Residential Care Provider) – Service currently managed by the same person who managed Treefields and Quarry Hill. An application had been made with CQC to add Park Hill to her registration
- Home Enabling - Inspected on 7th July 2016 and rated as Good overall. No recommended actions
- Davies Court (Elderly Residential provider) – Inspected on 24th August, 2016, and awarded an overall rating of Good although improvements were identified in the recording of its response to service users who have a Deprivation of Liberty Safeguarding (DoLS) in place. The service had undertaken an audit of files to ensure the correct documentation was in place
- Adult Services had a good compliance record with standards subject to inspection. Governance arrangements remained under ongoing review and the Directorate's development programme was not subject to the enhanced governance arrangements applied within the Transformation Board
- Housing Service – no inspections or recommendations since the last report in April 2016

Children and Young People's Improvement Plan

- Improvement Plan revised in May 2016 following an intense period of change and improvement within Children's Services
- Revised Improvement Plan provided a refocus on the priority actions to ensure they mapped against the Ofsted judgements/ recommendations/findings and provided the opportunity to ensure that realists RAG ratings were noted for each action
- The 26 recommendations from the OFSTED inspection would remain in place and "open" in the refreshed Plan until the Secretary of State for the Department of Education had made a decision for Rotherham to come out of intervention and satisfied that all the requirements had been met
- Focus of the Plan to put in place a sustainable approach enabling CYPS to meet aspirational objectives and provide a continuous improvement cycle to enable movement to become a child-centred Borough with outstanding services
- Introduction of "focus on" agenda items at meetings of the Improvement Board
- Governance of the CYPS Plan by the Children's Improvement Board at its monthly meetings which also oversaw progress through monitoring, challenging and supporting the actions of the Plan
- Establishment of a Performance Board in May 2016

Ofsted Improvement Visits

- There had been 5 visits since August 2015 as part of their improvement offer looking at the MASH, Duty and Assessment, Child in Need, Child Protection, Leadership, Management and Governance, CSE, Missing Children and Early Help. This had been supplemented by 2 regional Sector Led Peer Reviews looking at Leadership management and Government in June 2016 and Looked After Children and Care leavers in October 2016
- The first Monitoring Visit took place in October. Looked After Children had been the subject
- It was likely that there would be 4 formal Monitoring visits before an Ofsted re-inspection (expected to be in Autumn 2017)

Rotherham's Residential Children's Units

- The care offered across the whole of Rotherham's residential care services for children and young people had been reviewed
- Aspiration of the Council to reduce the numbers of children placed in residential care
- Consultation had taken place with affected stakeholders regarding the proposed closure of Cherry Tree House and Silverwood Children's Residential Care Homes. Commissioner Bradwell had approved the closure of both Homes on 13th September, 2016
- Liberty House Short Breaks Children's Home had received a full inspection on 2nd/3rd November within the current inspection cycle. An aspirational improvement plan had been in place which was expected to take the Home from Good to Outstanding.

Economic Development Services and Housing and Neighbourhoods Services

- Feedback from the LGA peer health checks programme was being using positively throughout the Service to improve performance and quality and deliver service improvement
- Review of structures in Waste Management
- No further external inspections or audits had been undertaken

Finance and Corporate Services

- The External Auditor issued a range of reports each year which were presented to the Audit Committee e.g. External Audit Plan, Annual Audit Letter
- 1 medium and 1 low priority recommendations made in relation to the ISA260 report regarding the 2015/16 financial year
- Audit of the Council's 2014/15 claim was completed. The Council received only very minor qualifications resulting in amendments being made to the final claim in accordance with the DWP arrangements
- The audit of the Council's 2015/16 claim was underway

Resolved:- (1) That the governance arrangements that were currently in place for the monitoring and managing of recommendations from external audits and inspections be noted.

(2) That regular reports in relation to external audit and inspections and progress in implementing recommendations

38. ITEMS FOR REFERRAL FOR SCRUTINY

There were no issues for referral.

39. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12(A) of such Act indicated, as now amended by the Local Government (Access to Information) (Variation) Order 2006 (information relates to finance and business affairs).

40. STRATEGIC RISK REGISTER - ADULT CARE AND HOUSING

Councillor Roche, Cabinet Member, Adult Social Care and Health, together with AnneMarie Lubanski, Strategic Director, Adult Care and Housing, presented the Adult Care and Housing Strategic Risk Register in particular highlighting:-

- How the Register was maintained/monitored and at what frequency
- Cabinet Member involvement
- How risks were included on/removed from the Register
- Anti-fraud activity in the Directorate

Discussion ensued with the following issues raised:-

- The Mental Capacity Act and the volume of referrals as a result of the Cheshire West judgement
- Approval of Housing Revenue Account Business Plan and Asset Management Policies

Resolved:- That the progress and current position in relation to risk management activity in Adult Care and Housing be noted.

41. STRATEGIC RISK REGISTER

Simon Dennis, Corporate Risk Manager, presented the current Strategic Risk Register which took account of updates from Directorates, the Strategic Leadership Team and the Audit Committee.

The Register was currently updated every 6 weeks with the latest updated presented to the Strategic Leadership Team on 25th October, 2016.

The current Register had been constructed from updates provided by risk owners. There were 2 new risks, 9 that had been removed and 2 that had been merged into 1 giving a total of 18 risks.

In the majority of cases, the risks that had been removed were due to the risk now being managed at Directorate rather than Strategic level. This was a reflection of the increasing maturity of the Risk management process as well as the Strategic Leadership Team's wish to focus on risks that were crosscutting or strategic in nature.

Resolved:- That the updated Strategic Risk Register be noted.

Rotherham Metropolitan Borough Council

Public Report

Council Report
Audit Committee Meeting – 8 February 2017

Title
Internal Audit Progress Report for the two months ending 31 December 2016.

Is this a Key Decision and has it been included on the Forward Plan?
No.

Strategic Director Approving Submission of the Report
Judith Badger, Strategic Director, Finance and Customer Services.

Report Author(s)
David Webster, Head of Internal Audit
Tel: 01709 823282 Email: david.webster@rotherham.gov.uk

Ward(s) Affected
All wards.

Executive Summary
This report provides a summary of Internal Audit work completed during the period November to December 2016 and the key issues that have arisen from it. It also provides information regarding the performance of the Internal Audit function during the period.
Performance against key indicators is generally positive. The audit plan was reviewed and amended at the half year. Delivery against the amended plan is on schedule. No adverse audit opinions were issued during the last three months.
Following the presentation of the PWC review of Internal Audit report to the Audit Committee in February 2016, Veritau Ltd was commissioned to independently review and provide commentary on Internal Audit progress reports presented to the Audit Committee in 2016/17. Veritau Ltd has reviewed the attached report and have stated "We've reviewed the report and made a number of suggestions on presentation and highlighted areas for review. Overall, the report accurately reflects the work being undertaken by the team".

Recommendations
The Audit Committee is asked to:

- **i) Note the Internal Audit work undertaken since the last Audit Committee, November to December 2016, and the key issues that have arisen from it.**
- **ii) Note the information contained regarding the performance of Internal Audit and the actions being taken by management in respect of the performance.**
- **iii) Note the independent assurance provided by Veritau Ltd on the report.**

List of Appendices Included
Appendix 1 – Internal Audit Progress Report for the two months ending 31 December 2016.

Background Papers
UK Public Sector Internal Audit Standards and Associated Local Government Application Note.
Accounts and Audit (England) Regulations 2015.

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No.

Council Approval Required
No.

Title: Internal Audit Progress Report for the three months ending 31 December 2016

1. Recommendations

The Audit Committee is asked to:

i) Note the Internal Audit work undertaken since the last Audit Committee, in the period November to December 2016, and the key issues that have arisen from it.

ii) Note the information contained regarding the performance of Internal Audit and the actions being taken by management in respect of the performance.

iii) Note the independent assurance provided by Veritau Ltd on the report.

2. Background

2.1 Internal Audit produced a risk based Annual Audit Plan in accordance with the UK Public Sector Internal Audit Standards. This was received by the Audit Committee at its meeting on 27 April 2016. The Plan is regularly reviewed and monitored during the year so that it provides sufficient coverage of the key risks facing the Council.

2.2 The plan was the subject of a half year review. All Strategic Directors were consulted to bring it up to date and match it to the available resources, whilst ensuring that it provides sufficient coverage to enable the year end Internal Audit opinion to be reached.

2.3 At the end of the financial year, Internal Audit will produce an Annual Internal Audit Report, which will provide our overall opinion on the adequacy of the Council's control environment and compliance with it during the year.

2.4 This is the fourth progress report and summarises the main activities of the Internal Audit service for the period since the last Audit Committee, in the period November 2016 to December 2016.

3. Key Issues

3.1 The fourth progress report is attached at **Appendix 1** and includes the following information:

- Progress against the Audit Plan
- Audit work, planned and responsive, undertaken during the period
- Management assurance on the implementation of recommendations
- Progress against the improvement actions from the external review
- Internal Audit performance indicators.

3.2 Headlines from the report include:

- An Internal Audit Plan for 2016/17 was produced in line with the UK Public Sector Internal Audit Standards.
- The plan was reviewed and updated at the half year. Although there is an overall reduction in audit days it is still sufficient to give the required coverage. In the context of the changes happening within the service during this year so far, this is not a disturbing position. The changes being made now will increase efficiencies in future years.
- Despite the challenges it faces, Internal Audit is exceeding other key performance targets, and feedback on several pieces of work completed demonstrate value added by the Service. This is demonstrating some positive progress on the improvement journey.

- Management responses and action plans were in place for most recommendations made by Internal Audit during the period. Management demonstrates a conscientious response to audit recommendations and overall ensures recommendations to improve internal controls are implemented. Details of the numbers of recommendations made; agreed; implemented and outstanding are also included in the progress report.

- Most of the actions from the external review have been completed. A new annual assessment against PSIAS has been carried out and the two remaining actions will become part of the action plan from that assessment.

3.3 Internal Audit progress reports are presented to the Audit Committee at each of its meetings. Veritau Ltd has been asked to review and provide independent comment on the progress reports during 2016/17. Veritau Ltd reviewed a draft copy of the progress report and selected supporting information. Veritau concluded: "We've reviewed the report and made a number of suggestions on presentation and highlighted areas for review. Overall, the report accurately reflects the work being undertaken by the team".

4. Options considered and recommended proposal

4.1 This report is presented to enable the Audit Committee to fulfil its responsibility for overseeing the work of Internal Audit. It provides a summary of Internal Audit work completed and the key issues arising from it for the two months ending 31 December 2016 and information about the performance of the Internal Audit function during this period.

5. Consultation

5.1 All Internal Audit reports referred to in this report have been discussed and agreed with management in the respective service areas.

6. Timetable and Accountability for Implementing this Decision

6.1 The Audit Committee is asked to receive this report at its February 2017 meeting.

7. Financial and Procurement Implications

7.1 There are no direct financial or procurement implications arising from this report. The budget for the Internal Audit function is contained within the budget for the Finance and Customer Services Directorate.

8. Legal Implications

8.1 The provision of Internal Audit is a statutory requirement for all local authorities that is set out in the Accounts and Audit (England) Regulations 2015. These state:

"each principal authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance."

8.2 Internal Audit also has a role in helping the Council to fulfil its responsibilities under s.151 of the Local Government Act 1972, which are:

"each local authority shall make arrangements for the proper administration of their financial affairs and shall secure that one of their officers has responsibility for the administration of those affairs"

9. Human Resources Implications

9.1 There are no direct Human Resources implications arising from this report. However, it should be noted that the Chief Internal Auditor and the Assistant Director Audit, ICT and Procurement both left the Authority on 30th September 2016 and the new Head of Internal Audit (HIA) commenced on 17th October 2016, reporting directly to the Strategic Director Finance and Customer Services. A Senior Auditor was appointed and commenced work on 3rd October 2016. Another Senior Auditor commenced work on 23rd January 2017. The contract auditor used to cover the vacancies has now finished working for the Council. For the first time this year the team has a full complement.

10. Implications for Children and Young People and Vulnerable Adults

10.1 This document constitutes a report of progress against delivery of the Internal Audit Plan 2016/17. A significant proportion of the Plan is devoted to the examination of risks facing Children and Young People's Services and Adult Social Care, and that remains the case after the review of the plan.

11. Equalities and Human Rights Implications

11.1 There are no direct Equalities and Human Rights Implications arising from this report.

12. Implications for Partners and Other Directorates

12.1 Internal Audit is an integral part of the Council's Governance Framework, which is wholly related to the achievement of the Council's objectives, including those set out in the Corporate Improvement Plan and Children's Services Improvement Plan.

13. Risks and Mitigation

13.1 An effective Internal Audit Department helps to minimise the Council's exposure to risk.

14. Accountable Officer(s)

David Webster, Head of Internal Audit.

Appendix 1:

Finance and Customer Services Directorate

Internal Audit Progress Report for the two months ending 31 December 2016

1. Purpose of the Report

1.1 To provide a summary of Internal Audit work completed and the key issues arising from it for the period since the last Audit Committee, covering November and December 2016.

1.2 To provide information regarding the performance of the Internal Audit function during the period.

2. Introduction

2.1 Internal Audit produced a risk based Annual Internal Audit Plan in accordance with the UK Public Sector Internal Audit Standards (PSIAS). This was received by the Audit Committee at its meeting on 27 April 2016. The plan is regularly monitored and reviewed during the year so that it provides sufficient coverage of the key risks facing the Council.

2.2 At the end of the financial year, Internal Audit will produce an Annual Internal Audit Report, which will incorporate an overall opinion on the adequacy of the Council's control environment and compliance with it during the year.

2.3 This report summarises the main activities of the Internal Audit service for the period since the last Audit Committee, covering November and December 2016. The report is presented to the Audit Committee to enable the Committee to fulfil its responsibility for overseeing the work of Internal Audit.

3. Legislation Surrounding Internal Audit

3.1 The provision of Internal Audit is a statutory requirement for all local authorities that for the period under consideration is set out in the Accounts and Audit (England) Regulations 2015. These state:

> *"each principal authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance."*

3.2 Internal Audit also has an important role in helping the Council to fulfil its responsibilities under s.151 of the Local Government Act 1972, which are that:

> *"each local authority shall make arrangements for the proper administration of their financial affairs and shall secure that one of their officers has responsibility for the administration of those affairs".*

3.3 In order to deliver its functions as determined by statute and professional standards, Internal Audit has unrestricted coverage and access to all employees, records and assets of the Council. It has the authority to enter any Council premises and receive prompt response, every assistance, all

information and explanation from Council employees and Council Members. Additionally, it has unrestricted access to, and the freedom to report to, the Commissioners appointed by the Government, The Chief Executive; Head of Paid Service, the Responsible Financial Officer, the Monitoring Officer and the Audit Committee as per the requirements set out in PSIAS and the Internal Audit Charter.

4. Audit Planning Process

4.1 The 2016/17 Audit Plan was produced in line with the UK Public Sector Internal Audit Standards and examined the whole audit universe, taking into account of the following:

- Analysis of the Council's risk registers
- Examination of revenue and capital budgets
- Cumulative audit knowledge and experience of previous work undertaken
- Review of both Corporate Improvement and Service Plan objectives and priorities
- Discussions with Strategic Directors and Directors
- Knowledge of existing management and control environments
- Professional judgement on the risk of fraud or error.

4.2 The 2016/17 Audit Plan was approved by Audit Committee on 27 April 2016.

5. Factors affecting audit work completion during the year

5.1 The service has faced a very significant transition period involving a restructure and a further reduction in resources available to the team to 7fte for 2016/17 (from 9fte in 2015/16). During the summer 2016 the Service operated with only 4ftes with an additional temporary contracted auditor, due to vacancies within the Team. All of the three vacant posts have now been filled; one Senior Auditor level and the new Head of Internal Audit commenced in October 2016; the other Senior Auditor commenced on 23rd January. The temporary contracted auditor has now finished working for the Council.

5.2 In addition to a shortfall in resources, various other factors have continued to impact on the delivery of planned audit work, including:

- There has been no let-up in the demand for responsive audit work on potential irregularities or in response to whistleblowing allegations (140 days used against an annual provision of 120 days).
- Work and time required to progress actions in the PWC Review of Internal Audit Action Plan, and the implementation of and the assessment of compliance with the UK Public Sector Internal Audit Standards (PSIAS) and Local Government Application Note (LGAN) Action Plan (60 days)
- Devotion of resources into ensuring progress on the delivery of recommendations contained in the Anti-Fraud and Corruption Action Plan.
- Devotion of resources to update a number of key documents that have also been presented to the Audit Committee, including the Internal Audit Charter; Strategy, and Anti-Fraud and Corruption Strategy and Policy.
- Carried forward work from the 2015/16 audit plan (85 days)

5.3 The Veritau commentary on the Quarter 1 Progress Report in July included the following paragraph about reporting on the plan.

We would also suggest that aiming for 100% completion of the audit plan by year end is probably unrealistic. Even where the majority of fieldwork can be completed by March, there will inevitably be delays in finalising work. Most services we are aware of tend to set targets of audit plan completion in the range 80 - 90% - the point at which this is measured varies (end of March or end of April). The key is to make it clear that audit work is actually an ongoing process and % completion figures of less than 100% are a reflection of this. Veritau currently works on the basis of a 93% target for completion by the end of April. Actual planning years are April to March and we manage brought forward / carried forward work as part of work scheduling arrangements.

5.4 In the context of the challenges facing the Service and the changes happening during this year so far, the Service has made strong efforts and reasonable progress in keeping in touch with expectations relating to the delivery of planned work.

5.5 The Strategic Director Finance and Customer Services and Head of Internal Audit will continue to closely manage the situation, adjusting resources wherever required to ensure the service delivers the audit plan and achieves the necessary improvements outlined in the PWC report in February 2016.

6. Half year review of the Audit

6.1 The 2016/17 Audit plan was reviewed and updated at the half year. The aims of the review were to ensure that the plan remained relevant to match the available resources to the plan and to ensure that the plan enables the Head of Internal to give his annual opinion on the adequacy and effectiveness of the control environment. Progress against the plan is shown in **Appendix A**. This shows the original and revised plan. There have been no further changes to the plan.

7 Audit Work Undertaken During the Period

7.1 Internal Audit provides an 'opinion' on the control environment for all systems or services which are subject to audit review. These are taken into consideration when forming our overall opinion on the Council's control environment.

7.2 As part of its improvement plans, Internal Audit has introduced a new Executive Summary and reporting format, and a new opinion assessment scale. This provides four levels of assurance for any area under examination, these being "Substantial Assurance", "Reasonable Assurance" "Partial Assurance" and "No Assurance". This approach is considered to be more informative than the previous simple "adequate" / "inadequate" opinion that was given. Audit opinions and a brief comment for all audit work concluded since the last Audit Committee are set out in **Appendix B**.

7.3 In addition to the planned audit assurance work, Internal Audit also carries out responsive work and investigations into any allegations of fraud, corruption or other irregularity. Details of significant responsive work carried out since the last Audit Committee are set out in **Appendix C**.

7.4 There were no adverse opinions issued during the period.

8. Management Response to Audit Reports

8.1 Following the completion of audit work, draft reports are sent to the responsible managers to obtain their agreement to the report and commitment to the

implementation of recommendations. This results in the production of agreed action plans, containing details of implementation dates and the officers responsible for delivery.

8.2 Confirmation of implementation of audit recommendations is sought from service managers, in most cases two months after actions have been agreed. Where fundamental weaknesses in internal control arrangements have been identified, more detailed follow work is undertaken.

8.3 Internal Audit has now also introduced procedures to report any lack of progress in implementing recommendations to Directorate Leadership Teams, and where relevant, the Strategic Leadership Team and the Audit Committee.

8.4 A list of the number of recommendations made and their current status is attached at **Appendix D.** This now includes recommendations made in 2015/16 which are still outstanding. These will continue to be followed up with management.

9. Work for Outside Bodies

9.1 During the period Internal Audit provided audit services on a fee earning basis to two academies. Since academies are separate legal entities to the Council, this work does not have any impact on our overall opinion of the Council's control environment.

10. Internal Audit Performance Indicators

10.1 Internal Audit's performance against a number of indicators is summarised below. Both the chargeable time % and the cost per chargeable day were adversely affected in the last three months by the Christmas holidays. One report was issued late – an ICT report prepared by external resource which required greater review.

Performance Indicator	2016/17 Target	Sept and Oct 2016	Nov and Dec 2016
Draft reports issued within 15 working days of field work being completed.	95%	100%	100%
Percentage of 3 star (fundamental control weakness) recommendations agreed.	100%	100%	100%
Chargeable Time / Gross Time.	72%	77%	67%
Audits completed within planned time	95%	100%	92%
Cost per Chargeable Day.	£295	£280	£320
Client Satisfaction Survey.	100%	100%	100%

11 Actions from the PwC Review

11.1 PricewaterhouseCoopers (PwC) completed a review of Internal Audit, reporting to the Audit Committee in February 2016. This was a comprehensive review and it recommended 19 actions to improve the service and ensure compliance with audit standards. Progress reports have been presented to each Audit Committee since then. At the November meeting 13 actions were reported as Green (completed) with 6 as Amber (outstanding). Those six actions are shown in **Appendix E.** Of the six

- Two are now completed (nos. 4 and 10 - green).
- Two are certain to be completed early in 2017/18 (nos.15 and 17).
- Two will be addressed in 2017/18 (nos. 5 and 9). They are now actions from the annual assessment against Public Sector Internal Audit Standards.

12 Future Development

12.1 The Council is in the process of procuring integrated internal audit software for the department. When fully implemented the software will integrate all aspects of the internal audit cycle: strategic planning; scheduling; scoping; testing; reporting; recommendation tracking; client satisfaction; time and performance management. It will entail a large amount of work initially but will greatly increase the efficiency of the team in the future. It is hoped to start the introduction of the software within this financial year.

Appendix A

Internal Audit Plan 2016/17

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
CHILDREN AND YOUNG PEOPLE'S SERVICES				
Family Care	To ensure that children placed away from birth parents within family / friends settings are properly looked after.	**15**	**15**	
Sustainable Improvements: Children and Young Peoples Quality Assurance Framework	To ensure that Children and Young People's Services has an effective quality assurance framework in place.	**15**	**0**	
Children in Care Placements Process	To ensure that the placement process delivers children the care they need and the Council secures value for money.	**15**	**0**	
Direct Payments	To ensure that the Council has proper arrangements for the administration of Direct Payments	**10**	**10**	**In Progress**
Children missing	To ensure that children who go missing from home or care are properly catered for.	**15**	**5**	**In Progress**
New Children's Social Care System: Liquid Logic	To ensure that Children's Services are supported by an information system that enables them to delivery statutory functions.	**15**	**15**	**Completed**
Children's Homes	To ensure that systems are in place to ensure the proper administration of children's homes.	**5**	**5**	
Troubled Families Grant	To ensure that the Council claims grant properly.	**5**	**5**	**Completed**
Fostering Allowances	To ensure that payments made to foster carers are correct.	**15**	**10**	
Procedures for investigation of safeguarding concerns	To ensure that safeguarding concerns are properly investigated.	**10**	**10**	

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
Schools: Financial Administration	To ensure that the finances of maintained schools are being administered properly.	**35**	**15**	
Early Years Childcare Provision	To ensure that payments to independent sector childcare providers are made in accordance with conditions attached to the funding.	**15**	**15**	
Schools Deficit Budget	To ensure that the risks associated with schools operating with, or falling into, deficit budgets are recorded, mitigated and strictly monitored.	**0**	**10**	**In Progress**
ADULT CARE AND HOUSING				
Housing Repairs and Maintenance Contracts	To ensure that the Council has effective contract management arrangements with respect to its contracts with Mears and Willmott Dixon Partnership.	**20**	**10**	
Housing Capital Programme	To ensure that the Council has robust contract management arrangements for the Housing Capital Programme.	**20**	**10**	
Housing IHMS Phase 2	To ensure the successful implementation of the 2nd phase of the IHMS system.	**15**	**15**	**Completed**
Housing Rents System	To ensure the new housing rents system is fit for purpose and is operating in line with expectations.	**20**	**10**	
Housing Revenue Account Business Plan	Ensure that Housing Revenue Account Business Plan is delivered.	**10**	**5**	
Adult Social Care Direct Payments	To ensure that payments made via the direct payments system are bona fide.	**20**	**20**	
Adult Social Care Supported Living	Ensure that adults receive the care they need.	**10**	**10**	**In Progress**
Adult Social Care Social Care Establishments	Ensure that systems are in place to monitor the quality and effective running of residential homes, day	**20**	**20**	**Completed**

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
	centres and other establishments.			
PUBLIC HEALTH				
Public Health Commissioning Payments Process	To assess the adequacy of the processes in place for making payments to GPs, Pharmacies and other providers for Public Health commissioned services.	**25**	**15**	
Public Health Commissioning Contract Compliance Process	To assess the adequacy of Council's arrangements for ensuring that GP's, pharmacies and other providers carry out their work in accordance with contract	**10**	**0**	
Public Health Grant Spend	To assess how the public health budget has been spent across the borough and verify that it has been spent on Public Health Outcomes	**0**	**10**	**Draft**
REGENERATION AND ENVIRONMENT				
Business Continuity Arrangements	To ensure that RMBC has effective Business Continuity arrangements in place.	**15**	**15**	**In Progress**
Contract Management	To ensure that the Council has effective management arrangements in place for both revenue and capital contracts.	**20**	**20**	**In Progress**
Licensing Administration and Licensing Enforcement	To ensure that the Licensing function is fit for purpose so as to contribute to: • the prevention of crime and disorder • public safety • the prevention of public nuisance • the protection of children from harm	**30**	**30**	**Completed**
Waste Disposal including operation of BDR facility at Manvers	To ensure that there are proper financial management and governance procedures in place for the new Waste Treatment facility at Manvers.	**15**	**15**	**Completed**

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
Heritage Services	To ensure that the Council's Historical Sites are safeguarded from deterioration, neglect and vandalism and are safe to the public.	**10**	**10**	**Completed**
Corporate Landlord Responsibilities	To ensure that the Council's operational and non-operational estate is safe.	**20**	**10**	
Income Collection	To ensure that the Council has robust arrangements for income collection at its establishments.	**20**	**20**	**In Progress**
Hellaby Depot: Fleet contract / Hire of plant and equipment	To ensure that robust arrangements are in place at the Hellaby Depot for management of the fleet contract and the hire of plant and equipment.	**15**	**15**	**Completed**
Schools Catering Service **Building Cleaning Service**	To ensure that the Schools Catering Service and the Building Cleaning Service maintain financial stability.	**20**	**20**	
FINANCE AND CUSTOMER SERVICES				
Housing Benefits and Council Tax Reduction	To ensure that the Council has proper arrangements for the administration of Housing Benefits and Council Tax Support.	**15**	**15**	**Completed**
Creditor Payments / Purchase to Pay	To ensure that the Council has proper arrangements for making payments to suppliers for goods and services	**15**	**15**	**Completed**
Creditor Payments / Purchase to Pay	To ensure that the Council has proper arrangements for making payments to suppliers for goods and services	**0**	**10**	**Completed**
Procurement	To ensure that the Council has effective arrangements to ensure value for money when buying goods and services.	**15**	**15**	**In Progress**
Council Tax	Ensure that the Council has proper arrangements for the	**10**	**10**	**Completed**

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
	collection of Council Tax.			
Debtors	To ensure that the Council has proper arrangements for the collection of debt.	**10**	**10**	**Completed**
NNDR	To ensure that the Council has proper arrangements for the collection of national non domestic rates.	**10**	**10**	**Completed**
Adult Social Care Financial Assessments	To ensure that the Council has proper arrangements for carrying out financial assessments.	**10**	**10**	
CIDS: Freedom of Information / Data Subject Access Requests	To ensure the Council is dealing with Freedom of Information requests and Data Subject Access requests effectively.	**10**	**10**	**In Progress**
CIDS: Information Governance	To ensure that the Council has effective information governance arrangements.	**20**	**20**	**In Progress**
Whistleblowing Procedures	To ensure that the Council listens to whistle-blowers and investigates their concerns properly.	**10**	**10**	
ICT: Active Directory	To ensure Active Directory arrangements are effective.	**10**	**10**	
ICT: Network Security	Ensure sufficient security arrangements are in place to protect the Council's network and business critical systems	**10**	**0**	
ICT: Asset Management	Ensure that the Council has effective arrangements to manage its ICT assets.	**10**	**10**	**Completed**
ICT: Data Security	Ensure that the Council has effective arrangements in place to protect its own data and its service users' data.	**10**	**10** **(external)**	
ICT: Business Continuity	Ensure that the Council's business critical systems can continue to operate through unforeseen circumstances.	**10**	**0**	
Digital Council	To ensure that the Council has effective control of its major systems developments.	**10**	**0**	
Corporate	To ensure that services are	**20**	**0**	

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
Improvement Plan and Children's Services Improvement Plan	improved and there is a good understanding of improvement priorities across the organisation to ensure that the Government takes no further intervention steps and no services are permanently removed (e.g. Children's).			
Agency Workers	To ensure that value for money is obtained in the procurement of agency staff.	**15**	**15**	**In Progress**
Communications & Marketing	Ensure the Council is able to maintain and preserve required levels of sensitivity when dealing with information in relation to Communications and Marketing.	**10**	**0**	
Payroll	To ensure that the Council has proper arrangements for the payment of wages, salaries and expenses to employees.	**20**	**20**	**Completed**
Human Resources Policies	To ensure the Council is compliant with HR Policies and Procedures	**20**	**0**	
DBS Checks	To ensure that DBS checks are carried out properly where required.	**10**	**10**	**Draft**
Risk Management	To ensure that the Council has effective risk management arrangements.	**10**	**10**	**Draft**
Democratic Services: Elected Members	Ensure that the conduct of elected members meets the highest standards expected in public life (The outcome of elections could have a significant impact on the administration of the authority moving forward)	**5**	**5**	**Completed**
Annual Governance Statement / Review of Internal Control Effectiveness	To ensure that the Council has an effective system of internal control and an evidenced AGS.	**15**	**10**	

Appendix A

Audit Area	*Assurance Objective*	*Original Audit Days*	*Half Year Review*	*Status*
ANTI FRAUD AND CORRUPTION WORK				
Fraud NFI Datasets	Mandatory requirement.	**10**	**10**	**In Progress**
Fraud Annual Report	Corporate requirement.	**5**	**5**	
Fraud Proactive Anti-Fraud Activity		**20**	**20**	**In Progress**
Fraud Advice / Guidance	Ensure that the Council limits as far as possible its exposure to fraud.	**20**	**20**	
GRANTS				
Sport England 1 Sport England 2 Pot Hole Additional Highway Maintenance Disabled Adaptations Bus Operators		**18**	**18**	**Completed**
WORK FOR EXTERNAL AGENCIES				
Academies	Provision of paid audit service for academies	**48**	**48**	**In Progress**
AUDIT PLANNING, FOLLOW UP AND RESPONSIVE				
Planning; Control and Reporting	Provide quarterly update reports to Audit Committee.	**50**	**50**	
Follow Up Work	Ensure significant recommendations made during 2015/16 are followed up	**37**	**37**	
Responsive	Ensure audit resources and experience, is available to provide a professional level of advice and investigatory experience in the event of any incidents of fraud or corruption.	**120**	**120**	**140**
TOTAL DAYS		**1143**	**968**	

Summary of Audit Work Completed since the last meeting

Note:- Internal Audit has introduced a new Executive Summary and reporting structure which now gives four levels of overall assurance for areas under examination. Within each area audited individual risks are assessed as being either "Substantial Assurance", Reasonable Assurance", "Partial Assurance" and "No Assurance", with an overall assurance opinion taking into account the opinions of all the risks assessed.

Audit Area	Assurance Objective	Final Report to man't	Overall Audit Opinion	Summary of Significant Issues
ACH				
Social Care Establishments	Ensure that systems are in place to monitor the quality and effective running of residential homes, day centres and other establishments	22.11.16	Reasonable	The audit looked at a number of areas and found no fundamental concerns. Recommendations were made on the controls around clients' money and inventory.
Finance and Customer Services				
ICT Asset Management	Ensure that the Council has effective arrangements to manage its ICT assets.	18.11.16	Reasonable	The audit found generally good control, with a few concerns around old and out of date IT equipment, and some inventory records being incomplete.
Debtors	To ensure that the Council has proper arrangements for the collection of debt.	14.12.16	Reasonable	The audit found areas of good practice around the debt recovery and write off processes. Recommendations were made to improve controls around monitoring and reporting, and the authorisation of reconciliations.
National Non Domestic Rates	To ensure that the Council has proper arrangements for the collection of national non domestic rates.	18.11.16	Substantial	The audit found that controls and processes were operating effectively. Areas of good practice included the review of exception reports, valuation and liability.
Regeneration and Environment Services				
Licensing Administration and Enforcement	To ensure that the Licensing function is fit for purpose so as to contribute to: the prevention	8.12.16	Reasonable	The audit found reasonable assurance but with some areas where controls were not developed, or were not consistently or effectively applied. Recommendations

Audit Area	Assurance Objective	Final Report to man't	Overall Audit Opinion	Summary of Significant Issues
	of crime and disorder; public safety; the prevention of public nuisance; the protection of children from harm.			were made to improve the controls.
Heritage Services	To ensure that the Council's operational and non-operational estate is safe.	10.11.16	Reasonable	The audit found that policies and procedures were adequate. Some minor recommendations were made to increase controls.

Appendix C

Investigations / Responsive Audit Work

Audit Area	Completion Date	Summary of Significant Issues
Whistle blowing allegations – contracts	December 2016	The police had already investigated these allegations and concluded that were not valid. Further investigations by Internal Audit of contract monitoring arrangements did not find any evidence to support the allegations.
Whistle blowing allegations - contracts	2.12.2016	We found no evidence to suggest that bias had been shown or the existence of inappropriate relationships between officers and suppliers that might have compromised the integrity of the process. However, we did identify some weaknesses in the controls and processes and instances where existing processes were not applied.
Evaluation and awarding of contracts	November 2016	Current Council procedures were followed. However, recommendations were made to improve the procedures in the future.
Review of financial systems at an external site.	14.12.2016	All transactions were successfully evidenced to documentation. However, we were not able to examine financial records relating to non-Council activity so could not give overall assurance.

Appendix D

		Total Recommendations								3* Recommendations						
Audit	Final Report Issued	Made	Agreed	Not Yet Due	No response	Implemented	Deferred / Outstanding	New response due date		3* Recs Made	3* Recs Agreed	3* Recs Not yet due	3* Recs No response	3* Recs Implemented	3* Recs Deferred / Outstanding	3* Recs New Due Date
Assistant Chief Exec																
Whistleblowing Arrangements - RES05-1516	09/09/2016	4	4			2	2	31/01/2017		0						
Adult Care and Housing																
Housing: IHMS Phase 2	30/08/2016	9	9			5	4	31/01/2017		4	4			2	2	31/01/2017
Adult Social Care: Social Care Establishments: Lo	06/09/2016	17	17			8	9	23/01/2017		0						
Adult Social Care: Social Care Establishments: Parkhill Lodge		13	13	13						0						
CYPS																
Closed Childrens Homes (Laptops) - R04-1516	15/08/2016	3	3			1	2	20/01/2017		2	2			1	1	20/01/2017
Children Centres Administration - CYPS08-1516	28/04/2016	5	5			4	1	31/03/2017		0						
New Children's Social Care System: Liquidlogic	09/09/2016	9	9				9	27/01/2017		0						
Regeneration and Environment																
Licensing Enforcement Follow Up	31/08/2016	6	6				6	31/01/2017		3	3				3	31/01/2017
Licensing Service	08/12/2016	15	15	15						0						
Heritage Sites	10/11/2016	4	4				4	27/01/2017		0						
Waste Treatment Facility	07/11/2016	8	8			6	2	31/01/2017		0						
Hellaby Depot: HTST Contract Monitoring	02/12/2016	11	11	11						0						
Finance and Customer Services																
ICT: Asset Management	18/11/2016	6	6			1	5	30/04/2017		1	1				1	30/04/2017
Responsive																
Confidential Waste Disposal - R05-1516	02/07/2016	4	4				4	31/01/2017		2	2				2	28/11/2016
Breathing Space	22/07/2016	11	11			7	4	27/01/2017		0						
Hellaby Whistleblowing Allegations - Taxi Camera	09/12/2016	4	4	4						0						
Public Health - Awarding Contracts	25/11/2016	3	3	3						0						
Fundamental Systems																
Housing Rents - S010-1516	19/09/2016	4	4			1	3	31/01/2017		0						
Debtors	13/12/2016	12	12	12						0						
National Non Domestic Rates	18/11/2016	0								0						
Last Year																
Finance and Customer Services																
Information Governance: Freedom of Information	19/02/2016	5	5			4	1	30/04/2017		0						
Adult Care and Housing																
Direct Payments - Key Controls	31/03/2016	1	1				1	30/04/2017		0						
CYPS																
Fostering and Adoption Allowances: Adoption Allo	21/05/2015	8	8			6	2	20/01/2017		0						
Home to School Transport - EDS	19/01/2016	5	5			4	1	01/04/2017		0						
Home to School Transport - CYPS	20/01/2016	6	6			3	3	31/01/2017		1	1			1		
Growth Plan	05/04/2016	7	7			1	6	31/01/2017		0						
Special Educational Needs and Disabilities	03/12/2015	12	12			11	1	31/01/2017		0						
Public Health																
Housing Landlord Responsibilities	24/03/2016	10	10			8	2	30/04/2017		3	3			3		

Appendix E

Ref	Recommendation	Priority Rating	Progress	Current Status (RAG)
4	**PSIAS and improvement plan** An improvement plan should be developed by the CAE/CIA based on the recommendations made in this report and the improvements required to fully meet the PSIAS requirements. This should include allocations of responsibility and timescales and should be tracked to evidence improvement.	**High**	**Completed** – An action plan has been produced. Separate updates have been provided on a regular basis to the Audit Committee. The annual assessment against PSIAS has been completed and will form the basis of the improvement plan for 2017/18.	
5	**Implementing change – new working practices** Changes to working practices should be supported by an implementation plan and the provision of support and training if required. Staff should be able to see opportunities for personal development in the introduction of new practices – opportunities to increase coaching and supervisory skills and increase empowerment should be emphasised so that staff buy into the proposed changes.	**High**	A team development plan has been produced but not yet implemented. Now an action from the annual assessment.	**Implementation of team development plan during 2017/18.**
9	**Assurance map – identifying gaps in assurance** An assurance map should be developed identifying key risks not being addressed through IA work and detailing any other sources of assurance. This should be presented to the Audit Committee as part of the annual planning process.	**Medium**	Audit planning for 2017/18 includes an initial evaluation of assurances available in addressing the Council's key risks. To be developed further during 2017/18. Now an action from the annual assessment.	**Initial evaluation made, but further development is required.**

10	**Risk management within the Council** Consideration should be given to the role of IA in improving the Council's risk management arrangements. This should be in the form of support and facilitation building on the audit teams expertise in risk and control, whilst acknowledging that overall responsibility lies with management. We have been advised that steps are being taken by the Council to review and improve its risk management arrangements.	**Medium**	An audit review of Risk Management has been completed. The draft report shows Reasonable Assurance.	
15	**Performance information** IA should review the process for management information including time recording and job analysis. This will facilitate greater control over audit productivity as well as providing a basis for performance monitoring. The CAE/CIA should look to agree a series of performance indicators with the S151 Officer and regularly report on these indicators to demonstrate performance of the IA function.	**Medium**	Revisions have been made to streamline the current, manual, arrangements. Further efficiencies will be achieved through the implementation of an electronic audit system (rec 17).	**Amber**
17	**Technology** The CIA/CAE should consider the benefits of introducing an automated audit system to increase consistency and improve the quality assurance process. They should also consider what immediate skills are required to deliver the current IA plan.	**Medium**	The supplier has been chosen after a competitive tendering exercise. Currently awaiting contract completion before implementation can commence. Implementation will take time and the benefits will not be apparent until the next financial year.	**Amber**

Rotherham Metropolitan Borough Council

Public Report

Summary Sheet

Council Report:
Audit Committee

Title:
Internal Audit Self-Assessment against the Public Sector Internal Audit Standards.

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report:
Judith Badger (*Strategic Director of Finance and Customer Services)*

Report Author(s):
David Webster (Head of Internal Audit)

Ward(s) Affected:
None

Executive Summary:
All Internal Audit departments in Local Government must comply with the Public Sector Internal Audit Standards (PSIAS). The standards include the need for an annual self-assessment to confirm compliance, with an external assessment at least every five years.

An external assessment was completed by PwC in 2015-16, who found that the department did not conform with the standards. This paper gives the results of the internal self-assessment for 2016-17 completed by the new Head of Internal Audit. It finds that substantial progress has been made in the past year, so that the department now demonstrates partial conformance with the standards. Summary and detailed results are given in the paper.

Actions will be taken over the coming year to bring the department to general conformance with the standards. It is recommended that another external assessment take place next year to verify general conformance at that time.

Recommendation:
The Audit Committee is asked to

a. **Note the result of the self-assessment against the PSIAS.**

b. **Note the progress made from the external assessment carried out in 2015/16.**

c. **Confirm that an external peer review should be completed in 2018 when general conformance will be reached.**

Background Papers:
Public Sector Internal Audit Standards.
Local Government Advice Note.

Consideration by any other Council Committee, Scrutiny or Advisory Panel:
No

Council Approval Required:
No

Exempt from the Press and Public:
No

Title:
Internal Audit Self-Assessment against the Public Sector Internal Audit Standards.

1. Recommendations

The Audit Committee is asked to:

- **Note the result of the self-assessment against the PSIAS.**
- **Note the progress made from the external assessment carried out in 2015/16.**
- **Confirm that an external peer review should be completed in 2018 when general conformance will be reached.**

2. Background

2.1 Professional Standards for Internal Audit are set out in the Public Sector Internal Audit Standards (PSIAS). These require an annual internal assessment of conformance against the standards, with an independent assessment of internal audit at least every 5 years.

2.2 In 2015, the Interim Director of Finance and Corporate Services commissioned a review of Internal Audit to be conducted by PWC, following a competitive tender exercise. The PWC review was a comprehensive assessment. The report following the review was presented to the Audit Committee in February 2016. It recommended a number of actions required to improve the service and ensure full compliance with audit standards.

2.3 One of the areas the review considered was the extent of Internal Audit's conformance with the PSIAS. Of the ten Standards tested at that time, Internal Audit was assessed as non-compliant in five, partially conforming in two and generally conforming in three.

2.4 The Chartered Institute of Internal Auditors (CIIA) definitions and guidance for conformance with the Standards are given in Appendix A.

3. Annual Self-Assessment against the PSIAS.

3.1 The self-assessment for 2016-17 has been completed by the new Head of Internal Audit using the checklist used by the Chartered Institute of Internal Auditors (CIIA) when they conduct external assessments. The checklist gives details of the standards and the key conformance criteria for each one. There is space for the reviewer assessment and suggestions for improvement.

3.2 The review consists of an assessment against the definition of Internal Audit, the code of ethics, the four attribute standards and the seven performance standards.

3.3 Appendix 1 contains results of the review in the full checklist. It gives the definitions of general, partial, and non-conformance followed by a summary of the results, then the detailed result against each standard.

For comparison the results of the PwC review in 2015/16 are noted. Key points are:

- The Internal Audit department has made substantial progress in the last year, now achieving an overall partial conformance (last year did not conform).
- The overall position and progress since the PwC report to the Audit Committee can be indicated as follows:

		PwC 2015/16	Annual Assessment 2016/17
Overall Assessment		DNC	PC
Definition		Not reported	GC
Code of Ethics			
Integrity		Not reported	**GC**
Objectivity		Not reported	**GC**
Confidentiality		Not reported	**GC**
Competence		Not reported	**GC**
Attribute Standards			
1000	Purpose, Authority and Responsibility	**GC**	**GC**
1100	Independence and Objectivity	**GC**	**GC**
1200	Proficiency and Due Professional Care	**DNC**	**PC**
1300	Quality Assurance and Improvement Programme	**DNC**	**GC**
Performance Standards			
2000	Managing the Internal Audit Activity	**PC**	**GC**
2100	Nature of Work	**DNC**	**PC**
2200	Engagement Planning	**DNC**	**PC**
2300	Performing the Engagement	**DNC**	**PC**
2400	Communicating Results	**PC**	**GC**
2500	Monitoring Progress	**GC**	**GC**
2600	Resolution of Senior Management's Acceptance of Risk	Not reported	**GC**

Key:

GC – Generally Conforms PC – Partially Conforms DNC – Does Not Conform

3.4 Since the PwC report there have been many changes to the department including a new structure; new management; recruitment to fill two vacancies; a risk based annual plan; an updated Audit Charter; changes to procedures; and an updated Audit Manual. There remains a significant amount of development and improvement to bring the service up to full compliance with standards and to where it can better add value to the development of the Council's control arrangements.

3.5 The areas of partial conformance give rise to actions which will form the Quality Assurance and Improvement Plan for the next year. This has the aim of achieving general conformance with the standards by the time of the next assessment.

- Key actions include:
  - Embedding new audit scoping, reporting and performance monitoring and management processes.
  - Individual and team development plans implemented.
  - Implementation of the electronic audit system, streamlining of administration and reduction of non-productive time.
  - Development of assurance mapping.
  - Fully refreshing the Internal Audit Manual to reflect new, PSIAS compliant, audit policies and procedures.
  - Establishing a programme to review the Council's Governance Arrangements set out in its Code of Governance.

  (nb this is not a full list)

3.6 Progress against the action plan will be reported to the Audit Committee at each of its meetings.

3.7 The standards require that an external assessment be carried out every five years by a qualified independent assessor. One was completed last year, so to meet the standards another does not have to be completed until 2020-21. Previously it was intended to have an external assessment this year. However, as it is acknowledged that general conformance has not yet been reached, it is recommended that the next external assessment be carried out next year. By that time general conformance will have been reached and the external assessment will confirm it.

4. Options considered and recommended proposal

4.1 Internal Audit work through the Quality Assurance and Improvement Plan to address those areas of PSIAS that have been self-assessed as partially or non-conforming.

4.2 The next external assessment to be carried out in a year's time when it is expected that it will confirm General Conformance against the standards.

5. Consultation

5.1 The report is presented to the Audit Committee to enable it to fulfil its responsibility for overseeing the work and standards of internal audit.

5.2 The Strategic Director, Finance and Customer Services has been fully briefed on progress.

6. Timetable and Accountability for Implementing this Decision

6.1 Actions will be completed during 2017/18. Progress will be monitored on an ongoing basis and reported to the Audit Committee at each of its meetings during 2017/18.

7. Financial and Procurement Implications

7.1 Internal Audit is required to achieve £25,000 savings in 2016/17 and this is being achieved through a reduction in the size of core establishment as a result of vacancies and voluntary severance / retirement. The resources required to deliver the Council's audit requirements from 2016/17 were contained within the 2016/17 budget, and included a combination of in-house and specialist (external) resources, in line with the mixed model approach approved by Commissioners and Members.

7.2 Any financial implications specifically arising from the implementation of recommendations made in this report will be dealt with as appropriate.

8. Legal Implications

8.1 The provision of Internal Audit is a statutory requirement for all local authorities that is set out in the Accounts and Audit (England) Regulations 2015. These state:

"each principal authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance."

8.2 Internal Audit also has a role in helping the Council to fulfil its responsibilities under s.151 of the Local Government Act 1972, which are:

"each local authority shall make arrangements for the proper administration of their financial affairs and shall secure that one of their officers has responsibility for the administration of those affairs".

9. Human Resources Implications

9.1 Any HR implications emanating from the implementation of the recommendations will be addressed in full consultation with Human Resources. This could involve matters relating to staff development, skills and capabilities.

10. Implications for Children and Young People and Vulnerable Adults

10.1 There are no direct implications for Children and Young People and Vulnerable Adults arising from this report.

11. Equalities and Human Rights Implications

11.1 There are no direct Equalities or Human Rights implications arising from this report.

12. Implications for Partners and Other Directorates

12.1 Internal Audit is an integral part of the Council's Governance Framework, which is wholly related to the achievement of the Council's objectives, including those set out in the Corporate Plan, the Corporate Improvement Plan and Children's Services Improvement Plan.

12.2 Senior management, Members and other stakeholders will be consulted in relation to the future expectations for the internal audit service, as part of the planning for 2017/18. The aim will be to ensure major issues and risks for services are reflected in the audit planning processes, including where relevant, partnership working.

13. Risks and Mitigation

13.1 The failure to maintain an effective audit function means the Council fails to comply with the Accounts and Audit Regulations, as well as failing to secure the benefits of an effective and modern internal audit that helps the Council manage its risks and adds value to control arrangements in place at the Council. More comprehensive performance management arrangements will provide better control this risk.

13.2 The following risks have been identified: -
(i) Limitations in resources to implement the changes planned
(ii) Failure to meet implementation timescales due to unforeseen 'responsive' or other unplanned work.

13.3 Close and regular monitoring of the implementation of recommendations included in the action plan, including regular presentation of progress to the Audit Committee, will ensure any risks of failing to achieve improvements will be monitored and addressed.

14. Accountable Officer(s):

David Webster (Head of Internal Audit).

Internal assessment of compliance with PSIAS

Name of the organisation:	Rotherham Metropolitan Borough Council		
Date of the internal audit evaluation	January 2017	**Date of the previous internal audit evaluation:**	January 2016
Title of the designated Chief Audit Executive:	Head of Internal Audit	**Name of the designated Chief Audit Executive:**	David Webster
Name of the committee that is responsible for audit matters and to whom the Chief Audit Executive reports (When the standards say "board", who does that mean in the organisation)	Audit Committee	**Reporting line of the Chief Audit Executive** (When the standards say senior management, who does that mean)	Strategic Director Finance and Customer Services

Name and title of reviewer	David Webster, Head of Internal Audit

Internal assessment of compliance with PSIAS

Evaluation Procedure

- Examine and reflect upon the requirements of the *Definition of Internal Auditing*, the *Code of Ethics* and each *International Standard*. Use the relevant *Interpretation* within the Standards to build your understanding.

- Consider the key conformance criteria that will demonstrate compliance. You may wish to add other conformance criteria that are specific to your organisation or there may be additional criteria you wish to suggest. If you have suggestions use the form at Appendix 1 to provide feedback.

- Record the full range and extent of the evidence that exists within the internal audit activity and the organisation that demonstrates conformance with the *Standard*. There are lots of ways to gather information to support your assessments. This might include interviews with stakeholders and internal auditors as well as reviewing files, work papers reports and personnel records. As a result you may need to prepare an interview schedule and timetable.

- Compare the evidence to the key conformance criteria and assess the degree of conformance. Use the definitions that are provided below to guide your evaluation. Any of the key conformance criteria that is not achieved, would strongly suggest a rating of '**does not conform'** or '**partially conforms'**.

- Record the assessments in the table provided (pages 4 to 6) shading the boxes green, amber or red. Use this to present a summary of the results and to make an overall assessment. If most of the *Standards* are judged to be '**does not conform'**, then the overall assessment must be '**does not conform'**.

Definitions

GC Generally Conforms means the evaluator has concluded that the relevant structures, policies, and procedures of the activity, as well as the processes by which they are applied, comply with the requirements of the individual *Standard* or element of the Code of Ethics in all material respects. For the sections and major categories, this means that there is general conformance to a majority of the individual *Standards* or elements of the Code of Ethics, and at least partial conformance to the others, within the section/category. There may be significant opportunities for improvement, but these must not represent situations where the activity has not implemented the *Standards* or the Code of Ethics, has not applied them effectively, or has not achieved their stated objectives. As indicated above, general conformance does not require complete/perfect conformance, the ideal situation, successful practice, etc.

PC Partially Conforms means the evaluator has concluded that the activity is making good-faith efforts to comply with the requirements of the individual *Standard* or element of the Code of Ethics, section, or major category, but falls short of achieving some major objectives. These will usually represent significant opportunities for improvement in effectively applying the *Standards* or Code of Ethics and/or achieving their objectives. Some deficiencies may be beyond the control of the activity and may result in recommendations to senior management or the board of the organisation.

DNC Does Not Conform means the evaluator has concluded that the activity is not aware of, is not making good-faith efforts to comply with, or is failing to achieve many/all of the objectives of the individual *Standard* or element of the Code of Ethics, section, or major category. These deficiencies will usually have a significant negative impact on the activity's effectiveness and its potential to add value to the organisation. These may also represent significant opportunities for improvement, including actions by senior management or the board. Often, the most difficult evaluation is the distinction between general and partial. It is a judgment call keeping in mind the definition of general conformance above. Carefully read the *Standard* to determine if basic conformance exists. The existence of opportunities for improvement, better alternatives, or other successful practices do not reduce a generally conforms rating.

Internal assessment of compliance with PSIAS

Summary table showing the level of conformance overall and against each individual standard.

		GC	PC	DNC
	OVERALL ASSESSMENT			PWC
	Definition of Internal Auditing			
Reference	**Code of Ethics**			
1	Integrity			
2	Objectivity			
3	Confidentiality			
4	Competence			
Reference	**Attribute Standards**			
1000	Purpose, Authority and Responsibility	PWC		
1010	Recognition of the Definition of Internal Auditing, the Code of Ethics, and the Standards in the Internal Audit Charter			
1100	Independence and Objectivity	PWC		
1110	Organisational Independence			
1111	Direct Interaction with the Board			
1120	Individual Objectivity			

Internal assessment of compliance with PSIAS

1130	Impairments to Independence or Objectivity			
1200	Proficiency and Due Professional Care (The sum of *Standards* 1210-1230)			PWC
1210	Proficiency			
1220	Due Professional Care			
1230	Continuing Professional Development			
1300	Quality Assurance and Improvement Programme (The sum of *Standards* 1310-1322)			PWC
1310	Requirements of the Quality Assurance and Improvement Programme			
1311	Internal Assessments			
1312	External Assessments			
1320	Reporting on the Quality Assurance and Improvement Programme			
1321	Use of Conforms with the International Standards for the Professional Practice of Internal Auditing			
1322	Disclosure of Non-conformance			
Reference	**Performance Standards**			
2000	Managing the Internal Audit Activity (Sum total of *Standards* 2010 – 2070)		PWC	
2010	Planning			
2020	Communication and Approval			
2030	Resource Management			

Internal assessment of compliance with PSIAS

2040	Policies and Procedures			
2050	Coordination			
2060	Reporting to Senior Management and the Board			
2070	External Service Provider and Organisational Responsibility for Internal Audit			
2100	Nature of Work (Sum of *Standards* 2110 – 2130)			PWC
2110	Governance			
2120	Risk Management			
2130	Control			
2200	Engagement Planning (Sum of *Standards* 2201-2240)			PWC
2201	Planning Considerations			
2210	Engagement Objectives			
2220	Engagement Scope			
2230	Engagement Resource Allocation			
2240	Engagement Work Programme			
2300	Performing the Engagement (The sum of *Standards* 2310-2340)			PWC
2310	Identifying Information			
2320	Analysis and Evaluation			

Internal assessment of compliance with PSIAS

2330	Documenting Information			
2340	Engagement Supervision			
2400	Communicating Results (Sum of *Standards* 2410-2450)		PWC	
2410	Criteria for Communicating			
2420	Quality of Communications			
2421	Errors and Omissions			
2430	Use of 'conducted in conformance with the International Standards for the Professional Practice of Internal Auditing'			
2431	Engagement Disclosure of Non-conformance			
2440	Disseminating Results			
2450	Overall Opinions			
2500	Monitoring Progress	PWC		
2600	Resolution of Senior Management s Acceptance of Risks			

Internal assessment of compliance with PSIAS

Definition of Internal Auditing & Code of Ethics	Key conformance criteria	Evidence to support assessment	Actions for further improvement
Definition of internal auditing			
Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.	There are key areas with the International Standards that will help to decide whether or not internal audit meets the definition of internal auditing. These are: Attribute Standards 1010, 1100, 1110 and 1130 Performance Standards 2010 and the 2100 series. However, an important aspect is the extent to which internal audit helps the organisation to achieve its objective and improve: • The internal audit plan and the work of internal audit must focus on the things that matter to the organisation. • The opinions and recommendations that internal audit provide must help the organisation and be valued by stakeholders.	Plan is based on the objectives of the organisation. Opinions and recommendations are valued and implemented. Feedback from stakeholders shows that the department is valued.	
Code of Ethics			
1. Integrity			
The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement.			
Rules of Conduct – Internal auditors:			

Internal assessment of compliance with PSIAS

Definition of Internal Auditing & Code of Ethics	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1.1 Shall perform their work with honesty, diligence and responsibility. 1.2 Shall observe the law and make disclosures expected by the law and the profession. 1.3 Shall not knowingly be a party to any illegal activity, or engage in acts that are discreditable to the profession of internal auditing or to the organisation. 1.4 Shall respect and contribute to the legitimate and ethical objectives of the organisation.	Internal audit has: • A high profile within the organisation. • A reputation for honesty, fair dealing and truthfulness – behaves with integrity. • Resilience and determination – is persistent when required. • High standards for doing their job and maintains these in practice. • Involvement in reviewing and developing ethical behaviour in the organisation.	All auditors meet the standards. There are regular meetings with all DMTs to raise the profile. The Head of IA reports to a Strategic Director. The team has a good reputation within the Authority. All enquiries are followed up – any lack of response is escalated. Standards – see this assessment. Ethics – Head of IA is a member of a working group and reviewed the revised Corporate Code of Governance.	
2. Objectivity			
Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements.			
Rules of Conduct - Internal auditors:			
2.1 Shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation.	Individual objectivity, which includes an interpretation of 'conflict of interest', is set out within Attribute Standards 1120 and 1130. Compliance with these Attribute Standards will generally result in compliance with the Rules of Conduct.	See standards. **#**	

Internal assessment of compliance with PSIAS

Definition of Internal Auditing & Code of Ethics	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2.2 Shall not accept anything that may impair or be presumed to impair their professional judgement. 2.3 Shall disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review.	Internal audit is free from any bias or conflict of interest that would undermine or question their judgement – either in reality or perception.	All auditors meet these standards. An annual declaration of interest form is completed by all members of the team.	
3. Confidentiality			
Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so.			
Rules of Conduct - Internal auditors:			
3.1 Shall be prudent in the use and protection of information acquired in the course of their duties. 3.2 Shall not use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the organisation.	Confidentiality relating to internal audit work is set out within Performance Standard 2330 and compliance with this will generally result in compliance with the Rules of Conduct. Security and protection of information should be subject to daily routine and safeguards. Potential and actual breaches in confidentiality should be taken seriously and acted upon accordingly.	See standard. All information is kept electronically with access restricted to the team. Hard copy files are kept in locked cupboards. There have been no breaches in confidentiality.	
4. Competency			
Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services.			

Internal assessment of compliance with PSIAS

Definition of Internal Auditing & Code of Ethics	**Key conformance criteria**	**Evidence to support assessment**	**Actions for further improvement**
Rules of Conduct - Internal auditors:			
4.1 Shall engage only in those services for which they have the necessary knowledge, skills and experience. 4.2 Shall perform internal auditing services in accordance with the International Standards for the Professional Practice of Internal Auditing. 4.3 Shall continually improve their proficiency and the effectiveness and quality of their services.	Competency is covered by the 1200 series of the Attribute Standards and compliance with these will generally result in compliance with the Rules of Conduct. Overall there should be a culture of continuous improvement, a commitment to staff retention and development, an appreciation of the IPPF among staff and assignment of work based on competency.	See standards. There is a QAIP in place, with an action plan after the external assessment. All staff receive appraisals and have development plans in place. Staff are aware of these standards. Work is assigned based on competency – where the competency is not held in the team, work is assigned externally.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
Attribute Standards			
1000 Purpose, Authority, and Responsibility			
The purpose, authority, and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Definition of Internal Auditing, the Code of Ethics, and the Standards. The chief audit executive must periodically review the internal audit charter and present it to senior management and the board for approval. ***Interpretation:*** The internal audit charter is 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 reporting 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. Final approval of the internal audit charter resides with the board. **1000. A1** The nature of assurance services provided to the organisation must be defined in the internal audit charter. If assurances are to be provided to parties outside the organisation, the nature of these assurances must also be defined in the internal audit charter. **1000. C1** The nature of consulting services must be defined in the internal audit charter.	The internal audit (IA) activity has a formal definition of its purpose, authority and responsibility, which recognises the IIA definition of IA. Whatever document provides the formal definition will be the "internal audit charter" for the purposes of the standards - no matter what the document is actually called. The charter: • Establishes the position and reporting lines of IA within the organisation - both functional and administrative reporting lines. • Provides IA with unrestricted access to records, personnel, and physical properties relevant to the performance of engagements. • Sets the tone for IA activities and interaction with the board. • Defines the nature and scope of activities to be performed by IA – assurance, and consultancy engagements. • Sets out the nature and scope of IA assurance provided to parties outside the organisation. • Is approved by the board. The charter is kept up to date by: • Periodic review, which involves consultation with the senior management and the board. • Incorporating changes in the International Professional Practice Framework (IPPF) as and when they occur.	The Charter was updated and approved by the Audit Committee in September 2016. It defines the terms 'board' and 'senior management', but does not explicitly establish reporting lines. Unrestricted access is provided. It includes the relationship with the board and senior management. The nature and scope of activities is defined. The nature and scope for external work is set out. The Charter will be reviewed annually. The IPPF will be referred to when the annual updates are being completed,	Make reporting lines explicit in next revision of the Charter

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1000 Conclusion	**Purpose, Authority, and Responsibility**	☒**GC**	
1010 Recognition of the Definition of Internal Auditing, the Code of Ethics, and the Standards in the Internal Audit Charter			
The mandatory nature of the Definition of Internal Auditing, the Code of Ethics, and the Standards must be recognised in the internal audit charter. The chief audit executive should discuss the Definition of Internal Auditing, the Code of Ethics, and the Standards with senior management and the board.	The charter includes reference to the mandatory nature of the *Definition of Internal Auditing*, the *Code of Ethics* and the *International Standard.* The charter makes a formal commitment to the *Definition of Internal Auditing*, *Code of Ethics* and *International Standards*. There is a record of discussions with senior management and the board regarding the mandatory aspects of the IPPF and the extent of the commitment to them e.g. within minutes of the board or other formal record	The Charter refers to the mandatory nature of PSIAS, including the definition, Code of Ethics and Standards. The ten Core Principles are listed and embedded in the Charter. The Charter was discussed by the Audit Committee in September 2016.	
1010 Conclusion	**Recognition of the Definition of Internal Auditing, the Code of Ethics, and the Standards in the Internal Audit Charter**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1100 Independence and Objectivity			
The internal audit activity must be independent, and internal auditors must be objective in performing their work. ***Interpretation:*** Independence is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the chief audit executive has direct and unrestricted access to senior management and the board. This can be achieved through a dual-reporting relationship. Threats to independence must be managed at the individual auditor, engagement, functional, and organisational levels. Objectivity is an unbiased mental attitude that allows internal auditors to perform engagements in such a manner that they believe in their work product and that no quality compromises are made. Objectivity requires that internal auditors do not subordinate their judgment on audit matters to others. Threats to objectivity must be managed at the individual auditor, engagement, functional, and organisational levels.	The board review and approve the: • Internal audit charter • Risk based internal audit plan • Performance against the plan • The appointment and removal of CAE • Any restrictions on scope and or resources The internal audit charter and planning documents – such as IA strategy, annual IA plan and business plans- do not contain major restrictions upon IA activity. IA plans are consistent with the scope, authority and responsibility of the IA activity set out in the internal audit charter. IA plans account for all of the resources and time available to IA. IA does not have responsibility for the management of operations within the organisation. IA role and relationship with regard to other assurance providers, inside and outside the organisation is established and documented. The justification for the use of internal audit contingency time is recorded and reported to the board.	The Committee review and approve the Charter and Plan. They receive reports on performance against the plan and any restrictions on scope or resources. The appointment of the HIA did not include AC involvement. There are no restrictions on IA activity. Plans cover all areas of the Council and are consistent with the scope, authority and responsibility of IA. Yes. IA does not have management responsibility for other functions. The use of contingency time is included in Progress Reports.	To be developed.
1100 Conclusion	**Independence and Objectivity**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1110 Organisational Independence			

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
The chief audit executive must report to a level within the organisation that allows the internal audit activity to fulfil its responsibilities. The chief audit executive must confirm to the board, at least annually, the organisational independence of the internal audit activity. ***Interpretation:*** Organisational independence is effectively achieved when the chief audit executive reports functionally to the board. Examples of functional reporting to the board involve the board: • approving the internal audit charter, • approving the risk based internal audit plan, • approving the internal audit budget and resource plan, • receiving communications from the chief audit executive on the internal audit activity's performance relative to its plan and other matters, • approving decisions regarding the appointment and removal of the chief audit executive, • approving the remuneration of the chief audit executive, and • making appropriate enquiries of management and the chief audit executive to determine whether there are inappropriate scope or resource limitations. **1110.A1** The internal audit activity must be free from interference in determining the scope of internal auditing, performing work, and communicating results.	The chief audit executive reports to a level in the organisation that is adequate to discharge his or her responsibilities – to the board functionally and the CEO administratively. To apply functional reporting the board typically: • Approves the IA Charter, IA risk assessment and related IA plan. • Receives the results of IA activities, performance and other matters that the CAE determines are necessary, • Hold private meetings with the CAE. • Receives annual confirmation of IA's organisational independence. • Approves decisions regarding the performance evaluation, appointment, or removal of the CAE. • Approve the IA strategy, plan and budget. • Makes appropriate inquiries of senior management and the CAE to determine whether there is audit scope or budgetary limitations that impede the ability of the IA activity to execute its responsibilities. To apply administrative reporting the CEO ensures: • The preparation on an annual budget and appropriate budgetary control. • Human resource administration, including personnel evaluations and compensation. • Internal communications and information flows.	HIA reports to Committee and the Strategic Director Finance and Customer Services. AC approves those. AC receives progress reports. Included in the Annual Report. Appraisal of the HIA will be referred to the Chair of Audit in accordance with the standards. AC approves the strategy and plan. Budget approved under Council procedures. Audit Committee enquires about any limitations. SD Finance ensures that these all happen.	Private meetings to be arranged. HIA appraisal will be reviewed by Chief Executive and Chair of Audit

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1110 Conclusion	**Organisational Independence**	☒**GC**	
1111 Direct Interaction with the Board The chief audit executive must communicate and interact directly with the board.	CAE regularly attends board meetings, reporting upon IA plans and activities. CAE is given the opportunity to understand the way the board conducts its oversight of governance, risk management and control. One to one sessions between the CAE and the board are planned into the annual timetable, either as part of the annual schedule of meetings or through the agreed working relationship between CAE and chair of the board. This occurs at least annually.	HIA attends every meeting of the AC. HIA is involved in preparing the programme for the AC. Not yet planned.	To be included in forward work plan.
1111 Conclusion	**Direct Interaction with the Board**	☒**PC**	
1120 Individual Objectivity			
Internal auditors must have an impartial, unbiased attitude and avoid any conflict of interest. ***Interpretation:*** Conflict of interest is a situation in which an internal auditor, who is in a position of trust, has a competing professional or personal interest. Such competing interests can make it difficult to fulfil his or her duties impartially. A conflict of interest exists even if no unethical or improper act results. A conflict of interest can create an appearance of impropriety that can undermine confidence in the internal auditor, the internal audit activity, and the profession. A conflict of interest could impair an individual's ability to perform his or her duties and responsibilities objectively.	Information relating to internal auditors includes responsibilities held prior to appointment. The organisational chart and IA plans showing placement of internal auditors is compared to the information on the previous positions and responsibilities of internal auditors to ensure individual independence and objectivity. There is regular review of the placement/location of IA team members to ensure independence. This takes into account the consultancy work individual internal auditors have performed when assigning assurance engagement. Internal auditors do not provide assurance in areas where they have been involved in advising management.	Audit team has been in place for many years or recruited from outside the Council. No conflicts of interest arise. N/A Work is assigned by PA's, taking into account any consultancy work.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1120 Conclusion	**Individual Objectivity**	☒**GC**	
1130 Impairment to Independence or Objectivity			

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
If independence or objectivity is impaired in fact or appearance, the details of the impairment must be disclosed to appropriate parties. The nature of the disclosure will depend upon the impairment. ***Interpretation:*** Impairment to organisational independence and individual objectivity may include, but is not limited to, personal conflict of interest, scope limitations, restrictions on access to records, personnel, and properties, and resource limitations, such as funding. The determination of appropriate parties to which the details of an impairment to independence or objectivity must be disclosed is dependent upon the expectations of the internal audit activity's and the chief audit executive's responsibilities to senior management and the board as described in the internal audit charter, as well as the nature of the impairment. **1130. A1** Internal auditors must refrain from assessing specific operations for which they were previously responsible. Objectivity is presumed to be impaired if an internal auditor provides assurance services for an activity for which the internal auditor had responsibility within the previous year. **1130. A2** Assurance engagements for functions over which the chief audit executive has responsibility must be overseen by a party outside the internal audit activity. **1130. C1** Internal auditors may provide consulting services relating to operations for which they had previous responsibilities.	CAE has established rules of conduct that clearly set out expected behaviour and defines the nature of conflict of interest and impairment of objectivity. This may include recognition or adoption of the organisation's Code of Practice provided this contains sufficient detail – including the acceptance of gift and hospitality. Where these do not exist or they lack clarity IA should formulate separate policies. Internal auditors are required to register hospitality and gifts, which is reviewed on a regular basis. Policies make auditors aware they must report any real or perceived conflict of interest as soon as such conflict arises. Procedures exist to support the policy and there is information to illustrate application – conflict of interest statements. Policy exists to ensure that assurance engagements of areas that are under the control or direct influence of the CAE are overseen by a party external to the CAE IA engagements are rotated ensuring that activities and entities are not audited by the same auditor. The assignment of internal engagements are rotated to ensure that internal auditors involved in the development of systems and procedures do not review the management of risks and application of risk responses in these areas.	Included in Manual. Also expected to adhere to Council policies and Code of Practice. Annual declaration of interest completed by all auditors. All hospitality and gifts recorded. Included in manual. N/A Engagements are allocated by PA's, taking this into account. As above.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1130.C2 If internal auditors have potential impairments to independence or objectivity relating to proposed consulting services, disclosure must be made to the engagement client prior to accepting the engagement.			
1130 Conclusion	**Impairment to Independence or Objectivity**	☒**GC**	
1200 Proficiency and Due Professional Care			
Engagements must be performed with proficiency and due professional care.	The sum of *Standards* 1210-1230	☒**PC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1210 Proficiency			
Internal auditors must possess the knowledge, skills, and other competencies needed to perform their individual responsibilities. The internal audit activity collectively must possess or obtain the knowledge, skills, and other competencies needed to perform its responsibilities. ***Interpretation:*** Knowledge, skills, and other competencies is a collective term that refers to the professional proficiency required of internal auditors to effectively carry out their professional responsibilities. Internal auditors are encouraged to demonstrate their proficiency by obtaining appropriate professional certifications and qualifications, such as the Certified Internal Auditor designation and other designations offered by The Institute of Internal Auditors and other appropriate professional organisations.	There is a job description or person specification for each post with the IA organisation structure that defines appropriate knowledge, skills and experience. The job descriptions/person specifications are reviewed periodically or when positions become available. The knowledge, skills and competencies referred to might include: • Applying internal audit standards, procedures, and techniques in performing engagements. • Accounting principles and techniques if internal auditors work extensively with financial records and reports. • Knowledge to identify the indicators of fraud. • Knowledge of key information technology risks and controls and available technology-based audit techniques. • Communication and networking skills. • Managing people.	Job descriptions and person specifications in place for all posts in the team, defining knowledge, skills and experience required. They were renewed in 2016 after a department restructure. These are not specified in detail in the job descriptions.	Job descriptions to be amended to include specific IA responsibilities.

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1210.A1 The chief audit executive must obtain competent advice and assistance if the internal auditors lack the knowledge, skills, or other competencies needed to perform all or part of the engagement. **1210.A2** Internal Auditors must have sufficient knowledge to evaluate the risk of fraud and the manner in which it is managed by the organisation, but are not expected to have the expertise of a person whose primary responsibility is detecting and investigating fraud. **1210.A3** Internal auditors must have sufficient knowledge of key information technology risks and controls and available technology-based audit techniques to perform their assigned work. However, not all internal auditors are expected to have the expertise of an internal auditor whose primary responsibility is information technology auditing. **1210.C1** The chief audit executive must decline the consulting engagement or obtain competent advice and assistance if the internal auditors lack the knowledge, skills, or other competencies needed to perform all or part of the engagement.	A process exists that identifies individual internal auditor training and development needs with support for qualification programmes and other training and development activities. Internal auditor performance is reviewed on a regular basis, the results of which feed back into the needs assessment and CPD process. Internal auditors who perform specialised audit and consulting work such as information technology, tax, actuarial, or systems design undertake specific training and development. The CAE identifies gaps in knowledge and skills in the formulation of internal audit plans and engages capable assistance with approval of senior management and the audit committee. Capable assistance includes co-sourcing arrangements, use of internal experts and other assurance provides and specialist service providers external to the organisation. The CAE assesses the competency and objectivity of external service providers prior to their appointment.	Annual appraisals (PDRs) have been completed for all members of the team. These include development needs, but not how they will be achieved. One team member is studying for CIIA, another for CIPFA, both supported by the Council. Annual PDR process, with six monthly reviews. Only specialised audit area is Fraud. The team includes a CIPFA accredited investigator. Gaps identified in areas of ICT and Childrens Services. External resource engaged, with relevant approval. ICT – Leicester Council qualified IT Auditor. Veritau engaged to provide assistance in improving standards and validating reports to Audit Committee. Veritau conform with PSIAS, confirmed by their own external assessment.	Development needs to be linked to training.

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1210 Conclusion	**Proficiency**	☒**GC**	
1220 Due Professional Care			
Internal auditors must apply the care and skill expected of a reasonably prudent and competent internal auditor. Due professional care does not imply infallibility.	The IA activity formally defines how it operates in a series of policies and procedures. For some the collection of documents may take the form of an Internal Audit Manual.	An Audit Manual existed but had not been fully updated since 2007. Now being comprehensively reviewed and updated. Some updates were communicated separately in 2015.	Completion of review of Audit Manual ready for software implementation, and needed again after implementation to reflect changes.

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1220.A1 Internal auditors must exercise due professional care by considering the: • Extent of work needed to achieve the engagement's objectives; • Relative complexity, materiality, or significance of matters to which assurance procedures are applied; • Adequacy and effectiveness of governance, risk management, and control processes; • Probability of significant errors, fraud, or non-compliance; and • Cost of assurance in relation to potential benefits. **1220.A2** In exercising due professional care internal auditors must consider the use of technology-based audit and other data analysis techniques. **1220.A3** Internal auditors must be alert to the significant risks that might affect objectives, operations, or resources. However, assurance procedures alone, even when performed with due professional care, do not guarantee that all significant risks will be identified. **1220.C1** Internal auditors must exercise due professional care during a consulting engagement by considering the: • Needs and expectations of clients, including the nature, timing, and communication of engagement results; • Relative complexity and extent of work needed to achieve the engagement's objectives; and • Cost of the consulting engagement in relation to potential benefits.	The policies and procedures specify the way audit files and working papers need to be kept to record the information gathered and analysis performed during the audit engagement. Policies and procedure recognise the elements and requirements of the IPPF. Internal auditors research and gather background information to help them prioritise objectives and set boundaries for each audit engagement – assurance and consulting. The objectives and priorities for audit engagements are discussed with senior management and stakeholders where appropriate. Audit engagements focus upon management's assessment of risk responses. Taking into consideration residual risk and management assurance upon the effectiveness of the risk response. Where this is not available internal auditors perform their own assessment of risks. Where appropriate audit engagements are supported by appropriate tools, including reporting within information systems, interrogation techniques and other CAATTs. The communication of conclusions and audit opinions are based on appropriate information such as observations, tests, analyses and other documentation. This is indexed and classified in working papers linked to the engagement work programme, schedule of testing and audit objectives.	Manual and updates specify the contents of files and working papers. Findings and conclusions adequately supported by working papers. No. Yes. Utilise previous audit, internet, internal reports / policies, CIPFA matrices. Not formalised in a scoping document process. Yes, but not recorded. Now included in scoping document Audit planning is risk based. In previous years this has been the IA assessment of risk. With further development of council risk registers, management's assessment is now used. CAATS not used. Conclusions and opinions based on the results of working papers. Few consulting engagements completed.	Develop use of CAATS.

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1220 Conclusion	**Due Professional Care**	☒**PC**	
1230 Continuing Professional Development			
Internal auditors must enhance their knowledge, skills, and other competencies through continuing professional development.	There is a process to assess the training and development needs of internal auditors that provides input to the continuous professional development (CPD) programme required by the Institute. The process may be based upon the organisation's staff appraisal procedure but centres upon the development of professional proficiency and the changing demands upon the profession.	Annual appraisals completed for all staff, leading to identification of training needs. Programme of departmental training identified for 2016/17, but not delivered. Individuals are responsible for update of their own CPD. A record is kept within the dept.	Link between appraisals, training needs and CPD.
1230 Conclusion	**Continuing Professional Development**	☒**PC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1300 Quality Assurance and Improvement Programme (QAIP)	The sum of *Standards* 1310-1322.		
The chief audit executive must develop and maintain a quality assurance and improvement program that covers all aspects of the internal audit activity. ***Interpretation:*** A quality assurance and improvement program is designed to enable an evaluation of the internal audit activity's conformance with the Definition of Internal Auditing and the Standards and an evaluation of whether internal auditors apply the Code of Ethics. The program also assesses the efficiency and effectiveness of the internal audit activity and identifies opportunities for improvement.	The QAIP is about establishing a culture of continuous improvement to prevent problems and to underpin day-to-day delivery of a reliable assurance and consulting service. This is led by the CAE who sets a vision, a strategy and service expectations through policies, procedures and review arrangements based upon stakeholder requirements and consultation with the internal audit team. Stakeholder expectations and the results of consultations with staff are documented. The establishment of QAIP and its purpose is reflected in the internal audit charter. This refers to the arrangements for supervision and review of the work that staff do.	An action plan was produced after the external review in January 2016. Procedures, audit manual and KPI's have been updated. Service Plan completed and communicated to all staff – includes vision for the department. Charter includes Mission Statement and definition. Manual includes internal requirements. All work is subject to review. Not documented. Fully referred to in the Charter.	Needs more feedback from stakeholders.
1310 Requirements of the Quality Assurance and Improvement Program			
The quality assurance and improvement program must include both internal and external assessments.	There is a plan or schedule agreed with senior management and the board that sets out the type, nature and timing of future assessments – both internal and external.	November 2016 – Audit Committee agreed that there would be an Internal Assessment presented to them in February 2017, followed by an External Assessment in April 2017 if required.	
1310 Conclusion	**Requirements of the Quality Assurance and Improvement Program**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1311 Internal Assessments			
• Ongoing monitoring of the performance of the internal audit activity; and • Periodic self assessments or assessments by other persons within the organisation with sufficient knowledge of internal audit practices. ***Interpretation:*** Ongoing monitoring is an integral part of the day-to-day supervision, review, and measurement of the internal audit activity. Ongoing monitoring is incorporated into the routine policies and practices used to manage the internal audit activity and uses processes, tools, and information considered necessary to evaluate conformance with the Definition of Internal Auditing, the Code of Ethics, and the Standards. Periodic assessments are conducted to evaluate conformance with the Definition of Internal Auditing, the Code of Ethics, and the Standards. Sufficient knowledge of internal audit practices requires at least an understanding of all elements of the International Professional Practices Framework.	There is evidence of ongoing internal reviews of the performance of the internal audit activity. There are a variety of options for this depending on the size and structure of the service including self assessment by the internal audit activity, peer reviews, benchmarking exercises, post audit and/or annual client questionnaires, monitoring by the audit committee and other reviews initiated internally by the organisation. The ISO quality standard, EFQM and other models can be used to establish and maintain the QAIP. The precise nature and mix of the internal assessments will be decided by the organisation to best suit circumstances but all should evaluate internal audit activity in accordance with: • The professional requirements in the IPPF. • The vision and policies set by the CAE. • The Internal Audit Charter. • Internal audit procedures that set out to achieve quality on a daily basis – including the recognition and prevention of 'defects'.	All audit work is subject to review. Performance is reported to the AC. Previous external assessment by PwC presented to Audit Committee in February 2016. Annual internal assessments had been carried out before that. Post audit questionnaires are issued to gain feedback from clients. Performance is reported to Audit Committee at every meeting. QAIP has been developed to deal with the failings identified by PwC. An Action plan has been used and progress reported to the Audit Committee. Previous internal assessments used the CIPFA checklist from PSIAS / LGAN. This assessment uses this checklist and covers all areas.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1311 Conclusion	**Internal Assessments**	☒**GC**	
1312 External Assessments			

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. The chief audit executive must discuss with the board: • The form and frequency of external assessments; and • The qualifications and independence of the assessor or assessment team, including any potential conflict of interest. ***Interpretation:*** External assessments can be in the form of a full external assessment, or a self-assessment with independent external validation. A qualified assessor or assessment team demonstrates competence in two areas: the professional practice of internal auditing and the external assessment process. Competence can be demonstrated through a mixture of experience and theoretical learning. Experience gained in organisations of similar size, complexity, sector or industry and technical issues is more valuable than less relevant experience. In the case of a assessment team, not all members of the team need to have all the competencies; it is the team as a whole that is qualified. The chief audit executive uses professional judgment when assessing whether an assessor or assessment team demonstrates sufficient competence to be qualified. An independent assessor or assessment team means not having either a real or an apparent conflict of interest and not being a part of, or under the control of, the organisation to which the internal audit activity belongs.	The CAE consults with the board when deciding the frequency of the external assessment and the qualifications and independence of the external reviewer or review team. The reviewer or review team is from outside the organisation and is free from any obligations to or interests in the organisation – in particular consulting services. Reviewers are qualified, with appropriate competence and experience of IA – at least three years at manager level - and knowledge of leading practices in IA, as well as current, in-depth knowledge of the IPPF. There is evidence of comprehensive external reviews at least every 5 years (This is includes peer review where there is an element of independence in the process). For some organisations external quality reviews may be carried out more regularly based upon regulatory or funding requirements – particularly the public sector. External audit reviews may also be appropriate where significant change has occurred within the organisation of internal audit activity.	External assessment carried out in late 2015 by PwC. In November 2016 Audit Committee agreed to an internal assessment by February 2017 followed by an external validation, carried out as a peer review by Veritau or a member of the South and West Yorkshire Audit Group.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1312 Conclusion	**External Assessments**	☒**GC**	
1320 Reporting on the Quality Assurance and Improvement Programme			
The chief audit executive must communicate the results of the quality assurance and improvement program to senior management and the board. ***Interpretation:*** The form, content, and frequency of communicating the results of the quality assurance and improvement program is established through discussions with senior management and the board and considers the responsibilities of the internal audit activity and chief audit executive as contained in the internal audit charter. To demonstrate conformance with the Definition of Internal Auditing, the Code of Ethics, and the Standards, the results of external and periodic internal assessments are communicated upon completion of such assessments and the results of ongoing monitoring are communicated at least annually. The results include the assessor's or assessment team's evaluation with respect to the degree of conformance.	The results of the QAIP are reported to the stakeholders of IA. Where the IA activity cannot conform with one aspect or other of the IPPF the details of the non-conformance and its implications are reported to the board. All aspects of the QAIP generate improvements in what is done and in how it is done. This is done using agreed and assigned action plans with target dates Follow-up and reporting of the implementation of actions to senior management and the board.	PwC report presented to Audit Committee in February 2016, including details of non-conformance and their implications. An action plan to achieve conformance was also produced and has been presented to the Audit Committee in April, June and September to show the progress being made.	
1320 Conclusion	**Reporting on the Quality Assurance and Improvement Program**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1321 Use of Conforms with the International Standards for the Professional Practice of Internal Auditing			
The chief audit executive may state that the internal audit activity conforms with the International Standards for the Professional Practice of Internal Auditing only if the results of the quality assurance and improvement program support this statement. ***Interpretation:*** The internal audit activity conforms with the *International Standards* when it achieves the outcomes described in the *Definition of Internal Auditing, Code of Ethics and International Standards*. The results of the quality assurance and improvement programme include the results of both internal and external assessments. All internal audit activities will have the results of internal assessments. Internal audit activities in existence for at least five years will also have the results of external assessments.	The wording that the IA activity uses in reports regarding conformance with the IPPF is consistent with the results of the quality assessments – internal and external. The IA activity conforms to the IPPF when it achieves the outcomes described in the Definition of Internal Auditing, Code of Ethics and International Standards.	The department does not state in reports that it conforms with the International Standards – in accordance with the PwC conclusion. Results of QAIP are reported to Audit Committee in Progress Reports and will be reported in the Annual Report.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
1321 Conclusion	**Use of Conforms with the International Standards for the Professional Practice of Internal Auditing**	☒**GC**	
1322 Disclosure of Non-conformance			
When non-conformance with the Definition of Internal Auditing, the Code of Ethics, or the Standards impacts the overall scope or operation of the internal audit activity, the chief audit executive must disclose the non-conformance and the impact to senior management and the board.	There is evidence of appropriate disclosure linked to 1321.	Paper including the PwC report taken to the Audit Committee in February 2016, approved by the Chief Executive. The paper included actions to be taken to ensure that the non-conformance was addressed and would not affect the scope or operation of the activity.	
1322 Conclusion	**Disclosure of Non-conformance**	☒**GC**	
Performance Standards			
2000 Managing the Internal Audit Activity	The sum of *Standards* 2010 - 2060		
The chief audit executive must effectively manage the internal audit activity to ensure it adds value to the organisation.	The internal audit activity adds value to the organisation (and its stakeholders) when it provides: • Objective and relevant assurance, and • Contributes to the effectiveness and efficiency of governance, risk management and control processes.	The department provides objective assurance and contributes to governance, risk management and control. Conclusions are given against each objective within each assignment.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
Interpretation: The internal audit activity is effectively managed when: • The results of the internal audit activity's work achieve the purpose and responsibility included in the internal audit charter; • The internal audit activity conforms with the Definition of Internal Auditing and the Standards; and • The individuals who are part of the internal audit activity demonstrate conformance with the Code of Ethics and the Standards. The internal audit activity adds value to the organisation (and its stakeholders) when it provides objective and relevant assurance, and contributes to the effectiveness and efficiency of governance, risk management and control processes.	Delivery of the internal audit service to the organisation involves planning, communication and approval, resource management, policies and procedures, coordination and reporting to senior management and the board. As well as functional management the CAE may be required to comply with organisational administrative and personnel management requirements. This might include: business planning, budget forecasting and management, staff appraisal, succession planning etc.	These are all completed throughout the year. Council HR and budgeting requirements are adhered to.	
2000 Conclusion	**Managing the Internal Audit Activity**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2010 Planning			
The chief audit executive must establish a risk-based plan to determine the priorities of the internal audit activity, consistent with the organisation's goals. ***Interpretation:*** The chief audit executive is responsible for developing a risk-based plan. The chief audit executive takes into account the organisation's risk management framework, including using risk appetite levels set by management for the different activities or parts of the organisation. If a framework does not exist, the chief audit executive uses his/her own judgment of risks after consideration of input from senior management and the board. The chief audit executive must review and adjust the plan, as necessary, in response to changes in the organisation's business, risks, operations, programs, systems, and controls. .	The CAE has established risk-based internal audit plans (RBIA) in consultation with the board and senior management that identifies where assurance and consultancy is required on risk management processes, management assurances and risk responses. The audit plan establishes a link between the proposed audit topics and the priorities and risks of the organisation taking into account: • Stakeholder expectations, and feedback from senior and operational managers. • Objectives set in the strategic plan and business plans, including major projects and financial forecasts. • Risk maturity in the organisation to provide an indication of the reliability of risk registers. • Management's identification and response to risk, including risk mitigation strategies and levels of residual risk. • Legal and regulatory requirements. • The audit universe – all the audits that could be performed within the scope of the IA Charter. • Previous IA plans and the results of audit engagements.	RBIA in place, risk based plan used by the team. Known sources of assurance taken into account when planning, but full assurance mapping not completed. The plan is based on the priorities and risks of the organisation. Stakeholders are consulted in the preparation of the plan. The plan is based on strategic objectives. Risk management has been audited in 2016/17. Risk registers are used to produce the plan. Risk registers and management consultation give this. Regulatory work completed as necessary. Audit universe completed and utilised. Taken into account during planning.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2010.A1 The internal audit activity plan of engagements must be based on a documented risk assessment, undertaken at least annually. The input of senior management and the board must be considered in this process **2010.A2** The chief audit executive must identify and consider the expectations of senior management, the board and other stakeholders for internal audit opinions and other conclusions. **2010.C1** The chief audit executive 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.	The CAE determines stakeholder expectations for IA opinions including the levels of assurance required, scope and the way assurance is given such as narrative or rating by discussion with senior management and the board. Where the organisation's risk maturity is at formative level – defined as 'naïve' or 'aware' - IA may perform consulting engagements to support the improvement of risk management. In this situation IA performs its own risk assessment in formulating risk based IA plans. There is a degree of flexibility and contingency within IA plans to cater for the changing risk environment. There is formal approval of the plan by the board – in some cases internal audit is required to formulate a plan for approval that enables them to provide an annual opinion. This is understood and reflected in discussions and approval of the plan with senior management and the board.	Amended and agreed during 2016. N/A Plan includes contingency for responsive work. The plan is updated throughout the year as necessary to take into account any changes. All updates are reported to the Audit Committee. A mid-year review of the plan was completed, including consultation with Strategic Directors. This was reported to the Audit Committee. Plan approved by Audit Committee.	
2010 Conclusion	**Planning**	☒**GC**	
2020 Communication and Approval			
The chief audit executive must communicate the internal audit activity's plans and resource requirements, including significant interim changes, to senior management and the board for review and approval. The chief audit executive must also communicate the impact of resource limitations.	The CAE communicates progress against the annual plan, including significant changes, to senior management and the board. The board monitor progress against plans. IA explain and justify deviations from the plan and the use of contingency time.	Reports to Audit Committee. Changes communicated to relevant Strategic Director. Monitored at each meeting. Within progress report.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2020 Conclusion	**Communication and Approval**	☒**GC**	
2030 Resource Management			
The chief audit executive must ensure that internal audit resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.	The level of resources included in the plan is determined by the management assurances and risks on which the board require objective assurance and consultancy – a needs assessment.	Department review and restructure during 2016 to give resources matched to the needs of the Council. Also provision for external resources where needed.	
Interpretation: Appropriate refers to the mix of knowledge, skills, and other competencies needed to perform the plan. Sufficient refers to the quantity of resources needed to accomplish the plan. Resources are effectively deployed when they are used in a way that optimises the achievement of the approved plan.	The CAE has communicated to senior management and the board the impact of resource limitations. Staffing plans and financial budgets are determined from annual IA plans and activities. The CAE allocates internal engagements according to the competency levels and training plans of staff – refer back to the section of proficiency.	Mid-year review, presented to AC, including impact of changes. Annual plan includes number of days needed, matched to the staff in the team and external resource if needed. Engagements allocated by PA's according to competency levels. External resource used as necessary.	
2030 Conclusion	**Resource Management**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2040 Policies and Procedures			
The chief audit executive must establish policies and procedures to guide the internal audit activity. ***Interpretation:*** The form and content of policies and procedures are dependent upon the size and structure of the internal audit activity and the complexity of its work.	There are appropriate policies and procedures, which are communicated to and understood by the staff of the internal audit activity. Internal auditors understand what is expected of them and the procedures recognise and apply the requirements of the IPPF Managers and the QAIP examine the application of policies and procedures – there is evidence to support supervision and quality management. Internal auditors meet to discuss the application of policies and procedures – with agreed actions.	Audit Manual, Audit Charter. In the process of procuring integrated audit software which will help regulate this. Needs more communication to auditors There is ongoing review of work, showing supervision and quality management. Team meetings are held, but more needed.	Manual, Charter, policies need better communication to the team. Reliance has been placed on experience. Briefings and team meetings to be instigated.
2040 Conclusion	**Policies and Procedures**	☒**PC**	
2050 Coordination			
The chief audit executive should share information and coordinate activities with other internal and external providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.	IA work is coordinated with that of the external auditors and with other internal providers of assurance and consulting services. This might include regular meetings, documented agreements, coordinated plans, sharing resources, training arrangements. In some cases IA may be required to assess the reliability of the work of other assurance providers. This is established in the Internal Audit Charter and factored into the IA plans.	Meeting held with external audit to discuss plans. They will share their plan when it is available. Known sources of assurance are taken into account when producing the audit plan. Where relevant, the work of other providers of assurance is reviewed during audit assignments.	
2050 Conclusion	**Coordination**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2060 Reporting to Senior Management and the Board			
The chief audit executive must report periodically to senior management and the board on the internal audit activity's purpose, authority, responsibility, and performance relative to its plan. Reporting must also include significant risk exposures and control issues, including fraud risks, governance issues, and other matters needed or requested by senior management and the board. ***Interpretation:*** The frequency and content of reporting are determined in discussion with senior management and the board and depend on the importance of the information to be communicated and the urgency of the related actions to be taken by senior management or the board.	There is evidence that the CAE reports appropriately to the board and senior management on internal audit activities and performance. This might include: • Board minutes. • CAE presentation to board. • Activity reports. • Interviews, management reports, reports on meetings. • Senior management's responses to internal audit reports. • Tangible evidence (e-mail records, internal memos, reports on meetings, etc.) demonstrating that the board had been informed. • Status of action plans.	AC minutes Progress Reports Annual Report Responses to audit reports Confirmation of action taken.	
2060 Conclusion	**Reporting to Senior Management and the Board**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2070 External Service Provider and Organisational Responsibility for Internal Audit			
When an external service provider serves as the internal audit activity, the provider must make the organisation aware that the organisation has the responsibility for maintaining an effective internal audit activity. *Interpretation* This responsibility is demonstrated through the quality assurance and improvement programme which assesses conformance with the *Definition of Internal Auditing*, the *Code of Ethics*, and the *International Standards*.	While IA may be outsourced to a provider of internal audit the organisation retains responsibility for its effectiveness. Responsibility for IA will be assigned to a suitably experience manager who takes ownership for the performance and effectiveness of IA. Quality control will be demonstrated through the QA&IP with both internal and external assessments.	N/A	
2070 Conclusion	**External Service Provider and Organisational Responsibility for Internal Audit**	☒**GC**	
2100 Nature of Work			
The internal audit activity must evaluate and contribute to the improvement of governance, risk management, and control processes using a systematic and disciplined approach.	Sum of *Standards* 2110 – 2130 A significant part of internal audit's assurance role in relation to governance relates to the effectiveness of risk management – refer to the next section 2120		

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2110 Governance			
The internal audit activity must assess and make appropriate recommendations for improving the governance process in its accomplishment of the following objectives: • Promoting appropriate ethics and values within the organisation; • Ensuring effective organisational performance management and accountability; • Communicating risk and control information to appropriate areas of the organisation; and • Coordinating the activities of and communicating information among the board, external and internal auditors, and management. **2110.A1** The internal audit activity must evaluate the design, implementation, and effectiveness of the organisation's ethics-related objectives, programmes, and activities. **2110.A2** The internal audit activity must assess whether the information technology governance of the organisation supports the organisations strategies and objectives.	IA reviews the activities in place that manage and monitor the effective implementation of the organisation's; • Ethics and values. • Codes of conduct. • Levels of authority and responsibility. • Strategic objectives. • Compliance with laws and regulations. • Communication with stakeholders. • Social and ethical objectives, including validation of reported results. • IT governance, including information security. Internal audit's consultancy engagements support the improvement of the organisations governance framework, including the boards self assessment of performance, benchmarking and development of best practice based upon published reports such as the Combined Code.	Not ethics. Code of Conduct – part of working group to update. Not levels of authority and responsibility. Objectives – performance management included in plan. Compliance – regulatory audits Not Communications Not social and ethical objectives. IT governance and security part of audit plan. Work has been completed on the Information Governance Toolkit. Leicester Council ICT auditors used for specialist ICT reviews. Few consultancy engagements.	Full coverage of governance to be included in the Annual Plan for 2017/18.
2110 Conclusion	**Governance**	☒**DNC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2120 Risk Management			
The internal audit activity must evaluate the effectiveness and contribute to the improvement of risk management processes. ***Interpretation:*** Determining whether risk management processes are effective is a judgment resulting from the internal auditors assessment that: • Organisational objectives support and align with the organisation's mission; • Significant risks are identified and assessed; • Appropriate risk responses are selected that align risks with the organisation's risk appetite; and • Relevant risk information is captured and communicated in a timely manner across the organisation, enabling staff, management, and the board to carry out their responsibilities. The internal audit activity may 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. Risk management processes are monitored through ongoing management activities, separate evaluations, or both.	Internal audit's role with regard to risk management is set out in the internal audit charter. IA's role with regard to risk management will vary according to the level of risk maturity within the organisation. Where risk management is well established (risk managed or risk enabled) internal audit provide assurance upon: • The effective implementation of risk management processes in relation to strategic and operational objectives. • Reliable identification and assessment of risks with appropriate response. • The reporting of risk and control status by management. • The level of residual risk in relation to the organisations' risk appetite. • The effectiveness of the controls and other responses to risks. The IA activity gathers the information to support an assessment of risk management during multiple engagements. The results of these engagements, when viewed together, provide an understanding of the organisation's risk management and its effectiveness. Alternatively, IA may assess risk management processes as one single engagement.	Charter includes the role of IA with regards to risk management. Review of Risk Management completed in December 2016. Review included the implementation of risk management, identification and assessment of risks, reporting, residual risk and effectiveness of controls. All audit scopes include reviewing risk management in the area under review.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2120.A1 The internal audit activity must evaluate risk exposures relating to the organisation's governance, operations, and information systems regarding the: • Achievement of the organisation's strategic objectives, • Reliability and integrity of financial and operational information. • Effectiveness and efficiency of operations and programmes. • Safeguarding of assets; and • Compliance with laws, regulations, policies procedures and contracts. **2120.A2** The internal audit activity must evaluate the potential for the occurrence of fraud and how the organisation manages fraud risk. **2120.C1** During consulting engagements, internal auditors must address risk consistent with the engagement's objectives and be alert to the existence of other significant risks. **2120.C2** Internal auditors must incorporate knowledge of risks gained from consulting engagements into their evaluation of the organisation's risk management processes. **2120.C3** When assisting management in establishing or improving risk management processes, internal auditors must refrain from assuming any management responsibility by actually managing risks.	Where risk management is less developed (risk naïve, aware or defined) internal audit operate in a more advisory capacity to: • Report upon the level of risk maturity and scope for improvement. • Support development of risk management framework. • Facilitate identification and assessment of risks. • Coach management in responding to risks. Coordinate and consolidate reporting. IA refrains from taking full responsibility for risk management, including risk responses. IA carry out individual risk based engagements to provide assurance on part of the risk management framework, including on the mitigation of individual or groups of risks. IA evaluate the potential occurrence for fraud as part of audit engagements – included within objectives and referred to in communications at the end of the audit engagement.	IA is not responsible for risk management. Risk based internal audit engagements include reviewing risk management within that area. Consideration of fraud not included in all audit scopes. Now added to scoping document. A fraud risk register is currently being developed. Internal Audit does not have management responsibility for managing risks.	Complete and issue the fraud risk register
2120 Conclusion	**Risk Management**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2130 Control			
The internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement. **2130.A1** The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organisation's governance, operations, and information systems regarding the: • Achievement of the organisation's strategic objectives, • Reliability and integrity of financial and operational information; • Effectiveness and efficiency of operations; • Safeguarding of assets; and • Compliance with laws, regulations, and contracts.	IA engagements consider the efficiency of controls used to mitigate risks - whether there are too many or too few controls, which evaluates the cost of control in relation to the impact and likelihood of the risk. IA work programmes focus on high priority risks and adequately tests controls to ensure their effectiveness – there is a recognised approach to ensure sufficient sample sizes are taken and tested. IA verify, where appropriate: • The application and effectiveness of risk management procedures. • Management assurances on controls, including the results of self assessments. • KPIs are accurate, timely, relevant and reliable. • Reporting requirement are operating as planned	Risk Based Internal Audit methodology in use. Audit scopes refer to risks and controls to mitigate them. Working papers test the controls in place. Sample sizes applied to audit of fundamental systems – in accordance with KPMG guidelines. All verified where appropriate within the audit plan.	
2130.C1 Internal auditors must incorporate knowledge of controls gained from consulting engagements into evaluation of the organisation's control processes.	Internal auditors support management upon the design of controls at appropriate points in the development of major change programmes – examples would include implementation of new computer systems, building and supply contracts.	More involvement needed in change programmes.	Better liaison with DMTs during 2017/18, with the aim of improving IA involvement in change programmes.
2130 Conclusion	**Control**	☒**PC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2200 Engagement Planning			
Internal auditors must develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations.	Sum of *Standards* 2201-2240	All included in scoping document.	
2201 Planning Considerations			

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
In planning the engagement, internal auditors must consider: • The objectives of the activity being reviewed and the means by which the activity controls its performance; • The significant risks to the activity, its objectives, resources, and operations and the means by which the potential impact of risk is kept to an acceptable level; • The adequacy and effectiveness of the activity's governance, risk management, and control processes compared to a relevant framework or model; and • The opportunities for making significant improvements to the activity's governance, risk management, and control processes. **2201.A1** When planning an engagement for parties outside the organisation, internal auditors must establish a written understanding with them about objectives, scope, respective responsibilities, and other expectations, including restrictions on distribution of the results of the engagement and access to engagement records.	Procedure exists within the IA activity that requires internal auditors to research, scope and plan internal audit engagements – assurance and consultancy. Internal auditors document the following as part of their research and discussions with managers • The nature of the area under review and key areas of change and development • The activities that occur and the way performance is monitored. • Strategic objectives and the way the area contributes to the organisation's strategy or purpose. • The risks involved and the organisation's chosen responses to those risks. • How managers know the responses are effective. • Assurances managers give to whom and how often. The preparation for audit engagements leads to the documentation of objectives that are agreed with senior management and where appropriate clients outside the organisation. Options include: • Assurance that management assurance is effective and, therefore, reliable. • Assurance that specific responses, including controls, are effective in managing given risks. • Consultancy to help managers improve the design or implementation of governance processes, risk processes and risk responses, including controls.	Procedures exist for research and scoping. All scopes are signed off by a Principal Auditor or Head of Audit. Yes/no. Key areas of change may not routinely be covered. Yes/no. Performance elements of activity may not be considered. Objectives of the area noted. Risks confirmed to risk registers, including mitigating actions. Mitigating actions evidenced / tested in the review Governance around reporting included in the review. Objectives agreed with management before the start of fieldwork. Outside organisation arrangements to be updated (academies)	Arrangements for auditing academies to be reviewed.

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2201.C1 Internal auditors must establish an understanding with consulting engagement clients about objectives, scope, respective responsibilities, and other client expectations. For significant engagements, this understanding must be documented.	Documentation of the objectives and scope of consultancy engagements. This could include engagement letters, terms of reference and any other form of agreement that documents the responsibilities of the internal audit activity in a consultancy engagement.	N/A	
2201 Conclusion	**Planning Considerations**	☒**DNC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2210 Engagement Objectives			
Objectives must be established for each engagement. **2210.A1** Internal auditors must conduct a preliminary assessment of the risks relevant to the activity under review. Engagement objectives must reflect the results of this assessment. **2210.A2** Internal auditors must consider the probability of significant errors, fraud, non-compliance, and other exposures when developing the engagement objectives. **2210.A3** Adequate criteria are needed to evaluate governance, risk management and controls. Internal auditors must ascertain the extent to which management and/or the board has established adequate criteria to determine whether objectives and goals have been accomplished. If adequate, internal auditors must use such criteria in their evaluation. If inadequate, internal auditors must work with management and/or the board to develop appropriate evaluation criteria. **2210.C1** Consulting engagement objectives must address governance, risk management, and control processes to the extent agreed upon with the client. **2210.C2** Consulting engagement objectives must be consistent with the organisation's values, strategies and objectives.	In establishing objectives for assurance engagements the internal auditor considers: • The significant risks to the activity, its objectives, resources, and operations and the means by which the potential impact of risk is kept to an acceptable level. • The adequacy and effectiveness of the activity's risk management and control systems compared to a relevant control framework or model. • The opportunities for making significant improvements to the activity's risk management and control systems. For consultancy engagements the objectives reflect the expectation of managers and relate to aspects of governance, risk management and control	Risks and risk management considered during scoping. Findings produce recommendations to improve risk management and control. N/A	
2210 Conclusion	**Engagement Objectives**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2220 Engagement Scope			
The established scope must be sufficient to achieve the objectives of the engagement. **2220.A1** The scope of the engagement must include consideration of relevant systems, records, personnel, and physical properties, including those under the control of third parties. **2220.A2** If significant consulting opportunities arise during an assurance engagement, a specific written understanding as to the objectives, scope, respective responsibilities, and other expectations should be reached and the results of the consulting engagement communicated in accordance with consulting standards. **2220.C1** In performing consulting engagements, internal auditors must ensure that the scope of the engagement is sufficient to address the agreed-upon objectives. If internal auditors develop reservations about the scope during the engagement, these reservations must be discussed with the client to determine whether to continue with the engagement. **2220.C2** During consulting engagements, internal auditors must address controls consistent with the engagement's objectives and be alert to significant control issues.	The engagement scope is consistent with the audit objectives. In practice this means agreeing and documenting: • The extent of the audit - understanding what will and won't be looked at. • The nature of assurance to be provided or focus of the consulting work to be done, including timing and key stages. • Defining the people, systems, procedures, files and records that will form the audit engagement. • Defining the depth of the review, such as the period under review or any special conditions. The scope of consultancy engagements has reference to aspects of governance, risk management and control as per the definition of IA.	Scopes include what will and will not be looked at. Assurance and timing are included in the scope. Included in scopes. Included in scopes. N/A	
2220 Conclusion	**Engagement Scope**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2230 Engagement Resource Allocation			
Internal auditors must determine appropriate and sufficient resources to achieve engagement objectives based on an evaluation of the nature and complexity of each engagement, time constraints, and available resources.	Evidence of appropriate evaluation of how audit engagements are resourced based on the nature and complexity of the engagement, time constraints, and available resources**.** This would include the rational for using resources outside the IA activity based on the levels of competency required.	Audits are allocated according to complexity and resources. Where the audit team does not have the competency to complete the audit external resources are acquired, e.g. ICT and Children's Services.	
2230 Conclusion	**Engagement Resource Allocation**	☒**GC**	
2240 Engagement Work Programme			
Internal auditors must develop and document work programmes that achieve the engagement objectives. **2240.A1** Work programme must include the procedures for identifying, analysing, evaluating, and documenting information during the engagement. The work programme must be approved prior to its implementation, and any adjustments approved promptly. **2240.C1** Work programme for consulting engagements may vary in form and content depending upon the nature of the engagement.	The internal auditor has developed a programme of work outlining the resources and procedures needed to achieve the audit objectives. This might include: • Timetables and project plans. • Preparation of audit programmes and checklists. • Interview and testing schedules. For consultation work the planning and, documentation of activities is tailored according to the nature of the engagement. The one-off nature of such engagement may require detailed project plans and timetables. The engagement programme of work and any subsequent programme adjustments are approved by the CAE or designee.	Each scope and audit file includes the programme of work in terms of an audit programme and testing schedule. The scope is agreed with the client and signed off by a Principal Auditor or Head of Audit. Any changes are also agreed and signed off. N/A	
2240 Conclusion	**Engagement Work Programme**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2300 Performing the Engagement	Sum of *Standards* 2300-2340		
Internal auditors must identify, analyse, evaluate, and document sufficient information to achieve the engagement's objectives.	Information can be data or documents that internal auditors use, document or create to support and fulfil their audit engagements. Information is retained in some form of filing or storage system to support conclusions and opinions – hardcopy or electronic versions are acceptable.	Hardcopy files are used to record audit work.	
2310 Identifying Information			
Internal auditors must identify sufficient, reliable, relevant, and useful information to achieve the engagement's objectives. ***Interpretation:*** Sufficient information is factual, adequate, and convincing so that a prudent, informed person would reach the same conclusions as the auditor. Reliable information is the best attainable information through the use of appropriate engagement techniques. Relevant information supports engagement observations and recommendations and is consistent with the objectives for the engagement. Useful information helps the organisation meet its goals.	The internal auditor plans what information they may need, where that information could be obtained from and whether that information is sufficient, reliable, relevant, and timely. The working files/papers for the audit engagement contain information that shows how activities and processes are designed and how they are meant to work. Information is obtained from information systems about the way processing operates – options include reporting tools, exception reports and CAATTs. Information also includes observations, interviews and results of audit testing.	Information is gained in order to complete audit testing and support conclusions, and retained in the files. If documented systems / processes are available they will be obtained and used. If not such processes will usually be determined through discussion with auditee and recorded in the working papers. Reports are obtained where applicable. CAATs are not used.	Explore the possibility of using CAATs in 2017/18.
2310 Conclusion	**Identifying Information**	☒**GC**	
2320 Analysis and Evaluation			

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
Internal auditors must base conclusions and engagement results on appropriate analyses and evaluations.	Audit conclusions and engagement results are based on the information that has been gathered during the audit engagement. There is evidence that the information has been analysed and evaluations discussed with managers.	Conclusions are based on results of testing, reviewed and discussed with managers at the closing meeting.	
2320 Conclusion	**Analysis and Evaluation**	☒**GC**	
2330 Documenting Information			
Internal auditors must document relevant information to support the conclusions and engagement results. **2330.A1** The chief audit executive must control access to engagement records. The chief audit executive must obtain the approval of senior management and/or legal counsel prior to releasing such records to external parties, as appropriate. **2330.A2** The chief audit executive must develop retention requirements for engagement records, regardless of the medium in which each record is stored. These retention requirements must be consistent with the organisation‘s guidelines and any pertinent regulatory or other requirements. **2330.C1** The chief audit executive must develop policies governing the custody and retention of consulting engagement records, as well as their release to internal and external parties. These policies must be consistent with the organisation‘s guidelines and any pertinent regulatory or other requirements.	Sufficient information is documented to support the conclusions and audit opinions. Work files/papers have controlled access according to the policy of the organisation A policy and procedure exists relating to information archiving and retrieval. There is evidence that CAE obtains appropriate approvals prior to releasing records.	Audit files contain information to support conclusions and audit opinions. All files are subject to review. Files are kept in locked cupboards and archives. Procedures exist for archiving and retrieval. Retention periods are specified. Policy is in place for releasing records.	
2330 Conclusion	**Documenting Information**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2340 Engagement Supervision			
Engagements must be properly supervised to ensure objectives are achieved, quality is assured, and staff is developed. ***Interpretation:*** The extent of supervision required will depend on the proficiency and experience of internal auditors and the complexity of the engagement. The chief audit executive has overall responsibility for supervising the engagement, whether performed by or for the internal audit activity, but may designate appropriately experienced members of the internal audit activity to perform the review. Appropriate evidence of supervision is documented and retained.	There is an organisational and reporting structure within the internal audit activity that provides the basis for supervision. Job descriptions document supervisory requirements. Policies and procedures describe how supervision is supposed to be applied – this incorporates review of work in progress, amendment or corrective actions, follow-up and approval. IA files/working papers and reports illustrate how supervision works in practice. The results of supervision are incorporated into the QAIP and staff appraisal assessments – and where appropriate training and development plans.	Structure of the team has been agreed. Job descriptions document supervisory requirements. Manual. Audit files are reviewed by PA's, review sheet used to document actions and completion. Files include checklist to show supervision. To be completed	Refer results of reviews into QAIP and individual training requirements.
2340 Conclusion	**Engagement Supervision**	☒**PC**	
2400 Communicating Results	Sum of *Standards* 2410-2440		
Internal auditors must communicate results of engagements.			

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2410 Criteria for Communicating			
Communications must include the engagement's objectives and scope as well as applicable conclusions, recommendations, and action plans.	There is evidence of appropriate, timely communication with management throughout the audit engagement. This begins with discussions to research and scope an audit, leading to agreement upon objectives. Communication with managers also occurs as the audit engagement proceeds - discussing and analysing information. Close –out meetings that provide the basis for exchange views about conclusions, opinions and possible recommendations for improvement.	Opening meeting held to agree scope and objectives. Ongoing contact is maintained throughout the audits. Closing meetings held after all audits, including conclusions and opinions and recommendations.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2410.A1 Final communication of engagement results must, where appropriate, contain internal auditors' opinion and/or conclusions. When issued, an opinion or conclusion must take account of the expectations of senior management, the board and other stakeholders and must be supported by sufficient, reliable, relevant and useful information. ***Interpretation:*** Opinions at the engagement level may be ratings, conclusions or other descriptions of the results. Such an engagement may be in relation to controls around a specific process, risk or business unit. The formulation of such opinions requires consideration of the engagement results and their significance. **2410.A2** Internal auditors are encouraged to acknowledge satisfactory performance in engagement communications. **2410.A3** When releasing engagement results to parties outside the organisation, the communication must include limitations on distribution and use of the results. **2410.C1** Communication of the progress and results of consulting engagements will vary in form and content depending upon the nature of the engagement and the needs of the client.	An overall opinion or conclusion is included within audit communications in line with the stakeholder expectations and the original objectives of the audit engagement. Opinions are given according to the level, scope and detail agreed with senior management and the audit committee. Opinions at the engagement level may be ratings, conclusions or other descriptions of the results. Satisfactory performance is acknowledged in engagement communications. Communications outside the organisation are limited in distribution and use of results. There is evidence of progress and results on consulting engagements that is reasonable to the engagement.	Overall opinions are given according to the agreed process and linked to objectives. Standard rating for audit opinions. Reports include areas that are well controlled. N/A N/A	
2410 Conclusion	**Criteria for Communicating**	☒**GC** ☐**PC** ☐**DNC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2420 Quality of Communications			
Communications must be accurate, objective, clear, concise, constructive, complete, and timely. ***Interpretation:*** Accurate communications are free from errors and distortions and are faithful to the underlying facts. Objective communications are fair, impartial, and unbiased and are the result of a fair-minded and balanced assessment of all relevant facts and circumstances. Clear communications are easily understood and logical, avoiding unnecessary technical language and providing all significant and relevant information. Concise communications are to the point and avoid unnecessary elaboration, superfluous detail, redundancy, and wordiness. Constructive communications are helpful to the engagement client and the organisation and lead to improvements where needed. Complete communications lack nothing that is essential to the target audience and include all significant and relevant information and observations to support recommendations and conclusions. Timely communications are opportune and expedient, depending on the significance of the issue, allowing management to take appropriate corrective action.	There is a record of the timeline for the communication of results that spans the completion of the audit engagement through to communication with the board. There is a procedure that ensures discussions with managers between the close of the audit engagement and the delivery of communications are performed promptly. There is evidence to show IA communications are delivered in a timely manner and within the timeframe and level of resource set at the start of the audit engagement. Communications cover the full scope of the audit engagement. The form and style of communications has been discussed and agreed with senior management and the board including the method of communications, format, and any grading of opinions and recommendations. There is evidence of review and approval of communications prior to their release to ensure accuracy and objectivity. Communications are clear and concise.	Record kept of the progress of audits from completion of fieldwork to reporting to Audit Committee. Closing meetings are held as soon as possible after completion of fieldwork. There are targets for issue and return of draft and final reports, which are followed up if necessary. Actual dates are noted on the files. No. Have tended to be based on good practice / examples / templates from other authorities. Reports show the link between objectives and conclusions. Draft and final reports are reviewed before release. Yes.	To be presented to senior management and audit committee.
2420 Conclusion	**Quality of Communications**	☒**GC** ☐**PC** ☐**DNC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2421 Errors and Omissions			
If a final communication contains a significant error or omission, the chief audit executive must communicate corrected information to all parties who received the original communication.	Where appropriate, there is communication of corrected information to all parties.	Where appropriate, corrections are communicated.	
2421 Conclusion	**Errors and Omissions**	☒**GC**	
2430 Use of 'Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing'.			
Internal auditors may report that their engagements are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing, only if the results of the quality assurance and improvement program support the statement.	Internal and external assessments support any statements that are made inside and outside the organisation. Senior management and the board are aware of and agree such statements.	External assessment did not support the statement. It is not used.	
2430 Conclusion	**Use of 'Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing'.**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2431 Engagement Disclosure of Non-conformance			
When non-conformance with the Definition of Internal Auditing, the Code of Ethics or the Standards impacts a specific engagement, communication of the results must disclose the: • Principle or rule of conduct of the Code of Ethics or Standard(s) with which full conformance was not achieved; • Reason(s) for non-conformance; and • Impact of non-conformance on the engagement and the communicated engagement results.	Where appropriate, communication of results discloses non-conformance with the IPPF. The nature of the non-conformance is discussed and reviewed with senior management and the board with a record of any agreed action.	Non-conformance affecting a specific engagement would be picked up in the review process and reported. Overall non-conformance was disclosed to the Audit Committee last year, with an agreed action plan.	
2431 Conclusion	**Engagement Disclosure of Non-conformance**	☒**GC** ☐**PC** ☐**DNC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2440 Disseminating Results			
The chief audit executive must communicate results to the appropriate parties. ***Interpretation:*** The chief audit executive is responsible for approving the final engagement communication before issuance and for deciding to whom and how it will be disseminated. When the chief audit executive delegates these duties, he or she retains overall responsibility. **2440.A1** The chief audit executive is responsible for communicating the final results to parties who can ensure that the results are given due consideration. **2440.A2** If not otherwise mandated by legal, statutory, or regulatory requirements, prior to releasing results to parties outside the organisation the chief audit executive must: • Assess the potential risk to the organisation; • Consult with senior management and/or legal counsel as appropriate; and • Control dissemination by restricting the use of the results.	All audit communications are reviewed and approved by the CAE. Audit communications are provided to an appropriate level of senior management and distributed according to the agreed protocol of the organisation. When an overall opinion is issued (perhaps in support of a statement on internal control), it covers an appropriate time period and addresses the expectations as agreed with the board, senior management and other stakeholders. The opinion is supported by sufficient, reliable, relevant and accurate information. If applicable, the CAE is properly consulted and has considered the risks of disclosure outside the organisation. Consulting engagement reports are distributed appropriately, as established at the start of the audit engagement.	All draft reports are approved by the HIA. Any significant amendments to the reports at the final stage are also reviewed by him. Reports are distributed to management, Assistant Directors and Strategic Directors as necessary based on the area reviewed and the findings. An overall opinion is given in the annual report, covering the financial year. The report includes the supporting evidence. Yes, if applicable. N/A	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2440.C1 The chief audit executive is responsible for communicating the final results of consulting engagements to clients. **2440.C2** During consulting engagements, governance, risk management, and control issues may be identified. Whenever these issues are significant to the organisation, they must be communicated to senior management and the board.			
2440 Conclusion	**Disseminating Results**	☒**GC**	
2450 Overall Opinions			
When an overall opinion is issued, it must take into account the expectations of senior management, the board and other stakeholders and must be supported by sufficient, reliable, relevant and useful information. ***Interpretation:*** The communication will identify: • The scope including the time period to which the opinion pertains. • Scope limitations. • Consideration of all related projects including the reliance on other assurance providers. • The risk or control framework or other criteria used as a basis for the overall opinion. • The overall opinion, judgment or conclusion reached. The reasons for an unfavourable overall opinion must be stated	The annual opinion is delivered on time and in accordance with the expectations of senior management and the audit committee. The work completed in the annual internal audit plan is consistent with the opinion requirements. The opinion where appropriate takes into account the reliability of other assurance providers. There is a methodology and process in place to evaluate the cumulative results of audit assignments and audit findings to express such an opinion.	Annual Report to Audit Committee in May, first meeting after the end of year, in time for opinion to feed into AGS. Plan is designed to give sufficient evidence to enable the annual opinion to be given. Other assurance providers not relied on to gain the opinion. All results from the year are examined to form the opinion.	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2450 Conclusion	**Overall Opinions**	☒**GC**	
2500 Monitoring Progress			
The chief audit executive must establish and maintain a system to monitor the disposition of results communicated to management. **2500.A1** The chief audit executive must establish a follow-up process to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action. **2500.C1** The internal audit activity must monitor the disposition of results of consulting engagements to the extent agreed upon with the client.	The CAE has established a follow-up process to monitor and ensure that management actions have been effectively implemented or risk accepted. Records of follow-up meeting and discussions. There is a process that require internal audit to confirm the implementation of actions by management in relation to high priority, high importance areas.	All recommendations are tracked after two months. Progress is reported to the Audit Committee, including non-implementation. E mail records kept. High priority actions are subject to follow up.	
2500 Conclusion	**Monitoring Progress**	☒**GC**	

Internal assessment of compliance with PSIAS

International standard	Key conformance criteria	Evidence to support assessment	Actions for further improvement
2600 Communicating the Acceptance of Risks			
When the chief audit executive concludes that senior management has accepted a level of residual risk that may be unacceptable to the organization, the chief audit executive must discuss the matter with senior management. If the chief audit executive concludes that the matter has not been resolved, the chief audit executive must communicate the matter to the board for resolution. **Interpretation:** *The identification of risk accepted by management may be observed through an assurance or consulting engagement, monitoring progress on actions taken by management as a result of prior engagements, or other means. It is not the responsibility of the chief audit executive to resolve the risk.*	Decisions regarding residual risk that are not resolved are reported by the CAE to the board for resolution. The subsequent resolution/disposition of such residual risk issues is appropriately documented.	Any unaccepted actions or unimplemented actions are escalated to the Strategic Director and reported to the Audit Committee.	
2600 Conclusion	**Resolution of Senior Management s Acceptance of Risks**	☒**GC**	

Rotherham Metropolitan Borough Council

Public Report
Audit Committee Report

Summary Sheet

Council Report:
Audit Committee 8th February 2017

Title:
Local Code of Corporate Governance

Is this a Key Decision and has it been included on the Forward Plan?:
No

Strategic Director Approving Submission of the Report:
Shokat Lal *(Assistant Chief Executive)*

Report Author(s):
Simon Dennis (Corporate Risk Manager)
Andrew Shaw (Insurance & Risk Manager)

Ward(s) Affected:
All

Executive Summary:
In April 2016 CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives) published revised guidance on delivering good governance in local government. The Council's Local Code of Corporate Governance has been rewritten to set out how it will comply with this new guidance and is presented here for consideration by the Audit Committee.

Recommendations:

- **The Audit Committee is asked to consider the refreshed version of the Local Code of Corporate Governance**
- **Consider the proposal for the creation of a Governance Group to oversee the implementation of the Local Code as well as the provision of evidence to support the Annual Governance Statement**
- **After consideration, advise of any amendments or further development work deemed necessary**

List of Appendices Included:
Appendix 1 – Local Code of Corporate Governance.

Background Papers:
"Delivering Good Governance in Local Government", published by CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives) in April 2016.

Consideration by any other Council Committee, Scrutiny or Advisory Panel:
No

Council Approval Required:
No

Exempt from the Press and Public:
No

Title: Local Code of Corporate Governance

1. Recommendations

1.1 The Audit Committee is asked to consider the refreshed version of the Local Code of Corporate Governance

1.2 Consider the proposal for the creation of a Governance Group to oversee the implementation of the Local Code as well as the provision of evidence to support the Annual Governance Statement

1.3 After consideration, the Committee to advise of any amendments or further development work deemed necessary

.

2. Background

2.1 The Corporate Governance delivery programme section of the Rotherham Improvement Plan stressed the need for improvement in Governance, Decision making and Performance Management arrangements with the ultimate outcome being a robust Governance framework. A new local code of Corporate Governance was introduced in November 2015 in response to the need set out in the Improvement Plan.

2.2 In April 2016, CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives) published revised guidance on delivering good governance in Local government. The Council's Local Code of Corporate Governance has now been rewritten to set out how it intends to comply with this new guidance. This Local Code is presented here for consideration by the Audit Committee.

2.3 The new guidance sets out seven key principles of good governance and the Council's new Local Code reflects these principles.

2.4 Good governance leads to good management, performance, public engagement, stewardship of public money and, through all this, good outcomes for citizens and service users.

3. Key Issues

3.1 Rotherham Metropolitan Borough Council is committed to ensuring the highest possible standards of governance in order to fulfil its responsibilities. Integrity, openness and accountability are fundamental principles by which the Council operates and these are specifically reflected in two of the Council's values – "Honest" (Being open and truthful in everything we do) and "Accountable" (We own our decisions, we do what we say and we acknowledge and learn from our mistakes).

3.2 In 2014/15, the Council was heavily criticised in the Casey 'Corporate Governance Inspection' Report (February 2015) for a series of governance failings and was regarded overall as not 'fit for purpose'.

As part of the Improvement Plan which responded to these failings, the Council produced a new Code of Corporate Governance which brought all of its practices together in one document, making them open and explicit.

3.3 Appropriate procedures and processes are being integrated into the Council's Governance Framework to ensure there will be routine application and ongoing review of the arrangements described in the Code. Furthermore, the proposals considered by SLT on 13 December 2016, to establish a new, corporate "Performance, Intelligence and Improvement" capacity, would seek to bring together the Council's approaches performance monitoring and management, risk management and corporate governance, as part of the same service/function.

3.4 National guidance; "Delivering Good Governance in Local Government", was first published in 2007 by CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives) and at the time identified six core principles of good governance. Additional guidance, in the form of an addendum, was published in 2012 and the new Code, on which this Local Code is based, was published in April 2016.

3.5 The new Local Code sets out the seven key principles which underpin its operation. These are:

- Behaving with Integrity, demonstrating strong commitment to ethical values and respecting the rule of law
- Ensuring Openness and comprehensive stakeholder engagement
- Determining outcomes in terms of sustainable economic, social and environmental benefits
- Determining the interventions necessary to optimise the achievement of the intended outcomes
- Developing the Councils capacity, including the capability of its leadership and the individuals within it
- Managing risks and performance through robust internal control and strong public financial management
- Implementing good practice in transparency, reporting and audit to deliver effective accountability

3.6 The first two principles underpin the operation of the other five and represent a change in approach from earlier versions of the Code. As can also been seen from the list above, the Council's own values align closely to the key principles in the CIPFA/SOLACE code.

3.7 The Council has adopted this approach in producing its Local Code of Corporate Governance to give citizens and customers a clear understanding of how the Council manages its decision making, service planning, service delivery and accountability processes, how it ensures that the Council sets out its vision and priorities and how it provides effective and efficient outcomes to its citizens and customers.

3.8 In many Councils, the implementation and operation of the local Code is overseen by a "Governance Group". Such a group would have the following roles:

- Have oversight of the Local Code, including its implementation, review and revision on at least an Annual Basis
- Co-ordinate the production of the Annual Governance Statement and the assurances needed to underpin this
- Review the progress being made to address the issues reported in the previous year's Annual Governance Statement
- Ensure that recommendations from external bodies are appropriately followed up and reported to the Audit Committee
- Be responsible for responding to any ad hoc governance issues as required

3.9 Ideally the "Governance Group" would consist of staff directly involved in the implementation of the Code and the production of the Annual Governance Statement. For Rotherham, this would normally include:

- The Corporate Risk Manager
- The Head of Internal Audit
- The Insurance and Risk Manager
- A representative from Legal Services
- A representative from the Information Governance Group
- A member of SLT to chair the group

3.10 The Group would meet as required, envisaged to be at least three times a year to focus on the process for the production of the Annual Governance Statement as well as the progress on issues from previous Annual Governance Statements.

4. Options considered and recommended proposal

4.1 "Delivering Good Governance in Local Government", published by CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives) is widely acknowledged as the authoritative guide in this area.

4.2 All Local Authorities within the UK construct their Local Codes of Corporate Governance utilising the methodology advocated by this guidance. The revised framework was published in April 2016 and it is important that the Council complies with this new code. The revised framework has been analysed and the findings are reflected in this revision of our own Local Code.

4.3 The Audit Committee is invited to review the attached Local code and provide any comments.

4.4 The Audit Committee is also invited to consider the proposal to create a Corporate Governance Group.

5. Consultation

5.1 Research has been undertaken into sector codes of governance. The attached Code takes account of current arrangements in Rotherham.

6. Timetable and Accountability for Implementing this Decision

6.1 The refreshed code is to be presented to the Audit Committee for consideration at its meeting on 8th February 2017 and then should be signed off by both the Chief Executive and the Leader of the Council.

.

7. Financial and Procurement Implications

7.1 There are no immediate financial and procurement implications associated with the refreshed code although, previously stated, good governance leads to good stewardship of public money.

8. Legal Implications

8.1 There are no immediate legal implications associated with the proposals.

9. Human Resources Implications

9.1 There are no Human Resources implications associated with the proposals.

10. Implications for Children and Young People and Vulnerable Adults

10.1 There are no immediate implications associated with the proposals.

11. Equalities and Human Rights Implications

11.1 There are no immediate implications associated with the proposals.

12. Implications for Partners and Other Directorates

12.1 There are no immediate implications associated with the proposals.

13. Risks and Mitigation

13.1 The implementation of an effective Governance framework is designed to minimise the Authority's exposure to risk.

14. Accountable Officer(s):

Simon Dennis *(Corporate Risk Manager)*
Andrew Shaw *(Insurance and Risk Manager)*

Approvals Obtained from:-

Strategic Director of Finance and Customer Services: Judith Badger

Assistant Director of Legal Services: Dermot Pearson

This report is published on the Council's website or can be found at: http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories

Rotherham Metropolitan Borough Council

Local Code of Corporate Governance 2017

January 2017

LOCAL CODE OF CORPORATE GOVERNANCE

Governance is about organisations ensuring that they are doing the right things in the correct manner for the right people in a timely, open, honest, inclusive and accountable manner. It follows that good governance leads to good management, performance, public engagement, stewardship of public money and, through all this, good outcomes for citizens and service users.

Good governance also enables the Council to pursue its vision effectively as well as reinforcing that vision with the mechanisms for control and management of risk.

In 2014/15, Rotherham Council was subject to a corporate governance inspection. The Council was heavily criticised in the report resulting from the inspection* for a series of governance failings. The Secretary of State for Communities and Local Government and the Secretary of State for Education appointed five commissioners in February 2015 to take all executive and licensing responsibilities at the Council and lead the improvements necessary to deliver services that meet the needs of Rotherham. The intervention remains in force until 31 March 2019 unless the Secretaries of State, or, as the case may be, either one of them, consider it appropriate to amend or revoke it at an earlier date.

The Commissioners produced an Improvement Plan in May 2015 which was supported by the Council and accepted by the Secretaries of State. In February 2016, the Commissioners produced a twelve months progress review* which showed a considerable amount of positive progress has been made, while confirming the significant challenges still to be addressed. Subsequently, the Secretary of State for Communities and Local Government issued revised directions following a request from Commissioners to return responsibility for a number of functions to Councillors. These included services which in the Commissioners' views were well-led by officers, had Members in a position to exercise executive authority over these functions, and had clear service definitions and plans for improvement in place.

Actions set out in the original improvement plan have been reassessed and a new Phase Two plan, effective from May 2016, has been approved. Key priorities for 2016/17 are to continue to improve the services requiring improvement and ensure the Council focuses on implementing its corporate and service priorities, and meeting its responsibilities for achieving best value through the use of resources.

This Code of Corporate Governance explains all of the Council's policies and practices in one document, making them open and explicit. Appropriate procedures and processes are being integrated into the Council's Governance Framework to ensure there will be routine application and ongoing review of the arrangements described in the Code.

Councillor Chris Read
Leader, Rotherham MBC

Sharon Kemp
Chief Executive

* ***The Corporate Governance Inspection report (the Casey report), the Twelve Months Progress Review, The Corporate Improvement Plan 'A Fresh Start' and other associated documentation can be found at www.rotherham.gov.uk***

January 2017

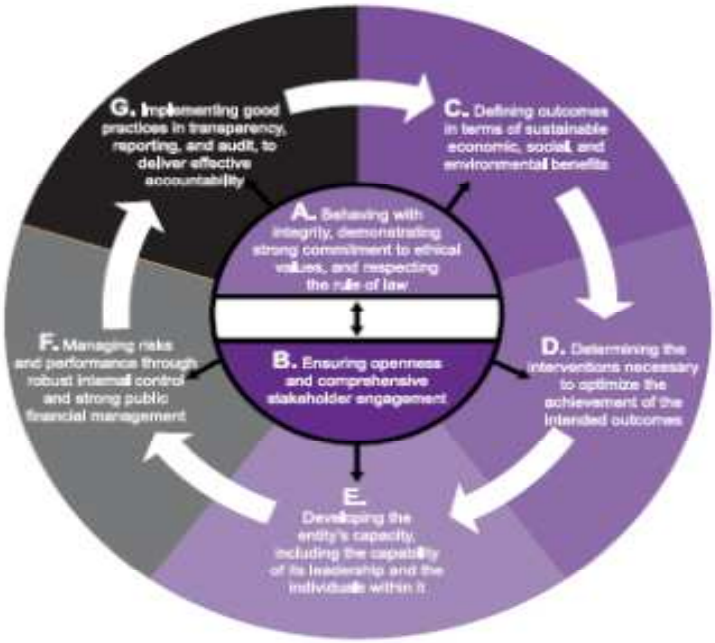
Introduction

All of the decisions made by Rotherham Council about the services it delivers, and how to deliver them, are supported by a whole set of systems and processes which make up the Council's 'governance arrangements'. These include holding meetings where decisions are made, the Council's legal framework, setting out priorities and roles clearly, holding decision makers to account through scrutiny, risk management processes, financial monitoring and ensuring high standards of conduct. Local authorities are encouraged to demonstrate how they ensure effective governance arrangements by setting these out in a local code of governance.

Rotherham Metropolitan Borough Council's 'Local Code of Corporate Governance' is based on the guidance "Delivering Good Governance in Local Government", published in 2016 by CIPFA (the Chartered Institute of Public Finance and Accountancy) and SOLACE (the Society of Local Authority Chief Executives).

The main principle underpinning the Delivering Good Governance in Local Government: Framework continues to be that local government is developing and shaping its own approach to governance, taking account of the environment in which it now operates. The Framework is intended to assist authorities individually in reviewing and accounting for their own unique approach. The overall aim is to ensure that resources are directed in accordance with agreed policies and according to priorities, that there is sound and inclusive decision making and that there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities. A diagram of the Framework from the guidance is copied below:

Achieving the Intended Outcomes While Acting in the Public Interest at all Times



The International Framework notes that:

Principles A and B permeate implementation of principles C to G. The diagram also illustrates that good governance is dynamic, and that an entity as a whole should be committed to improving governance on a continuing basis through a process of evaluation and review.

The Framework positions the attainment of sustainable economic, societal, and environmental outcomes as a key focus of governance processes and structures. Outcomes give the role of local government its meaning and importance, and it is fitting that they have this central role in the sector's governance. Furthermore, the focus on sustainability and the links between governance and public financial management are crucial – local authorities must recognise the need to focus on the long term.

The Framework defines the principles that should underpin the governance of each local government organisation. It provides a structure to help individual authorities with their approach to governance. Whatever forms of arrangements are in place, authorities should test their governance structures and partnerships against the principles contained in the Framework by:

- Reviewing existing governance arrangements
- Developing and maintaining an up-to-date local code of governance, including arrangements for ensuring ongoing effectiveness
- Reporting publicly on compliance with their own code on an annual basis and on how they have monitored the effectiveness of their governance arrangements in the year and on planned changes.

To achieve good governance, each local authority should be able to demonstrate that its governance structures comply with the core and sub-principles contained in this Framework. It should therefore develop and maintain a local code of governance and governance arrangements reflecting the principles set out.

It is also crucial that the Framework is applied in a way that demonstrates the spirit and ethos of good governance which cannot be achieved by rules and procedures alone. Shared values that are integrated into the culture of an organisation, and are reflected in behaviour and policy, are hallmarks of good governance.

The Council has adopted this Code of Corporate Governance (Code) with the intention of giving citizens and customers a clear understanding of how the Council intends to manage its decision making, service planning, service delivery and accountability processes, how it aims to ensure that the Council sets out its vision and priorities and how it aims to provide effective and efficient outcomes to its citizens and customers.

This Code is work in progress and reflects the Council's position in its improvement journey. It reflects the principles and evidence that we are striving towards as well as reflecting the Council's current position.

The Code will be subject to constant review to ensure its adequacy and its effectiveness will be assessed as part of an annual review process that will lead to the production of the Council's Annual Governance Statements from 2016/17 onwards.

Every Council officer and Member has a responsibility to ensure that their personal conduct and the organisation's governance arrangements are always of the highest standard possible.

Senior managers have a responsibility for reviewing governance standards in their areas of responsibility and for identifying and implementing any necessary improvement actions. Improvement actions should be reflected in the appropriate business plans.

The Chief Executive and Leader will ensure that an annual review of corporate governance arrangements is completed and give assurances on their adequacy in the published Annual Governance Statement, accompanying the Statement of Accounts.

The Strategic Leadership Team will ensure that the Code is reviewed regularly (at least yearly) to reflect ongoing developments and planned improvements to the framework, and to authorise any amendments.

How Rotherham Council intends to meet the Principles of Good Corporate Governance

This section sets out how Rotherham Council aims to works to the principles of good corporate governance.

Principle A - Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law.

Summary:

Local government organisations are accountable not only for how much they spend, but also for how they use the resources under their stewardship. This includes accountability for outputs, both positive and negative, and for the outcomes they have achieved. In addition, they have an overarching responsibility to serve the public interest in adhering to the requirements of legislation and government policies. It is essential that, as a whole, they can demonstrate the appropriateness of all their actions and have mechanisms in place to encourage and enforce adherence to ethical values and to respect the rule of law**.**

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Behaving with integrity	• Ensuring members and officers behave with integrity • Ensuring members and officers lead a culture where acting in the public interest is visibly and consistently demonstrated • Leading by example and using these standard operating principles or values as a framework for decision making and other actions. • Demonstrating, communicating and embedding the standard operating principles communicating and embedding the standard operating principles or values through appropriate policies and processes which are reviewed on a regular basis to ensure that they are operating effectively.	• Member's Code of Conduct • Employees' Code of Conduct • Anti-Fraud and Corruption Policy & Strategy • Dignity at Work Policy • Equal Opportunities Policy • Whistle-blowing Policy • Corporate Plan • LADO (Local Authority Designated Officer) to investigate allegations made against people working with children

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Demonstrating strong commitment to ethical values	• Seeking to establish, monitor and maintain the organisation's ethical standards and performance • Underpinning personal behaviour with ethical values and ensuring they permeate all aspects of the organisation's culture and operation. • Developing and maintaining robust policies and procedures which place emphasis on agreed ethical values. • Ensuring that external providers of services on behalf of the organisation are required to act with integrity and in compliance with high ethical standards expected by the organisation.	• Corporate Plan • Human Resources Policies • Induction Procedures • Registers of Interests • Registers of Gifts and Hospitality
Respecting the rule of law	• Ensuring members and staff demonstrate a strong commitment to the rule of the law as well as adhering to relevant laws and regulations. • Creating the conditions to ensure that the statutory officers, other key post holders and members are able to fulfil their responsibilities. • Striving to optimise the use of the full powers available for the benefit of citizens, communities and stakeholders. • Dealing with breaches of legal and regulatory provisions effectively. • Ensuring corruption and misuse of power are dealt with effectively.	• Legal (Monitoring) Officer Role • Internal Audit • KPMG (External Auditors) • Corporate Complaints Procedure • Standards Committee (supporting Members' observation of their Code of Conduct) • Employees' Personal Development Reviews • Publicising the process of how to complain about Members' conduct • Publicising the process of how to make a complaint to the Local Government Ombudsman • Overview and Scrutiny functions

Principle B - Ensuring openness and comprehensive stakeholder engagement.

Summary:

Local government is run for the public good; organisations therefore should ensure openness in their activities. Clear, trusted channels of communication and consultation should be used to engage effectively with all groups of stakeholders, such as individual citizens and service users, as well as institutional stakeholders.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Openness	• Ensuring an open culture through demonstrating, documenting and communicating the organisation's commitment to openness. • Making decisions that are open about actions, plans, resource use, forecasts, outputs and outcomes. • Providing clear reasoning and evidence for decisions in both public records and explanations to stakeholders and being explicit about the criteria, rationale and considerations used. In due course, ensuring that the impact and consequences of those decisions are clear. • Using formal and informal consultation and engagement to determine the most appropriate and effective interventions/courses of action.	• Corporate Plan • Community Strategy • Forward Plan • Council Website • Formal consultation arrangements • Community and voluntary sector representation on Partnership Boards • Freedom of Information publication scheme • Overview and Scrutiny functions
Engaging comprehensively with institutional stakeholders	• Effectively engaging with institutional stakeholders to ensure that the purpose, objectives and intended outcomes for each stakeholder relationship are clear so that outcomes are achieved successfully and	• Formal consultation arrangements • Community and voluntary sector representation on Partnership Boards • Council Website • Rotherham Local Safeguarding Children Board

	sustainably. • Developing formal and informal partnerships to allow for resources to be used more efficiently and outcomes achieved more effectively • Defining the purpose, objectives and intended outcomes for each stakeholder relationship • Using formal and informal consultation and engagement to determine the most appropriate and effective interventions	• Rotherham Safeguarding Adults • Community Safety and Anti-Social Behaviour Unit • Neighbourhood working group
Engaging stakeholders effectively, including individual citizens and service users	• Establishing a clear policy on the type of issues that the organisation will meaningfully consult with or involve individual citizens, service users and other stakeholders to ensure that service (or other) provision is contributing towards the achievement of intended outcomes. • Ensuring that communication methods are effective and members and officers are clear about their roles with regard to community engagement. • Encouraging, collecting and evaluating the views and experiences of communities, citizens, service users and organisations of different backgrounds including reference to future needs. • Implementing effective feedback mechanisms in order to demonstrate how their views have been taken into account. • Balancing feedback from more active stakeholder groups with other stakeholder groups to ensure inclusivity • Taking account of the interests of future generations of tax payers and service users.	• Corporate Plan published on RMBC website • Key 'minded to' decisions are made available for consultation for 5 days • External Auditor provides an annual organisational assessment of the Council's performance through the Value for Money conclusion • Council Website • Council minutes and agendas available on website • Formal consultation arrangements • Community and voluntary sector representation on Partnership Boards • Satisfaction Surveys • Freedom of Information publication scheme

Principle C - Defining outcomes in terms of sustainable economic, social, and environmental benefits.

Summary:

The long-term nature and impact of many of local government's responsibilities mean that it should define and plan outcomes and that these should be sustainable. Decisions should further the authority's purpose, contribute to intended benefits and outcomes, and remain within the limits of authority and resources. Input from all groups of stakeholders, including citizens, service users, and institutional stakeholders, is vital to the success of this process and in balancing competing demands when determining priorities for the finite resources available.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Defining Outcomes	• Having a clear vision which is an agreed formal statement of the organisation's purpose and intended outcomes containing appropriate performance indicators, which provides the basis for the organisation's overall strategy, planning and other decisions. • Specifying the intended impact on, or changes for, stakeholders including citizens and service users. It could be immediately or over the course of a year or longer. • Delivering defined outcomes on a sustainable basis within the resources that will be available. • Identifying and managing risks to the achievement of outcomes. • Managing service users' expectations effectively with regard to determining priorities and making the best use of the resources available.	• Corporate Plan • Forward Plan listing key decisions to be taken • Corporate report template requires information explaining the legal and financial implications of decisions • Community Safety and Anti-Social Behaviour Unit • Rotherham Housing Strategy • Risk Management Policy & Guide • Six weekly revision and consideration of Strategic Risk Register by Strategic Leadership Team and Quarterly consideration by Audit Committee • Monthly consideration of Directorate Risk Registers by Directorate Leadership Teams • Corporate report template contains 'risk implications' section • Audit Committee reviews risks and the Risk Management process

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Sustainable economic, social and environmental benefits	• Considering and balancing the combined economic, social and environmental impact of policies, plans and decisions when taking decisions about service provision. • Taking a longer-term view with regard to decision making, taking account of risk and acting transparently where there are potential conflicts between the organisation's intended outcomes and short-term factors such as the political cycle or financial constraints. • Determining the wider public interest associated with balancing conflicting interests between achieving the various economic, social and environmental benefits, through consultation where possible, in order to ensure appropriate trade-offs. • Ensuring equality of access.	• Corporate Plan • Forward Plan listing key decisions to be taken • Receipt of reports from numerous inspectorates and regulators throughout the year • Formal consultation arrangements • Rotherham Economic Growth Plan • Safer Rotherham Strategy • Rotherham Local Plan Core Strategy • Municipal Waste Management Strategy • Rotherham Health and Wellbeing Strategy

Principle D - Determining the interventions necessary to optimise the achievement of the intended outcomes.

Summary:

Local government achieves its intended outcomes by providing a mixture of legal, regulatory, and practical interventions. Determining the right mix of these courses of action is a critically important strategic choice that local government has to make to ensure intended outcomes are achieved They need robust decision-making mechanisms to ensure that their defined outcomes can be achieved in a way that provides the best trade-off between the various types of resource inputs while still enabling effective and efficient operations. Decisions made need to be reviewed continually to ensure that achievement of outcomes is optimised.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Determining interventions	• Ensuring decision makers receive objective and rigorous analysis of a variety of options indicating how intended outcomes would be achieved and including the risks associated with those options. • Ensuring best value is achieved however services are provided. • Considering feedback from citizens and service users when making decisions about service improvements or where services are no longer required in order to prioritise competing demands within limited resources available including people, skills, land and assets and bearing in mind future impacts.	• Business decisions are accompanied by a business case and options appraisal • Overview and Scrutiny functions • Corporate report template requires information explaining the legal and financial implications of decisions • Financial, legal and technical advice provided by the s151 Officer, the Monitoring Officer and other officers as required • Council Website • Formal consultation arrangements
Planning interventions	• Establishing and implementing robust planning and control cycles that cover strategic and operational plans, priorities and targets. • Engaging with internal and external stakeholders in determining how services and other courses of action should be planned and delivered. • Considering and monitoring risks facing each	• Corporate Plan • Directorate Service Plans • Quarterly Monitoring Reports • Contract Monitoring Reports • Performance Reports aligned to Corporate Plan priorities • Medium Term Financial Strategy

	partner when working collaboratively including shared risks. • Ensuring arrangements are flexible and agile so that the mechanisms for delivering outputs can be adapted to changing circumstances. • Establishing appropriate key performance indicators (KPIs) as part of the planning process in order to identify how the performance of services and projects is to be measured. • Ensuring capacity exists to generate the information required to review service quality regularly. • Preparing budgets in accordance with organisational objectives, strategies and the medium term financial plan. • Informing medium and long term resource planning by drawing up realistic estimates of revenue and capital expenditure aimed at developing a sustainable funding strategy.	• Capital Programme • Revenue budget process • Value for Money judgement by External Auditor
Optimising achievement of intended outcomes	• Ensuring the medium term financial strategy integrates and balances service priorities, affordability and other resource constraints. • Ensuring the budgeting process is all-inclusive, taking into account the full cost of operations over the medium and longer term. • Ensuring the medium term financial strategy sets the context for ongoing decisions on significant delivery issues or responses to changes in the external environment that may arise during the budgetary period in order for outcomes to be achieved while optimising resource usage. • Ensuring the achievement of 'social value' through service planning and commissioning.	• Medium Term Financial Strategy • Revenue budget process • Capital Programme • Procurement Policy • Procurement Standing Orders • Action Plans developed in response to external audit and inspections • Value for Money judgement by external auditor

Principle E - Developing the entity's capacity, including the capability of its leadership and the individuals within it.

Summary:

Local government needs appropriate structures and leadership, as well as people with the right skills, appropriate qualifications and mind-set, to operate efficiently and effectively and achieve their intended outcomes within the specified periods. A local government organisation must ensure that it has both the capacity to fulfil its own mandate and to make certain that there are policies in place to guarantee that its management has the operational capacity for the organisation as a whole. Because both individuals and the environment in which an authority operates will change over time, there will be a continuous need to develop its capacity as well as the skills and experience of the leadership of individual staff members. Leadership in local government entities is strengthened by the participation of people with many different types of backgrounds, reflecting the structure and diversity of communities.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Developing the entity's capacity	• Reviewing operations and performance on a regular basis to ensure their continuing effectiveness and enable organisational learning. • Improving resource use through appropriate application of techniques such as benchmarking and other options in order to determine how the authority's resources are allocated so that outcomes are achieved effectively and efficiently. • Recognising the benefits of partnerships and collaborative working where added value can be achieved.	• Phase Two of Improvement Plan implemented in May 2016 • Revised Corporate Plan published August 2016 • Organisational restructure ongoing together with appointment of new Senior Management Team • Benchmarking undertaken throughout the authority (e.g. CIPFA Benchmarking Clubs) • Officer participation in regional groups appropriate to their particular service • Involvement in Sheffield City Region initiative
Developing the capability of the entity's leadership and other individuals	• Clarifying roles and responsibilities of members and management at all levels. • Developing protocols to ensure that elected and appointed leaders negotiate with each other regarding their respective roles early on	• The Council Constitution • Members' Code of Conduct • Member training and seminars • Members' and officers' induction programmes • Personal Development Reviews

	in the relationship and that a shared understanding of roles and objectives is maintained. • Publishing a statement that specifies the types of decisions that are delegated and those reserved for the collective decision making of the governing body. • Ensuring the leader and the chief executive have clearly defined and distinctive leadership roles within a structure whereby the chief executive leads the authority in implementing strategy and managing the delivery of services and other outputs set by members and each provides a check and a balance for each other's authority. • Developing the capabilities of members and senior management to achieve effective shared leadership and to enable the organisation to respond successfully to changing legal and policy demands as well as economic, political and environmental changes and risks. • Ensuring that there are structures in place to encourage public participation. • Holding staff to account through regular performance reviews which take account of training or development needs. • Ensuring arrangements are in place to maintain the health and wellbeing of the workforce and support individuals in maintaining their own physical and mental wellbeing.	• Job descriptions and person specifications produced for all posts • Recruitment and appointment policies and procedures • Members' Development Panel • Comprehensive training programme for officers • Workforce Development Plan • Corporate Workforce Strategy (including employee health & wellbeing) • Staff surveys • A-Z list of HR Policies and Guidance on intranet

Principle F - Managing risks and performance through robust internal control and strong public financial management.

Summary:

Local government needs to ensure that the organisations and governance structures that it oversees have implemented, and can sustain, an effective performance management system that facilitates effective and efficient delivery of planned services. Risk management and internal control are important and integral parts of a performance management system and crucial to the achievement of outcomes. Risk should be considered and addressed as part of all decision making activities. A strong system of financial management is essential for the implementation of policies and the achievement of intended outcomes, as it will enforce financial discipline, strategic allocation of resources, efficient service delivery, and accountability. It is also essential that a culture and structure for scrutiny is in place as a key part of decision making, policy making and review. A positive working culture that accepts, promotes and encourages constructive challenge is critical to successful scrutiny and successful delivery.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Managing risk	• Recognising that risk management is an integral part of all activities and must be considered in all aspects of decision making. • Implementing robust and integrated risk management arrangements and ensuring that they are working effectively. • Ensuring that responsibilities for managing individual risks are clearly allocated.	• Risk Management Policy & Guide in place and reviewed annually • Strategic Risk Register in place and reviewed six weekly by Strategic Leadership team • Directorate and Service level risk registers in place and reviewed monthly • Corporate report template contains 'risk implications' section • Audit Committee reviews risks and the Risk Management process quarterly.
Managing performance	• Monitoring service delivery effectively including planning, specification, execution and independent post implementation review. • Making decisions based on relevant, clear objective analysis and advice pointing out the implications and risks inherent in the organisation's financial, social and environmental position and outlook	• Performance Reports aligned to Corporate Plan priorities • Quarterly Monitoring Reports • Contract Monitoring Reports • Corporate report template requires information explaining the legal and financial implications of decisions • Corporate report template contains 'risk implications'

	• Ensuring an effective scrutiny or oversight function is in place which encourages constructive challenge and debate on policies and objectives before, during and after decisions are made thereby enhancing the organisation's performance and that of any organisation for which it is responsible • Providing members and senior management with regular reports on service delivery plans and on progress towards outcome achievement. • Ensuring there is consistency between specification stages (such as budgets) and post implementation reporting (e.g. financial statements).	section • Overview and Scrutiny functions • Monthly spend/budget reports sent to all budget holders • Officers' make online monthly budget submissions as part of budget monitoring arrangements
Robust internal control	• Aligning the risk management strategy and policies on internal control with achieving the objectives. • Evaluating and monitoring the authority's risk management and internal control on a regular basis. • Ensuring effective counter fraud and anti-corruption arrangements are in place. • Ensuring additional assurance on the overall adequacy and effectiveness of the framework of governance, risk management and control is provided by the internal auditor. • Ensuring an audit committee or equivalent group or function which is independent of the executive provides further assurance regarding arrangements for managing risk and maintaining an effective control environment	• Risk Management Policy & Guide in place and reviewed annually • Strategic Risk Register in place and reviewed six weekly by Strategic Leadership team • Directorate and Service level risk registers in place and reviewed monthly • Anti-Fraud and Corruption Policy & Strategy • Internal Audit annual opinion on governance, risk management and internal control. • Audit Committee reviews risks and the Risk Management process quarterly • Corporate Information Governance Group • Completion and maintenance of a Corporate Fraud Risk Register

Managing data	• Ensuring effective arrangements are in place for the safe collection, storage, use and sharing of data, including processes to safeguard personal data. • Reviewing and auditing regularly the quality and accuracy of data used in decision making and performance monitoring. • Ensuring effective arrangements for sharing data with other bodies are in place.	• Corporate Communications Policy • Dedicated Information Governance Unit • Freedom of Information publication scheme • Digital Council Strategy • Ongoing monitoring of Data Protection Act / Freedom of Information compliance
Strong public financial management	• Ensuring financial management supports both long term achievement of outcomes and short-term financial and operational performance. • Ensuring well-developed financial management is integrated at all levels of planning and control, including management of financial risks and controls.	• Corporate Plan • Medium Term Financial Strategy • Revenue budget process • Procurement Policy • Procurement Standing Orders • Value for Money judgement from the External Auditor • External Auditors' Annual Audit letter

Principle G - Implementing good practices in transparency, reporting, and audit to deliver effective accountability.

Summary:

Accountability is about ensuring that those making decisions and delivering services are answerable for them. Effective accountability is concerned not only with reporting on actions completed, but also ensuring that stakeholders are able to understand and respond as the organisation plans and carries out its activities in a transparent manner. Both external and internal audit contribute to effective accountability.

Sub principles	Actions Demonstrating Good Governance	How this will be evidenced
Implementing good practice in transparency	• Writing and communicating reports for the public and other stakeholders in an understandable style appropriate to the intended audience and ensuring that they are easy to access and interrogate. • Striking a balance between providing the right amount of information to satisfy transparency demands and enhance public scrutiny while not being too onerous to provide and for users to understand.	• Council website • Corporate Communications Strategy • Budgets and spending published on website • Senior Officer remuneration published on website
Implementing good practices in reporting	• Reporting at least annually on performance, value for money and the stewardship of its resources. • Ensuring members and senior management own the results. • Assessing the extent to which the principles contained in the Framework have been applied and publishing the results on this assessment including an action plan for improvement and evidence to demonstrate good governance in action	• Publication of Annual Report and Statement of Accounts on website • Annual Governance Statement produced and published on website • Local Code of Corporate Governance refreshed annually in accordance with CIPFA/SOLACE principles • Documents are scrutinised and approved by Senior Leadership Team, Cabinet and Audit Committee prior to publication • Performance information and reports are published

	• Ensuring that the Framework is applied to jointly managed or shared service organisations as appropriate. • Ensuring the performance information that accompanies the financial statements is prepared on a consistent and timely basis and the statements allow for comparison with other similar entities.	on the website
Assurance and effective accountability	• Ensuring that recommendations for corrective action made by external audit are acted upon. • Ensuring an effective internal audit service with direct access to members is in place which provides assurance with regard to governance arrangements and recommendations are acted upon. • Welcoming peer challenge, reviews and inspections from regulatory bodies and implementing recommendations. • Gaining assurance on risks associated with delivering services through third parties and that this is evidenced in the Annual Governance Statement. • Ensuring that when working in partnership, arrangements for accountability are clear and that the need for wider public accountability has been recognised and met.	• The external auditors produce an Annual Audit Letter which is presented at Audit Committee and published on the website. The council produces a response to all issues and recommendations contained within. • The Chief Auditor presents an annual report to Audit Committee to inform members of Internal Audit activity that has taken place during the year • Audit Committee meets on a quarterly basis and receives reports from both Internal and External Audit • The authority is subject to regular inspections from regulatory bodies, including Ofsted, Care Quality Commission etc. The outcomes of these inspections, together with the council's responses are made available via the website • Annual Governance Statement produced and published on website

Rotherham Metropolitan Borough Council

Public Report
Audit Committee Report

Summary Sheet

Council Report:
Audit Committee 8th February 2017

Title:
Risk Policy and Strategy Update

Is this a Key Decision and has it been included on the Forward Plan?:
No

Strategic Director Approving Submission of the Report:
Shokat Lal (*Assistant Chief Executive)*

Report Author(s):
Simon Dennis *(Corporate Risk Manager)*
Assistant Chief Executive's Department
Extension 22114
simon.dennis@rotherham.gov.uk

Ward(s) Affected:
None

Executive Summary:

The Council introduced a completely revised Risk Policy and Guide in late 2015. This Policy and Guide was approved by the Audit Committee on 24th November 2015 and is available to all staff through the intranet. At the time of the refresh, the Policy and Guide represented a significant change to the Council's approach to Risk Management and this Guide has been the foundation underpinning the changes to Risk Management over the past 12 months.

This report is designed to make the Audit Committee aware of the proposed changes to the Policy and Strategy and seek their comments.

The changes to the Policy and Guide have been kept to a minimum. This is because the Council's Risk Management processes have been working effectively for less than a year and it is the view of the Risk Champions group that implementing significant change at this point would be unnecessarily disruptive to the development of risk management in the Council.

In summary the changes to the Policy and Strategy are:

- Changes to remove references to posts and structures that no longer exist (for example the post of Managing Commissioner has been replaced by the Chief Executive)
- Inclusion in the Guide of changes in practice that have been introduced in the light of operational experience (for example the requirement to update Directorate and Service Risk Registers monthly as request by Strategic Leadership Team (SLT) as opposed to quarterly as required by the current Guide)
- Minor changes to improve risk management practice in the Council (for example the requirement for deadline dates to be added to Risk Mitigation actions)

Paragraphs 3.5 and 3.6 set out the detail of the changes to the Policy and Guide and the Policy and Guide itself are attached at Appendix 2.

Recommendations:

- **The Audit Committee is asked to consider and note the attached revision of the Risk Policy and Strategy, and**
- **After consideration, advise of any further development work to be added to the items already noted.**

List of Appendices Included:
Appendix 1 – Diagram of Risk Management Arrangements
Appendix 2 - Proposed updated Risk Policy and Guide

Background Papers:
Report to Audit Committee; 23 September 2015 and 24 November 2015, Risk Management Policy and Guide

Report to Overview and Scrutiny Management Board, 26th February 2016.

Consideration by any other Council Committee, Scrutiny or Advisory Panel:
See above. This paper is not intended to be circulated to other Council Committees or Panels.

Council Approval Required:
No

Exempt from the Press and Public:
No

Title:
Risk Management Arrangements

1. Recommendations:

- **The Audit Committee is asked to consider and note the attached revision of the Risk Policy and Guide, and**
- **After consideration, advise of any further development work to be added to the items already noted.**

2. Background

2.1 The Council introduced a completely revised Risk Policy and Guide in late 2015. This original Policy and Guide was approved by SLT in July 2015 and, after revision, by the Audit Committee on 24th November 2015.

2.2 The Policy and Guide underpin the Council's approach to risk management and have formed the basis of all training and Risk Registers since its approval almost 12 months ago. The Policy and Guide is available to all staff through the intranet and all managers are referred to it when they complete their risk management training.

2.3 When it was first introduced, the Policy and Guide represented a significant change to the Council's approach to risk management and SLT and the Audit Committee have received regular reports on the development of risk management since its adoption.

2.4 This report is designed to make the Audit Committee aware of the proposed changes to the Policy and Guide and seek their comments.

2.5 The changes to the Policy and Guide have been kept to a minimum. This is because the Council's Risk Management processes have only been working effectively for less than a year and it is the view of the Risk Champions that brining in significant change at this point would be unnecessarily disruptive. An overview of the Council's current process for updating Risk Registers is attached for information at Appendix 1.

2.6 This paper endeavours to set out the key changes and the process that has been adopted as part of this update process. Specifically, it describes:

- The process that has been followed to update the Risk Policy and Guide;
- The detail of the specific changes to the Risk Management Policy and Guide that are being proposed;
- The areas that need to be developed further during the next cycle

.

3. The Update Process

3.1 There have been three main elements to the process to amend the Risk Policy and Guide to date. These are:

- Review of the Policy and Guide to remove references to posts and structures that no longer exist (for example the post of Managing Commissioner has been replaced by the Chief Executive);

- Inclusion in the Guide of changes in practice that have been introduced in the light of operational experience (for example the requirement to update Directorate and Service Risk Registers monthly as request by SLT as opposed to quarterly as required by the current Guide);

- Consideration by the Risk Champions Group of minor changes to improve risk management practice in the Council (for example the requirement for deadline dates to be added to Risk Mitigation actions).

3.2 For information, the Risk Champions Group consists of the following members of staff:

Directorate	Risk Champion
Children and Young People	Service Lead – School Planning, Admissions and Appeals
Adult Care and Housing	Change Manager
Public Health	Public Health Specialist
Finance and Customer Services	Insurance and Risk Manager
Regeneration and Environment	Regeneration and Environment Liaison Manager
Assistant Chief Executive	HR Service Centre Manager
Assistant Chief Executive	Corporate Risk Manager
Assistant Chief Executive	Assistant Chief Executive

3.3 Each of the areas have now been completed and the revised Policy and Guide now includes all elements of current operational risk management practice. A further refresh and revision is planned for summer 2017, although the extent of this revision will depend on progress in identifying improvements to the current risk management system.

Significant Changes to the Policy and Guide

3.4 As mentioned above, changes to the Policy and Strategy have been kept to a minimum so that the Council is able to consolidate the progress it has made in refreshing risk management without significant disruption. The proposed revised Policy and Guide is attached at Appendix 2.

3.5 The changes to the Policy are minimal and are limited to:

- Recognition in paragraph 2.1 that the Council is now in a second phase of its Improvement Plan;
- Rewording of paragraph 2.2 to refer to "supporting" rather than "reinstating" risk management;
- Expansion of paragraph 4.2 to refer to risk appetite;
- Replacement of the Managing Commissioner's signature with that of the Chief Executive.

3.6 There are a number of small typographical changes to the Risk Management Guide and some small changes to reflect the Council's changed circumstances. These are no listed in this report. However, the more significant changes in the guide are as follows:

- Paragraph 11.2.1 now includes specific references to the Council's Performance Management Process and also sets out the detail of how risks are to be referenced on risk registers;
- Paragraph 11.2.2 now includes reference to the risk scoring matrix – which had not previously been included as an integral part of the Guide;
- Paragraph 11.2.3 now includes the Council's guidance on responding to risk. This was previously held separately and now also refers to risk appetite. Additionally, this paragraph now requires that mitigation actions include a date when the mitigation will be in place;
- Paragraph 11.2.5 now includes basic guidance on the type of risks that should not be escalated to the Strategic Risk Register;
- Paragraph 16.1 now includes specific references to the Council's Quarterly performance monitoring process and an expectation that Risk Registers should be clearly linked to the quarterly process;
- Paragraph 17.4 has been added which recognises the existence and role of the Risk Champions and the Risk Champions group;
- Paragraph 18.2 now stresses that Risk Management training is compulsory for all staff of grades M2 and higher.

3.7 The Risk Guide includes two appendices, D and E, which are not new but have not yet been used in our Risk Management process. It is proposed that these appendices will be used in future to record the Strategic Risk Register. These will enable a great focus on the movement of risks between periods as well as the introduction of risk "heat maps" in place of the current "target risks". This revised process should enable a greater focus on the reduction and management of risk at a strategic level rather than mere risk recording.

Future Developments

3.8 Any future refresh of the Risk Policy and Strategy will need to take account of operational experience over the next 12 to 18 months. More refined definitions of Risk Appetite and an improved Risk recording process are both areas that may be included in a future Policy and Guide, but progress on these areas will require significant additional work.

Next Steps

3.9 The Audit Committee are invited to comment on any aspect of the Risk Policy and Guide attached to this report at Appendix A.

4. Options considered and recommended proposal

4.1 As this paper only considers the refresh of the Risk Management Policy and Guide, no specific options have been considered. The Audit Committee could choose to not refresh the Policy and Guide if they so wished, however the Committee should be aware that the current Policy and Guide is out of date.

5. Consultation

5.1 The refreshed Risk Management Policy and Guide was considered by a joint workshop of SLT and Assistant Directors on 15th December 2016, and also includes comments that the Risk Champions Group raised at their meeting on 11th October 2016.

6. Timetable and Accountability for Implementing this Decision

6.1 The Corporate Risk Manager will be responsible for ensuring that the Policy and Strategy are implemented once approved.

7. Financial and Procurement Implications

7.1 The Risk Policy and Strategy does not require additional cost at this time. There are no procurement issues. The risks contained in the Council's risk registers require ongoing management action. In some cases additional resources may be necessary to implement the relevant actions or mitigate risks. Any additional costs associated with the risks are reported to Strategic Leadership Team, Commissioners and elected Members for consideration.

8. Legal Implications

8.1 There are no direct legal implications arising from our risk management arrangements. Any actions taken by the Council in response to risks identified will take into account any specific legal implications.

9. Human Resources Implications

9.1 There are no Human Resources implications directly associated with the paper.

10. Implications for Children and Young People and Vulnerable Adults

10.1 Risk Management Arrangements are designed to identify Children and Young People's Services and Adult Services risks where appropriate.

11. Equalities and Human Rights Implications

11.1 Proposals for addressing individual risks captured by our arrangements incorporate equalities and human rights considerations where appropriate.

12. Implications for Partners and Other Directorates

12.1 We are currently working with our partners towards developing a joint risk register which will be owned by the Partnership Chief Executive Group.

13. Risks and Mitigation

13.1 It is important to review the effectiveness of our approach to capturing, managing and reporting risks on an ongoing basis. SLT review and update the risk register on a six-weekly basis to ensure risks relating to the Council's key priorities are effectively monitored and managed by SLT, Commissioners and elected Members. SLT will also be required to consider a review of the risk management policy later in the year.

14. Accountable Officer:

14.1 Shokat Lal *(Assistant Chief Executive)*

Approvals Obtained from:-

Assistant Director of Financial Services: Stuart Booth

Assistant Director, Legal Services: Dermot Pearson

Simon Dennis
Corporate Risk Manager

This report is published on the Council's website or can be found at: http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories

Appendix1
Diagram of Risk Management Arrangements

Process	Recording	Register Owner	Update Frequency	Administration
	**Strategic Risk Register**	Chief Executive	At least six weekly	Loaded to SharePoint by Corporate Risk Manager
	**Directorate (Operational) Risk Registers**	Relevant Strategic Director	Monthly	Loaded to SharePoint by Directorate Risk Champion
	**Service Area or Departmental Risk Registers**	Relevant Assistant Director or M3 Service Manager	Monthly for Assistant Director register - local decision for other registers but not less than quarterly.	Loaded to SharePoint by Service Risk Champion or support

Appendix 2 Risk Policy and Guide attached as separate document

Rotherham Metropolitan Borough Council

Rotherham Metropolitan Borough Council

Risk Management Policy and Guide

(Revised January 2017)

Contents Page

Rotherham Council: Risk Management Policy 2017

1. Introduction

1.1 Risk management is about managing threats and opportunities. By managing the Council's risks effectively we will be in a stronger position to deliver the Council's objectives.

1.2 This Policy commits to the application of risk management within the Council's planning and business processes and its organisation culture. It should be read in conjunction with the Risk Management Guide, which shows in practice how effective risk management will be achieved.

2. Corporate Improvement Plan

2.1 The Corporate Governance Inspection (CGI) highlighted the need to strengthen and embed risk management across the organisation. This Policy and the supporting Guide recognise the context described in the CGI report. Commissioners appointed by the Secretaries of State for Communities & Local Government and Education produced an improvement plan in May 2015 that was agreed by the Council. This plan included a requirement for reviewing, refreshing and re-launching risk management arrangements and these elements have now been delivered. Although risk management does not specifically feature in the Phase 2 Improvement Plan, its effective operation is fundamental to the successful delivery of that Plan.

2.2 This Policy and Guide are a key part of supporting effective risk management at Rotherham Council.

3. Approach to Managing Risks

3.1 Rotherham Council recognises that risk management is an integral part of good governance. Managing our risks effectively contributes to the delivery of the strategic and operational objectives of the authority. To do this:

- We will incorporate the principles of effective risk management into existing planning and management processes, including major projects and partnerships, to achieve a degree of formality and consistency.
- Risk management will be linked to and inform decision making across the Council.
- We will provide appropriate training and guidance for Council Members and staff so they can carry out their roles relating to risk management
- We will promote a risk management culture throughout the organisation and with our partners.
- The Council's Audit Committee will have a clear role of holding the organisation and its Members and managers to account for their management of risks.

4. Risk Appetite

4.1 Risk appetite is the degree to which the Council is willing to accept risk in the pursuit of its objectives. In order for the Council to achieve its objectives, some amount of risk taking is inevitable. The awareness of risk and the appropriate

management of it can lead to the realisation of opportunities. In this respect, risk is not perceived as a negative concept.

4.2 Decisions will depend on the nature of the risk, the potential losses or gains, and the quality of information available pertaining to the risk in question. The Council may choose to accept risks that cannot be mitigated or reduced, but should always be able to justify its decisions based on the risk information available. The Risk Management Guide includes more detail on the Council's definition of risk appetite which is key to determining which risks should be accepted and which should be mitigated or reduced.

5. Roles and Responsibilities

5.1 Clear roles of responsibility have been established for the successful implementation of the Council's Risk Management Policy. These roles are outlined in the Risk Management Guide.

6. Monitoring, Reviewing & Reporting Risks

6.1 Strategic risks will be monitored at Corporate level and operational risks will be monitored and reviewed at Directorate level. Risks may be promoted and demoted as part of the review processes, enabling the Council to effectively react to changes in priorities and/or risks.

7. Review

7.1. The Risk Management Policy and Guide will be reviewed on an annual basis to incorporate lessons learned, to accurately reflect the Council's position and to continually improve its risk management arrangements.

---------- ----------

Councillor Chris Read, Leader **Date**

---------- ----------

Councillor Ken Wyatt, Chair, Audit Committee **Date**

---------- ----------

Sharon Kemp, Chief Executive **Date**

Rotherham Council: Risk Management Guide 2017

8. Introduction

8.1 Rotherham MBC recognises that risk management is a principal element of good Corporate Governance. Effective risk management supports and underpins achievement of the key objectives set out in the Council's Corporate Plan, which in turn aims to improve the quality of life and services for all local people.

8.2 Commissioners, members and employees are expected to play an active and positive role in embedding risk management in all activities and in the organisation culture.

8.3 This Risk Management Guide provides a step by step approach to the Council's delivery of effective risk management. The Guide should be read in conjunction with the Risk Management Policy.

8.4 The Guide introduces the concept of risk and risk management, explains the general principles of risk management and clarifies the approach to and ownership of risk management within Rotherham Council.

8.5 This Guide highlights how risk management can be approached by each service area within the Council, and provides guidance on completing the individual stages of the risk management process to help services to identify, evaluate, manage, monitor and review risks.

9. Risk and Risk Management

9.1 A risk can be broadly defined as an event that, should it occur, will impact on the delivery of strategic or service objectives. Risks can be identified by posing three questions:

- What could go wrong?
- Would it prevent you from delivering your objectives?
- What would the impact be on your service?

An opportunity can be defined as an uncertainty that could have a favourable impact on objectives or benefits.

9.3 Risk management is the process by which we identify, evaluate and manage risks and opportunities. It is a positive process that can help the Council achieve positive outcomes from the decisions it makes.

9.4 Risk management should not simply be a process of identifying the negatives of why a decision, action or opportunity should not be taken as this can lead to a failure to pursue opportunities. Risk management, if used effectively, can help the Council to pursue innovative opportunities with higher levels of risk because exposure to risk is understood and managed down to acceptable levels.

9.5 Every organisation manages risk on a daily basis but not always in a way that is visible, repeatable and consistently applied throughout the organisation. A risk management process tries to ensure that the organisation undertakes cost-effective actions to manage and control risk to acceptable levels, through everyone following a well-defined and structured process. The aim of risk management is to enable better decision making, by having the best understanding of the potential problems before they happen and to enable pre-emptive action to be taken.

10. Objectives of Risk Management

10.1 The Council's risk management objectives are to:

- Promote a culture of risk management at all levels to inform all strategic and operational decision making and planning
- Ensure the Council successfully manages risks and opportunities corporately, operationally and within projects and partnerships
- Ensure that all parties understand their roles and responsibilities in the implementation of effective risk management
- Ensure that risk management makes an effective contribution to Corporate Governance and a satisfactory Annual Governance Statement
- Provide simple, intuitive processes to assist in the identification and prioritisation of risk and the appropriate allocation of resources
- Incorporate the principles of effective risk management into all planning and management processes to achieve consistency of approach
- Provide appropriate training and guidance for all parties involved in risk management roles, to enable them to fulfil their responsibilities and ensure the benefits of good corporate governance are realised
- Encourage the identification and sharing of potential or emerging risks so that risk prevention measures to be formulated as necessary
- Regularly consult with Members and officers in order to maintain a continuous review of the effectiveness of risk management processes.

10.2 The Council recognises it is not always possible, nor desirable, to eliminate risk entirely, and so has comprehensive insurance cover that protects the Council from significant financial loss following any damages or losses.

11. Approach to Risk Management

11.1 The risk management approach is based on good practice and can be applied at all levels of the organisation. It describes the key steps for identifying and managing risks within the Council. The approach intends to promote risk management as a positive process. It can bring value and benefit to each service area within the Council, by helping to identify and deal with issues before they happen.

11.2 Rotherham MBC utilises a five step approach in the identification and treatment of risks:

11.2.1 Step 1: Identify Risk – the identification of risk and its consequences.

It is important that all members of staff are involved in the risk management process. Managers should ensure that there is a process in place for employees to actively report risks as and when they arise, or when the profile or size of any risk changes. Risk should be on the agenda of all team meetings at any level in the organisation and also included and recorded in Performance Development Review discussions.

There are a number of ways that managers and staff can identify their risks. These include:-

- **Risk Workshops** – involve all stakeholders and ensure that the forum allows open and honest discussion. It is important to allow workshops to be as open as possible with no fear of come back. All initial ideas should be recorded and then reviewed one by one.
- **One to one meetings** – with staff who are involved in the delivery of the service within the Council.
- **Corporate Performance Management Process** – the corporate performance management process and those operating in each directorate and service area are important systems for identifying emerging risk – any risk identification process should take account of current performance information.
- **Learning from experience** – compare risks from similar operations – both internally and within peer groups at other authorities. Utilise any findings from recent reports by Internal Audit, regulatory bodies or Health and Safety teams; accident and incident reports; complaints; insurance claims etc.

A starting point for the identification of risk should be to examine the Council's priorities and key objectives and those identified within service plans.

The focus should then be on identifying risks (or opportunities) that are most likely to affect the performance and delivery of the Council's and/or services' priorities and their consequences. Any risks should also be identified in narrative performance reporting and Improvement Plan reporting.

When recording risks on the relevant Risk Register, each risk should be clearly linked to a Corporate Outcome in the Corporate Plan (if a Strategic Risk) or a Service Plan Objective (for Directorate or Service Risks). Each risk should also be allocated its own unique reference number when it is entered in the relevant risk register. At this stage the risk register (an example of which is included at Appendix A) should include:

- The unique risk number
- A description of the outcome we are trying to achieve (preferably linked to either the Improvement Plan or the Corporate Plan)
- A description of the risk itself

11.2.2 Step 2: Evaluate Risk – the Assessment of the risk, based on probability of occurrence and potential impact.

The primary goal in this step is to understand the effect of the identified risks and opportunities on the achievement of objectives or delivery of service plans.

In order to decide which risks are most important and merit most attention, there needs to be some way of comparing risks relative to each other. Using a score to rate risks provides a quantitative basis for comparison and can be achieved by assessing the risk along two dimensions:

- The **likelihood** (or probability) that the risk will occur
- The **impact** (or severity) that the risk will have if it occurs.

The first evaluation should be undertaken on the 'inherent risk' i.e. the risk before any control measures have been put in place. This is to ensure that all significant risks are highlighted and assurance provided that these risks are being managed.

If risks are only assessed after controls have been put in place, known as the 'residual risk', this would be assuming that the controls would always be in place and operating, which may not be the case. Consequently, controls also need to be identified, monitored and reviewed.

Both the inherent and residual risk scores are calculated using the following equation:

Likelihood score x Impact score

The Council has adopted a 5 x 5 risk matrix, as defined below.

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Very Likely 4	4	8	12	16	20
	Likely 3	3	6	9	12	15
	Possible 2	2	4	6	8	10
	Unlikely 1	1	2	3	4	5
		Insignificant 1	Minor 2	Significant 3	Major 4	Catastrophic 5
		IMPACT				

The Council's definitions of the Risk Scores are included at **Appendix B**. These definitions should be used as a guide to enable risks to be scored consistently across the Council.

The Council's risk register at Appendix A includes the following items which should be assessed at Step 2:

- The consequences of the risk should it happen
- The control measures that are already in place
- The "mitigated" risk score (i.e. the score after existing controls have been applied

Note that, in the interests of simplicity, the Risk Register does not currently include a space for recording the "inherent risk"

11.2.3 Step 3: Management – the identification of control measures required and the allocation of appropriate Action Managers.

Once the risks have been identified and assessed, additional appropriate management action needs to be taken. The 'Four Ts' is the generic approach that can be used when planning how to manage a risk or opportunity:

- **Tolerate -** The risk is accepted making limited, if any, efforts to mitigate it or reduce its likelihood / impact. This may be because the cost of mitigation exceeds the consequences of the risk.
- **Transfer -** The risk rating is reduced by transferring the risk to a third party by changing contractual terms. Typically this would mean the Council discontinuing the activity that gives rise to the risk, and sub-contracting / outsourcing that activity to another organisation. Alternatively, the Council can limit the consequences by obtaining insurance cover above acceptable levels of risk.
- **Treat -** Actions will be taken to reduce the risk, possibly by putting in additional controls.
- **Terminate -** The activity that gives rise to the risk will cease, be avoided or altered, thus eliminating the risk.

The Council determines the appropriate approach to addressing identified risk with reference to its risk appetite. In general terms, risks that have a score equal to or lower than the appropriate risk appetite will be tolerated and monitored. Risks that exceed the risk appetite will be subject to further controls/action (either transferred, treated or tolerated).

The Council's current expression of Risk Appetite is included at **Appendix C**. Any risk score should be compared to this expression before determining what action should be taken,

, It is critical that each risk is allocated an Owner who has ultimate responsibility (accountability) for the risk. The owner should be included in the Risk Register by both name and job role. The role of the Owner involves regularly monitoring the risk status and adjusting risk ratings accordingly, based on current information / intelligence and knowledge.

Mitigating actions **(Control Measures)** will need to be developed in order to effectively manage the risk, allocated to appropriate Managers and monitored regularly for compliance / implementation by the Risk Owner. Additional actions should include a timescale for their completion/implementation and this should be included on the Risk Register.

It is also possible that risks in one service area can have an impact on other areas of the organisation. It is important to be aware that actions to manage a risk in one area may create or increase a risk in another area. Consideration and communication of any possible impacts on other areas is essential.

At this stage the Risk Register will have in addition:

- The additional management action planned to bring the risk within the Council's appetite

- Target Score once the additional action is included

- Cost of the risk and the cost of the controls

- The name and job role of the designated risk owner

11.2.4 Step 4: Monitor Risk – ensure the controls measures are working effectively or amend accordingly.

This is a key stage of the risk management process. Risk Owners should ensure that the identified Control Measures are working effectively. In doing so, it may be useful to ask the following questions:

- **Have the chosen control measures been implemented as planned?**
  - Are the identified Control Measures in place?
  - Are these measures being used properly?
- **Are the chosen Control Measures working?**
  - Have the changes made to manage exposure to the assessed risks resulted in what was intended?
  - Has exposure to the assessed risks been eliminated or adequately reduced?
  - Have there been any 'near misses' and have any 'lessons learned' been applied?
  - Do any new controls need to be introduced?
- **Are there any new problems?**
  - Have the implemented control measures introduced any new problems?
  - Do the existing controls need to be reviewed and updated?

It is necessary to monitor and to report on the progress in managing risks so that the achievement of objectives is maximised and losses are minimised. In addition, the effectiveness of risk management controls to reduce the likelihood / impact of adverse risks occurring needs to be assessed and alternative controls introduced if the identified controls are proving ineffective.

When reviewing registers / risks it should also be ensured that the risk scores are still accurate. Are the red rated risks still red and the green rated risks still green? The focus should always be on **all** risks and not just on red or amber rated risks with the aim of identifying and preventing any risks from becoming a high (red) risk issues.

11.2.5 Step 5: Review & Report – Regular review of risks by Risk Owners to ensure continued validity. Report risks to the appropriate level of management and / or forum.

Corporate and service priorities will change over time. These changes may affect risks and opportunities and, therefore, need to be reviewed regularly by asking the following questions:

- Are my risks still the same?
- Are there any new risks arising?
- Has the risk been controlled effectively by the action taken to reduce or eliminate it?
- Has the action (or lack of actions) affected the overall impact (score) of the risk?
- Are there any other controls required? If so, what are they?

Risk registers should be live documents and changes should be updated promptly. The Risk Register at **Appendix A** includes a column to record to the next planned review date. Any risk with a rating of Amber or Red should be monitored at least monthly.

Risk management should be included as an agenda item on Directorate Management Team meetings at least monthly.

The Strategic Risk Register is reviewed six weekly. Increasing or emerging risks may also be elevated to strategic level to allow the Council to react effectively to changes in priorities. Risks that should be managed within a Directorate should not be escalated to the Strategic Risk Register. These would normally include risks assessed as Amber or Green or those with a "raw" impact score of 3 or less. The monitoring process includes annual peer reviews of each Strategic Director's Risk Register by SLT as well as regular "deep dives" of Strategic Risks by the Council's Audit Committee.

The review process will inform the contents of reports to the Strategic Leadership Team, Commissioners and the Audit Committee.

Risk management is a continuous cycle designed not only to identify, evaluate, manage, monitor and review risks, but also to support the strategic planning process. The strategic planning process and risk registers should be used as part of the budgetary decision making process.

12. Documentation

12.1 Risks will be recorded on standard documentation and held on the central SharePoint site, which can provide access to all risk owners and managers and ensure one version of each risk is maintained and can be easily updated. It is up to each Directorate to decide who should have access to their own risk register. An example of the risk register is held at **Appendix A**.

12.2 Risks will be presented in a consistent and uniform way. An example of a summary risk register is attached at **Appendix D** and the Strategic Risk Register at **Appendix E**.

13. Leadership, Roles and Responsibilities

13.1 Risk management should not be perceived as the responsibility of a small number of people. Where risk management is fully integrated into the culture and day to day working, everyone has a role to play and this is what Rotherham aims to achieve.

13.2 The expectations of Members, Commissioners and officers are as follows:

Executive	• Overall responsibility for ensuring the Council has in place effective risk management arrangements. • Lead in promoting a risk management culture within the Council and, where appropriate, with partners and stakeholders. • Regularly receive reports on risks and risk management and obtain assurance over the effective application of risk management.
Commissioners	• Approve the Council's Risk Management Policy and

	Guide. • Consider risk management implications when making decisions. • Agree the Council's actions in managing its high risks. • Receive regular reports on risk management activities.
Audit Committee	• Receive regular reports on risk management activities. • Approve an annual statement on the effectiveness of the Council's risk controls as part of the Annual Governance Statement. • Consider the effectiveness of the implementation of the Risk Management Policy • Carry out 'deep-dive' reviews into service risk registers and services' management of risks.
All Councillors	• To consider and challenge risk management implications as part of their roles.
Chief Executive	• Champion risk management arrangements • Ensure all risk management processes are completed • Issue directions with regard to risk management.
Strategic Directors / Assistant Chief Executive / Director of Public Health / SLT	• Responsibility for leading and managing the identification of significant strategic risks and the Strategic Risk register. • Ensure that there is a robust framework in place to identify, monitor and manage the Council's strategic risks and opportunities. • Ensure that the measures to mitigate these risks are identified, managed and completed within agreed, time-scales, ensuring that they bring about a successful outcome. • Promote a risk management culture within the Council and, where appropriate, with partners and stakeholders. • Ensure the requirement for all SLT reports, business cases and major projects to include risk assessments is met. • Ensure risk is considered as an integral part of service planning; performance management; financial planning; and, the strategic policy-making process. • Consider risk management implications in reports regarding strategic decisions. • Ensure that appropriate advice and training is available for all Members and staff. • Ensure that resources needed to deliver effective risk management are in place.
Assistant Directors	• Escalate risks / issues to the relevant Strategic Directors, where appropriate. • Ensure there is a clear process for risks being managed by their managers.

	• Embed risk management within the service areas they are responsible for. • Ensure compliance with corporate risk management standards. • Ensure that all employees, volunteers, contractors and partners are made aware of their responsibilities for risk management and are aware of the lines of escalation of risk related issues.
Directorate Management Teams	• Responsibility for leading and managing the identification of significant operational risks from all operational areas. • Ensuring that the measures to mitigate these risks are identified, managed and completed within agreed timescales, ensuring that they bring about a successful outcome. • Lead in promoting a risk management culture within the Directorate.
Corporate Risk Manager	• Provide facilitation, training and support to promote an embedded, proactive risk management culture throughout the Council. • Assist Strategic Directors, the Assistant Chief Executive, the Director of Public Health and Assistant Directors in identifying, mitigating and controlling risks. • Maintain the Strategic Risk Register of the Council's most significant risks. • Ensure that risk management records and procedures are properly maintained, decisions are recorded and an audit trail exists. • Ensure an annual programme of risk management training and awareness is established and maintained. • Review External and Internal Audit recommendations relating to risk management to ensure these are picked up and dealt with by the business.
All Employees	• Have an understanding of risk and their role in managing risks in their daily activities, including the identification and reporting of risks and opportunities. • Support and undertake risk management activities as required. • Attend relevant training courses focussing on risk and risk management.

14. Risk Assurance, Monitoring and Reporting

14.1 Rotherham's risk management function is routinely exposed to full scrutiny and validation:

- In the Annual Governance Statement that is signed off by the Leader and Managing Director and endorsed by the Audit Committee

- Commissioners and elected Members hold SLT accountable for the effective management of principal risks
- SLT, Commissioners and the Audit Committee monitor the delivery of the Risk Management Policy by receiving regular reports and/or presentations. As part of this process All Strategic Directors, the Assistant Chief Executive, Director of Public Health and Assistant Directors review their own risks and update them accordingly
- Risk management arrangements across the Council are independently reviewed for effectiveness on an annual basis by Internal Audit in order to inform the signing off of the Annual Governance Statement
- Service and Operational risks are monitored and reviewed at Directorate level and may be elevated to corporate level if deemed necessary (see 11.2.5)
- There is a formal reporting structure for advising SLT, Commissioners and elected Members of any risk management implications. The Council's reports template requires the completion of a section entitled Risks and Uncertainties in every report. Managers completing formal reports for Cabinet, SLT Council and its Committees should ensure that risks included in this section are reflected on their Risk Register and that those risks are referenced in the report.

15. Communication

15.1 Effective communication is integral to the identification of new threats and opportunities or changes in existing risks.

15.2 It is important for strategic leaders and managers to engage with staff across the Council to ensure that:

- Everyone understands the Council's risk policy, risk appetite and risk process in a way that is appropriate to their role. If this is not achieved, effective and consistent embedding of risk management will not be realised and risk priorities may not be addressed
- Everyone understands the benefits of effective risk management and the potential implications if it is not done or is done badly
- Each level of management actively seeks and receives appropriate and regular assurance about the management of risk within their control. Effective communication provides assurance that risk is being managed within the expressed risk appetite, and that risks exceeding tolerance levels are being escalated
- Any organisation providing outsourced services to the Council has adequate risk management skills and processes. Gaining assurance that a partner organisation has embedded risk management processes in place, and that responsibilities are clearly defined from the start, should help to avoid misunderstandings and any serious problems.

16. Performance Management

16.1 Risk management should form an integral part of the Council's Performance Management Framework. Awareness of potential risks that could impact the achievement of Council priorities and objectives, and planning for such possibilities, will contribute to the successful delivery of the objectives. The narrative element of the Council's Quarterly Performance Report includes a section covering ongoing risks and challenges for each Priority Outcome. This

section should link back to the completed Strategic Risk Register or to the Directorate Risk Register.

16.2 Risks associated with the delivery of the Corporate Plan are included in the Strategic Risk Register. This Register then goes to SLT, the Audit Committee and Commissioners.

17. Corporate Governance

17.1 Managing risk is integral to Rotherham's good Corporate Governance processes. It is a key feature in the production of the Annual Governance Statement that is signed by the Leader and Chief Executive.

17.2 There is high level risk management representation on the Strategic Leadership Team (The Assistant Chief Executive) and at Member level (Cabinet Manager for Corporate Services and Finance – Cllr Alam). They are the leads for risk management.

17.3 The Corporate Risk Manager is responsible for drafting the Annual Governance Statement and evaluating risk management assurances and supporting evidence.

17.4 Each Directorate has a Risk Champion who leads on Risk for their Strategic Director. The six Risk Champions, Assistant Chief Executive and the Corporate Risk Manager form the Risk Champions Group. This group is responsible for co-ordinating Risk Management across the Council.

18. Guidance and Training

18.1 The Council's Corporate Risk Manager is responsible for providing advice and training in respect of the Council's risk management arrangements.

18.2 All Strategic Directors, the Assistant Chief Executive and Director of Public Health, and their Management Teams should receive training in risk identification, analysis and control of risk. Risk Management training (including refresher training) is compulsory for all staff of M2 grade and above. Periodic "mop up" sessions will be held to pick up staff new to the M2 or M3 grade. Risk Workshops can be used as a prime method of educating and training managers in identifying and managing risks to their objectives. This approach can assist in creating a 'risk aware' culture.

18.3 Bespoke risk management training from external providers (Gallagher Bassett; Zurich Municipal) can be provided free of charge via Risk Control Days for targeted areas of risk, e.g. Schools, Health & Safety, Highways, Control of Legionella, Asbestos Awareness.

18.4 A risk management E-Learning package is accessible to all staff and Members on the Intranet.

19. Further Information

19.1 For further information on the Risk Policy and Guide or any risk management arrangements please contact either:

Simon Dennis	Corporate Risk Manager	Ext. 22114
Andrew Shaw	Insurance & Risk Manager	Ext. 22088

Appendix A: Risk Register Form

EXAMPLE Finance & Corporate Services - Risk Assessment/Register

Risk Register Owner: Named SLT member | **Date completed: 24/07/2016**

Business Objective *What is it you would like to achieve/need to deliver*	Risk What is the problem/hazard? *What is it that will prevent you from meeting your objectives?*	Consequence /effect: *what would actually happen as a result? How much of a problem would it be? To whom and why?*	Existing actions/controls (What are you doing to manage this now?)	Risk Score with existing measures (See Scoring Table)			Further management actions/controls required. (What would you like to do in addition to your existing controls?)	Target Score with further management actions/ controls required (See Scoring Table)			Cost (of Impact; of current controls; of further controls)	Risk Owner (Officer responsible for managing risk and controls)	Risk Review Date
				Impact	Probability	Risk Rating (I x P)		Impact	Probability	Risk Rating (I x P)			
To deliver free and fair elections in which all participants are satisfied that the result is accurate and which allows no opportunity for challenge.	Inability to comply with legislative and statutory election duties.	Election Failure - legal challenge in high court and associated costs of re-running the election and reputational damage.Business continuity issues such as loss of ICT function and /or office accommodation / count venue and / or polling stations	Strong links with internal ICT teams to ensure ICT systems are restored immediately. Training and awareness programme for staff. BCP in Place.	5	3	15	Alternative manual systems have been developed as a back up and can be implemented at short notice. OR Training and awareness programme for staff. BCP in Place.	3	3	9	There are no costs associated with the controls. Costs will be incurred when actioned.	Cliaire Wardle	Dec-16

	IMPACT	SCORE	BENCHMARK EFFECTS
CRITERIA	**CRITICAL/ CATASTROPHIC**	**5**	• Multiple deaths of employees or those in the Council's care • Inability to function effectively, Council-wide • Will lead to resignation of Chief Operating Officer and/or City Mayor • Corporate Manslaughter charges • Service delivery has to be taken over by Central Government • Front page news story in National Press • Financial loss over £10m
	MAJOR	**4**	• Suspicious death in Council's care • Major disruption to Council's critical services for more than 48hrs (e.g. major ICT failure) • Noticeable impact in achieving strategic objectives • Will lead to resignation of Strategic Director and/ or Executive Member • Adverse coverage in National Press/Front page news locally • Financial loss £5m - £10m
	MODERATE	**3**	• Serious Injury to employees or those in the Council's care • Disruption to one critical Council Service for more than 48hrs • Will lead to resignation of Divisional Director/ Project Director • Adverse coverage in local press • Financial loss £1m - £5m
	MINOR	**2**	• Minor Injury to employees or those in the Council's care • Manageable disruption to internal services • Disciplinary action against employee • Financial loss £100k to £1m
	INSIGNIFICANT/ NEGLIGIBLE	**1**	• Day-to-day operational problems • Financial loss less than £100k

Appendix B: Risk Scoring Guidance

LIKELIHOOD	SCORE	*EXPECTED FREQUENCY*
ALMOST CERTAIN	**5**	Reasonable to expect that the event WILL undoubtedly happen/recur, possibly frequently and is probable in the current year.
PROBABLE/LIKELY	**4**	Event is **MORE THAN LIKELY** to occur. Will probably happen/recur, but it is not a persisting issue. Will possibly happen in the current year and be likely in the longer term.
POSSIBLE	**3**	**LITTLE LIKELIHOOD** of event occurring. Not likely in the current year, but reasonably likely in the medium/long term.
UNLIKELY	**2**	Event **NOT EXPECTED.** Do not expect it to happen/recur. Extremely unlikely to happen in the current year, but possible in the longer term.
VERY UNLIKELY/RARE	**1**	**EXCEPTIONAL** event. This will probably never happen/recur. A barely feasible event.

Appendix C: The Council's Risk Appetite

The Council has a general policy to "accept" and monitor risk that is currently scored as less than "8" on the scoring matrix. Action should be taken on any risk with a score of more than "8" in line with the table shown below:

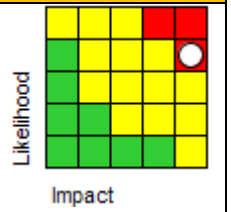
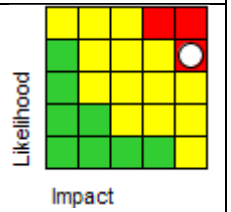
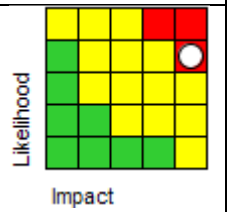
LEVEL OF RISK	OVERALL RATING	HOW THE RISK SHOULD BE TACKLED/ MANAGED
High Risk	15-25	IMMEDIATE MANAGEMENT ACTION
Medium Risk	9-12	Plan for CHANGE
Low Risk	1-8	Continue to MANAGE

In effect, the Council has an appetite to accept "Low" risk – with any other type of risk being planned to be addressed with additional controls or management action.

Appendix D: Example Strategic Risk Register Overview

Strategic Risks						
Risk Detail	**Risk Owner**	**Qtr 1 2015/16 Rating**	**Qtr 2 2015/16 Rating**	**Movement between Qtrs**	**Target Rating (Risk Appetite)**	**Target Date Agreed by SLT**
Introduction of £72k lifetime social care payments cap from 01/04/16 will place additional workload burden on service and may increase costs.	Named SLT member 1	**20**	**20**	-	**9**	April 2017
Council do not respond to media issues correctly or appropriately.	Named SLT member 2	**20**	**20**	-	**9**	November 2016
Sensitive and confidential information/data is not properly protected.	Named SLT member 3	**20**	**20**	-	**6**	November 2016

Appendix E: Example Strategic Risk Register template

Strategic Risks								
Business Objective	**Risk Detail**	**Consequence / Effect**	**Impact**	**Likelihood**	**Risk Rating**	**Risk Owner**	**Further Mitigating Actions**	**Current Risk Rating Heat Map**
Social care payments cap	Introduction of £72k lifetime social care payments cap from 01/04/16 will place additional workload burden on service and may increase costs.	Authority may have to meet a higher percentage of care costs; level of risk still unknown as additional funding from central government unknown at present.	**5**	**4**	**20**	Named Officer 1	Monitor situation with finance until further information is known.(Deadline 30/9/16)	
Dealing effectively with high profile media issues.	Council do not respond to media issues correctly or appropriately.	Failure to deal with media issues may damage the reputation of the authority and the Communications Team; possibility of slander claims and associated financial risk.	**5**	**4**	**20**	Named Officer 2	Continue to monitor cases and introduce revised ways of working as appropriate.(Ongoing)	
Act appropriately to maintain required levels of performance with respect to data protection and confidentiality issues	Sensitive and confidential information/data is not properly protected.	Failure to deal with media issues may damage the reputation of the authority and the Communications Team; possibility of slander claims and associated financial risk.	**5**	**4**	**20**	Named officer 3	Continue to monitor breaches and near misses and introduce revised ways of working accordingly. (Ongoing) Consider an authority-wide training programme. (Deadline 30/9/16)	

Rotherham Metropolitan Borough Council

Public Report

Summary Sheet

Council Report
Audit Committee – 8th February 2017

Title
Prudential Indicators and Treasury Management and Investment Strategy 2017/18 – 2019/20

Is this a Key Decision and has it been included on the Forward Plan?
Yes, included on the Forward Plan for this meeting.

Strategic Director Approving Submission of the Report
Judith Badger –Strategic Director of Finance & Customer Services

Report Author(s)
Stuart Booth (Assistant Director of Financial Services)
Finance & Customer Services Directorate
01709 822034 stuart.booth@rotherham.gov.uk

Ward(s) Affected
All

Executive Summary

The Local Government Act 2003 and supporting regulations require the Council to 'have regard to' the CIPFA Prudential Code and the CIPFA Treasury Management Code of Practice and prepare, set and publish prudential indicators and treasury indicators that ensure the Council's capital expenditure plans and affordable, prudent and sustainable in the long-term.

The Prudential Indicators and Treasury Management Strategy together form part of the process which ensures the Council meets the balanced budget requirement under the Local Government Finance Act 1992.

The report sets out the proposed Treasury Management Strategy Statement and Borrowing Limits for 2017/18 and Prudential Indicators for 2017/18 to 2019/20 and is being presented to Audit Committee in furtherance of its delegated role of scrutiny on Treasury matters, including the Treasury Management Strategy and related policies. The report will be presented to the Cabinet/Commissioners' Decision Making meeting as part of the Council's 2017/18 Budget setting process.

In accordance with the Prudential Code for Capital Finance, the Secretary of State's Guidance on Local Government Investments, CIPFA's Code of Practice for Treasury Management in Local Authorities and with Council policy, the Strategic Director of

Finance & Customer Services is required, prior to the commencement of each financial year to seek the approval of the Council to the following:

i. The Prudential Indicators and Limits for 2017/18 to 2019/20

ii. A Minimum Revenue Provision (MRP) Statement which sets out the Council's policy on MRP

iii. An Annual Treasury Management Strategy in accordance with the CIPFA Code of Practice on Treasury Management including the Authorised Limit

iv. An Investment Strategy in accordance with the Department for Communities and Local Government (CLG) investment guidance

Albeit a technical and complex report the key messages are:

a. Investments – the primary governing principle will remain **security** over return and the criteria for selecting counterparties reflect this. Cash available for investment will remain low, resulting in low returns;

b. Borrowing – overall, this is estimated to year on year increase over the period covered by this report as the Council plans to incrementally reduce its under-borrowing position as part of managing its daily and long term liquidity position. New borrowing will only be taken up as current portfolio debt matures and where approved capital investment is to be financed by borrowing; and,

c. Governance – strategies are reviewed by the Audit Committee with continuous monitoring which includes Mid-Year and Year End reporting.

Recommendations

The Audit Committee is asked to recommend to Cabinet that they recommend Council:

i. Approves the prudential indicators and limits for 2017/18 to 2019/20 contained in the report;

ii. Approves the Minimum Revenue Provision Policy Statement contained in Appendix A which sets out the Council's policy;

iii. Approves the Treasury Management Strategy for 2017/18 to 2019/20 and the Authorised Limit Prudential Indicator; and,

iv. Approves the Investment Strategy for 2017/18 to 2019/20.

List of Appendices Included

Appendix A – Proposed Wording of Minimum Revenue Provision Policy Statement
Appendix B – Borrowing and Investment Projections 2016/17 to 2019/20
Appendix C – Treasury Management Practice (TMP) 1 (5) – Credit and Counterparty Risk Management
Appendix D – Security, Liquidity and Yield Benchmarking

Background Papers
CIPFA – The Prudential Code for Capital Finance in Local Authorities 2011 (as amended 2012) and related Guidance Notes 2013
CIPFA – Treasury Management in the Public Services – Code of Practice and Cross-Sectoral Guidance Notes
CIPFA – Treasury Management in the Public Services – Guidance Notes for Local Authorities including Police Authorities and Fire Authorities
Communities and Local Government Investment Guidance – March 2010
The Local Government Act 2003

Consideration by any other Council Committee, Scrutiny or Advisory Panel
Yes, Audit Committee prior to submission to this Meeting

Council Approval Required
Yes

Exempt from the Press and Public
No

Prudential Indicators and Treasury Management and Investment Strategy 2017/18 – 2019/20

1. Recommendations

The Audit Committee is asked to recommend to Cabinet that they recommend Council:

i. Approves the prudential indicators and limits for 2017/18 to 2019/20 contained in the report;

ii. Approves the Minimum Revenue Provision Policy Statement contained in Appendix A which sets out the Council's policy;

iii. Approves the Treasury Management Strategy for 2017/18 to 2019/20 and the Authorised Limit Prudential Indicator; and,

iv. Approves the Investment Strategy for 2017/18 to 2019/20.

2. Background

2.1 The Local Government Act 2003 and supporting regulations require the Council to 'have regard to' the CIPFA Prudential Code and the CIPFA Treasury Management Code of Practice and prepare, set and publish prudential indicators and treasury indicators that ensure the Council's capital expenditure plans and affordable, prudent and sustainable in the long-term.

The prudential indicators consider the affordability and impact of capital expenditure plans, and set out the Council's overall capital framework. Each prudential indicator either summarises the expected activity or introduces limits upon the activity, and reflects the underlying capital programme.

Within the overall prudential framework there is a clear impact on the Council's treasury management activity, either through borrowing or investment activity. As a consequence a Treasury Management Strategy is prepared which considers the effective funding of the capital expenditure decisions and complements the prudential indicators.

2.2 The Prudential Indicators and Treasury Management Strategy together form part of the process which ensures the Council meets the balanced budget requirement under the Local Government Finance Act 1992. It is a statutory requirement under Section 33, revised under Section 31 of the Localism Bill 2011, for the Council to produce a **balanced budget**. In particular, Section 31 requires the Council to calculate its budget requirement for each financial year to include the revenue costs that flow from capital financing decisions.

This, therefore, means that increases in capital expenditure must be limited to a level whereby charges to revenue are also limited to a level which is affordable within the projected income of the Council for the foreseeable future. These increased charges may arise from:

- increases in interest charges and debt repayment caused by increased borrowing to finance additional capital expenditure; and
- any increases in operational running costs from new capital projects.

2.3 Treasury management is, therefore, an important part of the overall financial management of the Council's affairs and is defined as:

"The management of the local authority's investments and cash flows, its banking, money market and capital market transactions; the effective control of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks."

Specific treasury indicators are prepared and included in the Treasury Management Strategy which requires Member approval.

The Council's treasury activities are strictly regulated by statutory requirements and a professional code of practice (the CIPFA Code of Practice on Treasury Management – revised November 2009). The Council adopted the Code of Practice on Treasury Management (Cabinet, March 2004) and adopted the revisions to the Code in March 2010.

2.4 The Council's constitution (via Financial Regulations) requires the annual Treasury Management Strategy to be reported to Council outlining the expected treasury activity for the forthcoming 3 years. A key requirement of this report is to explain both the risks, and the management of the risks, associated with the treasury service. As a minimum a mid-year monitoring report is produced with a further report produced after the year-end to report on actual activity for the year.

Reports on Treasury matters are also required to be adequately scrutinised before being recommended to the Council and this role is undertaken by Audit Committee.

3. Key Issues

3.1 Overview

The Council's 2016/17 Prudential Indicators and Treasury Management Strategy was approved by Council on 2 March 2016, whilst a Mid-Year report which updated the 2016/17 approved indicators was considered by Audit Committee on the 23rd November 2016 and more recently by Cabinet on 9th January 2017. This report provides an update for the period 2016/17 to 2018/19 and introduces new indicators and forecasts for 2019/20.

Section 3.2 of the report details the key elements of the Council's Capital Expenditure Plans and associated Prudential Indicators. The Treasury Management Strategy (including the Investment Strategy) is detailed in Sections 3.3. Supporting detail is provided in the Appendices.

The Treasury Management Strategy has been drawn up in association with the Council's treasury management advisors, Capita Asset Services, part of The Capita Group plc.

This is a technical and complex report however the key messages are:

- Investments – the primary governing principle will remain **security** over return and the criteria for selecting counterparties reflect this. Cash available for investment will remain low, resulting in low returns.

- Borrowing – overall, this is estimated to year on year increase over the period covered by this report as the Council plans to incrementally reduce its under-borrowing position as part of managing its daily and long term liquidity position. New borrowing will only be taken up as current portfolio debt matures and where approved capital investment is to be financed by borrowing; and,

- Governance – strategies are reviewed by the Audit Committee with continuous monitoring which includes the Mid-Year and Year End reporting.

3.2 CAPITAL EXPENDITURE PLANS & PRUDENTIAL INDICATORS 2016/17 TO 2019/20

3.2.1 The Capital Expenditure Plans

The Council's capital expenditure plans are summarised below and form the first of the prudential indicators. A certain level of capital expenditure is grant supported by the Government; any decisions by the Council to spend above this level will be considered unsupported capital expenditure. This unsupported capital expenditure needs to have regard to:

- Service objectives (e.g. strategic planning);
- Stewardship of assets (e.g. asset management planning);
- Value for money (e.g. option appraisal)
- Prudence and sustainability (e.g. implications for external borrowing and whole life costing);
- Affordability (e.g. implications for the council tax and rents)
- Practicality (e.g. the achievability of the forward plan).

The revenue consequences of capital expenditure, particularly the unsupported expenditure, will need to be paid for from the Council's own revenue resources.

This capital expenditure can be paid for immediately (by applying capital resources such as capital receipts, capital grants etc., or revenue resources), but if these resources are insufficient any residual expenditure will add to the Council's borrowing need.

3.2.2 The key risks to the plans are that the level of Government support has been estimated and is therefore subject to change. Similarly some of estimates for other sources of funding, such as capital receipts, may also be subject to change over this timescale. For example, anticipated asset sales resulting from the Council's on-going asset rationalisation programme may be deferred due to the on-going impact of the current economic & financial conditions on the property market.

3.2.3 The revised capital expenditure plans in the updated Capital Strategy and Capital Programme being taken to Council on 8 March 2017, are summarised in the table below.

It should be noted, that these represent the capital investment forecasts under traditional forms of financing and exclude assets acquired under PFI and finance lease arrangements which are a type of borrowing but which are budgeted for separately outside of the capital financing budget.

	2016/17 Revised £m	**2017/18 Estimated £m**	**2018/19 Estimated £m**	**2019/20 Estimated £m**
Adult Care & Housing – Non HRA	3.526	3.489	5.490	11.490
Children & Young People's Services	8.017	10.464	3.025	7.605
Regeneration & Environment	16.077	25.293	21.051	23.464
Finance & Customer Services	3.370	3.636	2.562	1.859
Total Non HRA	**30.990**	**42.882**	**32.128**	**44.418**
HRA	26.826	26.756	30.022	24.680
Total HRA	**26.826**	**26.756**	**30.022**	**24.680**
Total expenditure	**57.816**	**69.638**	**62.150**	**69.098**
Capital receipts	3.262	10.134	5.262	1.859
Capital grants, capital contributions & sources other capital funding	42.488	42.085	40.165	53.421
Total financing	**45.750**	**52.219**	**45.427**	**55.280**
Prudential borrowing requirement for the year	**12.066**	**17.419**	**16.723**	**13.818**

3.2.4 **The Capital Financing Requirement (the Council's Borrowing Need)**

The Council's Capital Financing Requirement (CFR) is the total outstanding capital expenditure which has not yet been financed from either revenue or capital resources. It is essentially a measure of the Council's underlying borrowing need.

As can be seen in the table in 3.2.3 above, the latest revised estimated prudential borrowing requirement over the period 2016/17 to 2019/20 based on the updated Capital Strategy and Capital Programme is £60.026m. This will add to the CFR.

The CFR is then reduced by the amount the Council sets aside from revenue for the repayment of debt and other financing movements.

As explained in 3.2.3, in addition to the underlying borrowing need arising from the Council's capital investment programme, the overall CFR also includes other long term liabilities (OLTL) brought onto the Balance Sheet as a result of the recognition of PFI and Finance lease assets. This is a technical adjustment to recognise the underlying borrowing facility taken out by the PFI or Finance lease provider and does not require the Council to take out any additional borrow in its own right.

The CFR projections for which approval is being sought are set out in the table below:

	2016/17 Revised £m	**2017/18 Estimated £m**	**2018/19 Estimated £m**	**2019/20 Estimated £m**
CFR – General Fund	492.654	506.890	519.821	526.209
CFR – HRA	304.125	304.125	304.125	304.125
Total CFR	**796.779**	**811.015**	**823.946**	**830.334**
Movement in CFR	**9.017**	**14.236**	**12.931**	**6.388**
Of which:				
CFR – capital investment	661.224	678.226	694.320	703.558
OLTL	135.555	132.789	129.626	126.776
Movement in CFR represented by:				
Prudential borrowing requirement for the year (table at 3.2.3 above)	12.066	17.419	16.723	13.818
Net financing need for the year for OLTL	-2.033	-2.766	-3.163	-2.850
Less Minimum Revenue Provision and other financing movements	-1.016	-0.417	-0.629	-4.580
Movement in CFR	**9.017**	**14.236**	**12.931**	**6.388**

It should be noted that the total estimated CFR for 2017/18 and 2018/19 of £811.015m and £823.946m are broadly in line with the estimates reported in the previous year's 2016/17 Treasury Management Strategy (£810.926m 2017/18 and £826.273m 2018/19) approved by Council on 2nd March 2016.

3.2.5 **Minimum Revenue Provision Policy Statement**

3.2.5.1 The Council is required to pay off an element of the accumulated General Fund CFR each year through a revenue charge (the Minimum Revenue Provision - MRP). In addition, it is also allowed to make additional voluntary payments (VRP) where it is prudent to do so. Repayments included in annual PFI charges or finance lease payments are also applied as MRP.

No MRP charge is currently required for the HRA. The HRA charges depreciation on its assets, which is a revenue charge. To alleviate the impact of this charge falling on the tenants, HRA regulations allow the Major Repairs Allowance to be used as a proxy for depreciation for the first five years under self-financing (up until 2017/18). Thereafter, depreciation is determined in accordance with proper accounting practice.

3.2.5.2 CLG Regulations require full Council to approve an MRP Statement in advance of each financial year setting out how it will discharge its duty to charge an amount of MRP which the Council considers 'prudent'.

The Strategic Director of Finance & Customer Services will, where it is prudent to do so, use discretion to review the overall financing of the capital programme and the opportunities afforded by the regulations to maximise the benefit to the Council whilst ensuring it meets its duty to charge a 'prudent' provision. To provide maximum flexibility the recommended MRP policy includes the use of the annuity method and the equal instalments method.

The wording of the proposed MRP Policy Statement for which Council approval is being sought is shown at Appendix A.

3.2.6 **Affordability Prudential Indicators**

Affordability prudential indicators are used to assess the affordability of the capital expenditure plans by reference to their impact on the Council's finances overall. Cabinet will recommend that the Council be asked to approve the following indicators.

3.2.6.1 **Actual and Estimates of the ratio of financing costs to net revenue stream**

This indicator identifies the trend in the cost of capital (borrowing and other long term obligation costs net of investment income) against the net revenue stream of the Council.

The estimates of financing costs include all current commitments, the proposals contained in the proposed 2017/18 Revenue Budget and updated future years' capital expenditure plans.

Ratio of financing costs to Net Revenue Stream				
	2016/17 Revised %	2017/18 Estimated %	2018/19 Estimated %	2019/20 Estimated %
Non-HRA	6.38	7.01	8.55	9.38
HRA	16.27	16.37	16.51	16.71

3.2.6.2 **Estimates of the incremental impact of capital expenditure plans on Council Tax**

This indicator identifies the revenue costs associated with proposed changes to the capital programme compared to the Council's existing commitments and current plans.

Only schemes in the Council's approved capital programme are included in the indicators and there may be further schemes pending approval. Any additional approvals will normally have to be funded from unsupported borrowing as all identified available resources have been allocated. This would impact on the prudential indicators above.

The impact on Band D Council Tax, as shown in the table below, indicates the impact of the Council's capital expenditure plans as already budgeted for within the proposed Revenue Budget for 2017/18 and the Council's Medium Term Financial Strategy, **and does not indicate additional requirements of Rotherham council tax payers**.

Incremental impact of capital expenditure plans on the Band D Council Tax				
	Revised 2016/17 £	Estimated 2017/18 £	Estimated 2018/19 £	Estimated 2019/20 £
Council Tax – Band D	14.59	15.78	19.74	21.54

3.2.6.3 **Estimates of the incremental impact of capital expenditure plans on Housing Rent levels**

Similar to the Council tax calculation, this indicator identifies the revenue cost of proposed changes in the housing capital programme compared to the Council's existing approved commitments and current plans expressed in terms of the impact on weekly rent levels. Given the latest HRA 30 Year Business Plan does not currently forecast any change in borrowing levels over the period and therefore the incremental financing costs are assumed to be £Nil in each year.

Incremental impact of capital expenditure plans on the Housing Rent levels				
	Revised 2016/17 £	Proposed Budget 2017/18 £	Estimated 2018/19 £	Estimated 2019/20 £
Weekly Housing Rent levels	£0.00	£0.00	£0.00	£0.00

3.3 TREASURY MANAGEMENT STRATEGY 2017/18 – 2019/20

The Treasury Management Strategy covers:

a. The Council's borrowing and investment projections (para. 3.3.1);
b. The Council's estimates and limits to borrowing activity (para. 3.3.2 to 3.3.5);
c. The expected movement in interest rates (para. 3.3.6);
d. The Council's borrowing and debt strategy (para. 3.3.7);
e. The Council's investment strategy (para. 3.3.8);
f. Treasury Management prudential indicators and limits on activity (para. 3.3.9);
g. Treasury performance indicators (para. 3.3.10); and
h. Policy on the use of external service advisers (para. 3.3.12).

3.3.1 Borrowing and Investment Projections 2017/18 – 2019/20

The borrowing requirement comprises the expected movement in the CFR and any maturing debt which will need to be re-financed.

The effect on the treasury position over the next three years for both the Council and the ex-SYCC debt that the Council administers on behalf of the other South Yorkshire authorities is shown in the table attached at Appendix B. The table also highlights the expected level of investment balances.

3.3.2 Limits to Borrowing Activity

There are a number of key indicators to ensure the Council operates its activities within well-defined limits.

For the first of these, the Council needs to ensure that its total borrowing, does not, except in the short term, exceed the total of the CFR at the end of the preceding year plus the estimated additional CFR for the current year (2016/17) and the following two financial years. This is designed to ensure that in the medium term debt is only for a capital purpose. The purpose of including the estimated additional CFR for the following two financial years, is that it allows some flexibility for limited early borrowing for future years (para. 3.3.4).

The Strategic Director of Finance & Customer Services reports that the Council has complied with this indicator in the current year and does not envisage difficulties for the future (the table below refers). This view takes into account approved commitments and existing plans.

RMBC	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
CFR – excl. OLTL	661.224	678.226	694.320	703.558
CFR – OLTL	135.555	132.789	129.626	126.776
Total CFR	**796.779**	**811.015**	**823.946**	**830.334**
Borrowing (loans outstanding)	482.761	523.776	563.734	600.458
Borrowing - OLTL	135.555	132.789	129.626	126.776
Total Borrowing	**618.316**	**656.565**	**693.360**	**727.234**
CFR less Borrowing (underborrowed)	**178.463**	**154.450**	**130.586**	**103.100**

3.3.3 **The Overall Level of Borrowing**

A further two prudential indicators control or anticipate the overall level of borrowing. These are:

- The Authorised Limit for External Debt
- The Operational Boundary for External Debt

3.3.3.1 **The Authorised Limit for External Debt**

The Authorised Limit represents the maximum amount an authority can borrow for capital and cash flow purposes. It reflects the level of external debt which, while not desired, could be afforded in the short term, but is not sustainable in the longer term. This is the statutory limit determined under section 3 (1) of the Local Government Act 2003. The Authorised Limit is set by the Council and any breach must be reported. The Government retains an option to control either the total of all council's plans, or those of a specific council, although no such Government control has yet been exercised.

Cabinet is asked to recommend to Council the approval of the following Authorised Limit for RMBC:

Authorised Limit for External Debt (RMBC)	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
Borrowing	696.383	709.184	708.767	708.137
OLTL	137.588	135.555	132.789	129.627
Total	833.971	844.739	841.556	837.764

Cabinet is also asked to recommend approval to Council of the following Authorised Limit for the former SYCC:

Authorised Limit for External Debt (Former SYCC)	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
Borrowing	86.709	76.709	37.000	36.189
OLTL	0.000	0.000	0.000	0.000
Total	86.709	76.709	37.000	36.189

3.3.3.2 Separately, the Council is also limited to a maximum HRA CFR through the HRA self-financing regime. This limit remains unchanged until there is any change in Government legislation. The difference between the HRA CFR and HRA Debt Cap of £32.498m represents the maximum additional amount of borrowing the HRA could take up to finance its capital investment. Interest calculated with reference to the HRA CFR is charged on a fair & equitable basis.

HRA Debt Limit	2015/16 Revised £m	2016/17 Estimated £m	2017/18 Estimated £m	2018/19 Estimated £m
HRA Debt Cap	336.623	336.623	336.623	336.623
HRA CFR	304.125	304.125	304.125	304.125
HRA Headroom (+)	**+32.498**	**+32.498**	**+32.498**	**+32.498**

3.3.3.3 **The Operational Boundary for External Debt**

This is the amount beyond which external borrowing (for capital and cash flow purposes) is not normally expected to exceed. Its purpose is to act as a tool for monitoring day to day treasury activity. Occasionally, for operational reasons it may be necessary temporary breaches are not a cause for concern but sustained breaches may be an indication that the Council is acting imprudently or getting into major financial difficulty.

In most cases the operational boundary would be a similar figure to the CFR, but as a result of the planned continued under-borrowed position shown in the table in 3.3.2 above, the Operational Boundary for which Council approval is being sought set out in the table below is substantially less than the CFR:

Operational Boundary for External Debt (RMBC)	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
Borrowing	482.761	523.776	563.734	600.458
Other long term liabilities	137.588	135.555	132.789	129.626
Total	620.349	659.331	696.523	730.084

Cabinet is asked to recommend to Council that it approves the following Operational Boundary for the former SYCC:

Operational Boundary for External Debt (Former SYCC)	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
Borrowing	86.709	76.709	37.000	36.189
Other long term liabilities	0.000	0.000	0.000	0.000
Total	86.709	76.709	37.000	36.189

3.3.4 **Policy on Borrowing in Advance of Need**

The Council has some flexibility to borrow funds in advance for use in future years. The Strategic Director of Finance & Customer Services may do this under delegated powers where, for instance, a sharp rise in interest rates is expected, and so borrowing early at fixed interest rates will be economically beneficial or help meet budgetary constraints.

Whilst the Strategic Director of Finance & Customer Services will adopt a prudent approach to any such borrowing, where there is a clear business case for doing so borrowing may be undertaken to fund the approved capital programme or to fund debt maturities.

Risks associated with any advance borrowing activity will be subject to appraisal in advance and subsequent reporting through the mid-year and annual reporting mechanism.

3.3.5 **Debt Rescheduling**

As short term borrowing rates will be considerably cheaper than longer term fixed interest rates, there may be potential opportunities to generate savings by switching from long term debt to short term debt. These savings will need to be considered in the light of the current treasury position and the value of the cost of debt repayment (premiums incurred).

The reasons for any rescheduling to take place will include:

- The generation of cash savings and/or discounted cash flow savings;
- Helping to fulfil the treasury strategy; and,
- Enhancing the balance of the portfolio (amending the maturity profile and/or the balance of volatility.

3.3.6 **Expected Movement in Interest Rates**

The Bank Rate, currently 0.25%, underpins investment returns. There remains a great deal of economic uncertainty affecting growth forecasts for the UK economy and the rate of inflation both of which are key factors influencing the Bank Rate.

The uncertainty surrounds the UK's final terms for the leaving the EU, on-going issues in areas of the world economy which could result in weak growth or recession in the UK's main trading partners, Sterling's recent devaluation which may put upward pressure on the rate of inflation, and, pay growth in the UK which is expected to rise more slowly than inflation squeezing disposable incomes.

As a consequence, the Bank of England have not given a clear signal on the likely direction interest rates will take and are hedging their position until further economic data unfolds.

At present, for forecasting purposes we have taken a view that the Bank Rate will continue at its current historic low rate for at least the short term. Short-term borrowing rates are therefore expected to remain at favourably low levels. The outlook for longer-term interest rates also remains favourable in the near future, but are expected to start to creep upwards towards the end of 2017/18 or early 2018/19.

This challenging outlook has several key treasury management implications:

- Investment returns are likely to remain low in the short to medium term with target returns of around 0.25%;

- Borrowing interest rates are likely to remain attractive in the short to medium term, but are less likely to remain so going forward. The Council has adopted a policy of delaying new borrowing by utilising spare cash balances over the last few years. This approach will continue to be carefully reviewed to minimise the risk of incurring higher future borrowing costs, when the Council will not be able to delay new borrowing to finance new capital expenditure and/or to refinance maturing debt. The timing of any borrowing will, therefore, be monitored carefully; and

- There will remain a cost of carrying capital – any borrowing undertaken that results in an increase in investments will incur an incremental cost as the cost of borrowing is greater than the likely investment return.

3.3.7 **Borrowing and Debt Strategy 2017/18 – 2019/20**

As shown in the table in 3.3.2, the Council is currently maintaining an under-borrowed position. This means that the CFR has not been fully funded with loan debt as cash supporting the Council's reserves, balances and cash flow has been used as a temporary measure. This strategy is prudent as investment returns are low and counterparty risk remains relatively high.

The uncertainty over future interest rates increases the inherent risks associated with treasury activity. As a result the Council will continue to take a prudent approach to its treasury strategy.

The Strategic Director of Finance & Customer Services, under delegated powers, will take the most appropriate form of borrowing depending on the prevailing interest rates at the time, taking into account the risks shown in the forecast above. It is likely shorter term fixed rates may provide lower cost opportunities in the short to medium term.

3.3.8 **Investment Strategy 2017/18 – 2019/20**

The primary objectives of the Council's investment strategy are:

- Firstly to safeguard the timely repayment of principal and interest (security);
- Secondly to ensure adequate liquidity; and
- Thirdly to produce an investment return (yield).

3.3.8.1 As part of this Strategy, Members need to consider and approve security and liquidity benchmarks in addition to yield benchmarks which are currently widely used to assess investment performance and have previously been reported to Members. The proposed benchmarks are set down in Appendix D.

3.3.8.2 The primary principle governing the Council's investment criteria is the security of its investments, although the yield or return on the investment is also a key consideration. After this main principle the Council will ensure:

- It maintains a policy covering both the categories of investment types it will invest in, criteria for choosing investment counterparties with adequate security, and monitoring their security. This is set out in the Specified and Non-Specified investment sections of Appendix C.

- It has sufficient liquidity in its investments. For this purpose it will set out procedures for determining the maximum periods for which funds may prudently be committed. These procedures also apply to the Council's prudential indicators covering the maximum principal sums invested as set out in Appendix D.

3.3.8.3 The Strategic Director of Finance & Customer Services will maintain a counterparty list in compliance with the criteria set out in 3.3.8.5 and will revise the criteria and submit them to Council for approval as necessary. These criteria are different to those which are used to select Specified and Non-Specified investments.

The rating criteria use the lowest common denominator method of selecting counterparties and applying limits. This means that the application of the Council's minimum criteria will apply to the lowest available rating for any institution. For instance if an institution is rated by two agencies, one meets the Council's criteria, the other does not, the institution will fall outside the lending criteria. This is in compliance with a CIPFA Treasury Management Panel recommendation in March 2009 and the CIPFA Treasury Management Code of Practice.

3.3.8.4 Credit rating information is supplied by our treasury advisors on all active counterparties that comply with the criteria in section 3.3.8.5. Any counterparty failing to meet the criteria would be omitted from the counterparty list. Any rating changes, rating watches (notification of a likely change) and rating outlooks (notification of a possible long term change) are provided to officers almost immediately after they occur and this information is considered before any investment decision is taken.

3.3.8.5 The criteria for providing a portfolio of high quality investment counterparties (both Specified and Non-Specified investments) are:

- **Banks** – The Council will use banks which are rated by at least two rating agencies and have at least the following Fitch, Moody's and Standard and Poors' ratings (where rated):

	Fitch	Moody's	Standards & Poor's
Short-term	F1	P-1	A-1
Long-term	A-	A3	A-

To allow for the day to day management of the Council's cash flow the Council's bankers will also be retained on the list of counterparties if ratings fall below the above minimum criteria.

- **Building Societies** – the Council will use the top 20 Building Societies ranked by asset size but restricted to a maximum of 20% of the investment portfolio

- **Money Market Funds** – AAA – restricted to a maximum of 20% of the investment portfolio

- **UK Government** – Debt Management Office

- **UK Single Tier & County Councils** – (i.e. Metropolitan Districts, London Boroughs, County Councils, Unitary Authorities)

A limit of 35% will be applied to the use of Non-Specified investments within the investment portfolio, excluding day to day cash management through the Council's own bank.

Whilst the above criteria relies primarily on the application of credit ratings to provide a pool of appropriate counterparties for officers to use, additional operational market and sovereign information will continue to be applied before making any specific investment decision from the agreed portfolio of counterparties.

3.3.8.6 The time and monetary limits for institutions on the Council's Counterparty List are as follows and represent no change from those currently approved (these will cover both Specified and Non-Specified Investments):

	Fitch	Moody's	Standard & Poor's	Money Limit	Time Limit
Upper Limit Category	F1+/AA-	P-1/Aa3	A-1+/AA-	£20m	5 years
Middle Limit Category	F1/A-	P-1/A3	A-1/A-	£10m	364 days
Lower Limit Category *	All Building Soc's ranked 1 to 10			£5m	6 mths
	All Building Soc's ranked 11 to 20			£1m	3 mths
Debt Management Office	-	-	-	Unlimited **	6 months
Money Market Funds ***	-	-	-	£20m	n/a
UK Single Tier & County Councils	-	-	-	£20m	5 years
Council's Bankers	-	-	-	£10m	364 days
The above money limits are exclusive of bank balances held by schools * Based on maximum of 20% of the investment portfolio ** Provides maximum flexibility *** Based on maximum of 20% of the investment portfolio					

3.3.8.7 The proposed criteria for Specified and Non-Specified investments and monitoring of counterparties are shown in Appendix C for Member approval.

In the normal course of the Council's cash flow operations it is expected that both Specified and Non-specified investments will be utilised for the control of liquidity as both categories allow for short term investments.

The use of longer term instruments (greater than one year from inception to repayment) will fall in the Non-specified investment category. These instruments will only be used where the Council's liquidity requirements are safeguarded. This will also be limited by the long term investment limits.

3.3.9 **Treasury Management Prudential Indicators and Limits on Activity**

3.3.9.1 There are four further treasury activity limits the purpose of which are to contain the activity of the treasury function within certain limits, thereby managing risk and reducing the impact of an adverse movement in interest rates. However if these are set to be too restrictive they will impair the opportunities to reduce costs. The limits are:

- Upper limits on fixed interest rate exposure – This identifies a maximum limit for fixed interest rates based upon the fixed debt position net of fixed interest rate investments.

- Upper limits on variable interest rate exposure – as above this limit covers a maximum limit on variable interest rates based upon the variable debt position net of variable interest rate investments.

- Maturity structures of borrowing – These gross limits are set to reduce the Council's exposure to large fixed rate sums falling due for refinancing, and are required for upper and lower limits.

- Total funds invested for greater than 364 days – These limits are set to reduce the need for early sale of an investment, and are based on the availability of funds after each year-end.

For the purposes of these indicators the Council's market debt with Financial Institutions is treated as variable where debt may be subject to variation on specific call dates each year. However, over the period covered by this Strategy it is considered very unlikely that any market debt will be called due to the prevailing historically low interest rates.

3.3.9.2 The activity limits (prudential indicators) for Member approval are as follows:

RMBC	**2017/18**	**2018/19**	**2019/20**
Interest rate Exposures			
	Upper	**Upper**	**Upper**
Limits on fixed interest rate debt based on fixed net debt	100%	100%	100%
Limits on variable interest rate debt based on variable net debt	30%	30%	30%

RMBC Maturity Structure of fixed interest rate borrowing 2017/18		
	Lower	**Upper**
Under 12 months	0%	35%
12 months to 2 years	0%	35%
2 years to 5 years	0%	45%
5 years to 10 years	0%	45%
10 years to 20 years	0%	45%
20 years to 30 years	0%	50%
30 years to 40 years	0%	50%
40 years to 50 years	0%	55%
50 years and above	0%	60%

RMBC Maximum Funds invested > 364 days			
	1 to 2 years	2 to 3 years	3 to 5 years
Funds invested > 364 days	£m 10	£m 8	£m 6

Former SYCC	2017/18	2018/19	2019/20
Interest Rate Exposures			
	Upper	**Upper**	**Upper**
Limits on fixed interest rates based on total debt	100%	100%	100%
Limits on variable interest rates based on total debt	30%	30%	30%

Former SYCC Maturity Structure of fixed interest rate borrowing 2017/18		
	Lower	**Upper**
Under 12 months	0%	60%
12 months to 2 years	0%	75%
2 years to 5 years	0%	100%

3.3.10 **Treasury Performance Indicators**

The Code of Practice on Treasury Management requires the Council to set performance indicators to assess the adequacy of the treasury function over the year. These are distinct historic indicators, as opposed to the prudential indicators, which are predominantly forward looking. The results of the following two indicators will be reported in the Treasury Annual Report for 2017/18:

- Debt – Borrowing - Average rate of borrowing for the year compared to average available
- Investments – Internal returns above the 7 day London Interbank Bid rate (LIBID) which is the rate at which a bank is willing to borrow from other banks

3.3.11 **Training**

The CIPFA Code requires the responsible officer to ensure that members with responsibility for treasury management receive adequate training in treasury management. This especially applies to Members responsible for scrutiny. Training has recently been undertaken by Members of the Audit Committee and further training will be arranged as required. The training needs of treasury management officers are periodically reviewed.

3.3.12 **Policy on the use of external service advisors**

The Council uses Capita Asset Services a subsidiary of The Capita Group plc as its treasury management advisors.

The company provides a range of services which include:

- Technical support on treasury matters, capital finance issues and the drafting of Member reports;
- Economic and interest rate analysis;

- Debt services which includes advice on the timing of borrowing;
- Debt rescheduling advice surrounding the existing portfolio;
- Generic investment advice on interest rates, timing and investment instruments; and,
- Credit rating/market information service comprising the three main credit rating agencies.

Whilst the advisers provide support to the internal treasury function, under current market rules and the CIPFA Code of Practice the Council recognises that responsibility for treasury management decisions remains with the Council at all times. The service is provided to the Council under a contractual agreement which is subject to regular review.

4. Options considered and recommended proposal

4.1 The recommendations have been put forward taking account of the proposed capital programme, the prevailing conditions in the financial markets and expectations for the future with regard to the economic outlook and the effect on interest rate, together with the actions required to manage risk in the Treasury Management activity for the forthcoming financial year.

5. Consultation

5.1 Consultation has taken place with the Council's Treasury Management Advisers, Capita plc

6. Timetable and Accountability for Implementing this Decision

6.1 Following consideration by Audit Committee (8th February 2017) the report is being presented to Cabinet and then in accordance with the legislative requirements outlined in section 8 below the report will be submitted to full Council on 8th March 2017.

7. Financial and Procurement Implications

7.1 Treasury Management forms an integral part of the Council's overall financial arrangements.

7.2 The assumptions supporting the capital financing budget for 2017/18 and for the future years covered by the MTFS of the Council have been reviewed in light of the current economic and financial conditions and the revised future years' capital programme.

7.3 The proposed Treasury Management and Investment Strategy is not forecasted to have any further revenue consequences other than those identified and planned for in both the Council's 2017/18 Revenue Budget and approved MTFS.

8. Legal Implications

8.1 It is a requirement that changes to the Council's prudential indicators and approved by full Council

8.2 It is also a requirement that the Council's Minimum Revenue Provision Policy Statement for each financial year is approved by full Council.

9. Human Resources Implications

9.1 There are no Human Resource implications arising from the report.

10. Implications for Children and Young People and Vulnerable Adults

10.1 There are no implications arising from the proposals to Children and Young People and Vulnerable Adults.

11. Equalities and Human Rights Implications

11.1 There are no implications arising from this report to Equalities and Human Rights.

12. Implications for Partners and Other Directorates

12.1 There are no implications arising from this report to Partners or other directorates.

13. Risks and Mitigation

13.1 The proposed Treasury Management and Investment Strategy seeks to minimise the risks inherent in operating a Treasury Management function during these difficult economic and financial conditions.

Operational Treasury Management guidelines will continue to be kept in place and reviewed to ensure they are appropriate given the circumstances faced, supported by regular monitoring to ensure that any risks and uncertainties are addressed at an early stage and hence kept to a minimum.

14. Accountable Officer(s)

Stuart Booth – Assistant Director of Financial Services

Approvals Obtained from:- Strategic Director for Finance & Customer Services:- Judith Badger

This report is published on the Council's website or can be found at:-
http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

Appendix A

Proposed Wording of Minimum Revenue Provision Policy Statement

It is being recommended Council approve the following MRP policy in relation to the charge for the 2017/18 financial year:

(a) The MRP charge in relation to capital expenditure incurred prior to 2007/08 where the expenditure was funded by either supported or unsupported borrowing will be calculated using the expected useful life of the asset and the calculation of the provision will be by the annuity method;

(b) The MRP charge in relation to capital expenditure incurred since 2007/08 where the expenditure is funded by either supported or unsupported borrowing will be calculated using the expected useful life of the asset at the point the asset is brought into use. The calculation of the provision will be either the annuity method or the equal instalments method depending on which is most appropriate; and

(c) The MRP charge in relation to capital expenditure incurred since 2007/08 where the expenditure is funded by a 'capitalisation directive' (e.g. equal pay) will be calculated on the basis of the specified period(s) set down within the regulations. The calculation of the provision will be either the annuity method or the equal instalments method depending on which is most appropriate.

(d) For the sake of clarity, where MRP has been overcharged in previous years, the recovery of the overcharge will be effected by taking an MRP holiday in full or in part against future years charges that would otherwise have been made. The MRP holiday adjustment to the future years charge will be done in such a way as to ensure that:

- the total MRP after applying the adjustment will not be less than zero in any financial year
- the cumulative amount adjusted for will never exceed the amount over-charged;
- the extent of the adjustment will be reviewed on an annual basis

Appendix B

Borrowing and Investment Projections 2016/17 to 2019/20

RMBC	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
External Debt				
Borrowing at 1 April	476.598	482.761	523.776	563.734
Expected change in debt	6.163	41.015	39.958	36.724
Borrowing at 31 March	482.761	523.776	563.734	600.458
Other long-term liabilities (OLTL) at 1 April	137.588	135.555	132.789	129.626
Expected change in OLTL	-2.033	-2.766	-3.163	-2.850
Other long-term liabilities (OLTL) at 31 March	135.555	132.789	129.626	126.776
Total Borrowing & OLTL at 31 March	618.316	656.565	693.360	727.234
Investments				
Total Investments at 1 April	0.034	20.000	20.000	20.000
Investment change	19.996	0.000	0.000	0.000
Total Investments at 31 March	20.000	20.000	20.000	20.000
Net borrowing at 31 March	598.316	636.565	673.360	707.234

Ex SYCC	2016/17 Revised £m	2017/18 Estimated £m	2018/19 Estimated £m	2019/20 Estimated £m
External Debt				
Borrowing at 1 April	86.709	76.709	37.000	36.189
Expected change in debt	-10.000	-39.709	-0.811	-16.500
Borrowing at 31 March	76.709	37.000	36.189	19.689
Investments				
Total Investments at 1 April	0.000	0.000	0.000	0.000
Investment change	0.000	0.000	0.000	0.000
Total Investments 31 March	0.000	0.000	0.000	0.000
Net borrowing at 31 March	76.709	37.000	36.189	19.689

Appendix C

Treasury Management Practice (TMP) 1 (5) – Credit and Counterparty Risk Management

1. Overview

1.1 The Office of the Deputy Prime Minister (now CLG) issued Revised Investment Guidance in March 2010, and this forms the structure of the Council's policy below.

The key intention of the Guidance is to maintain the current requirement for councils to invest prudently, and that priority is given to security and liquidity before yield.

1.2 In order to facilitate this objective the guidance requires this Council to have regard to the CIPFA publication Treasury Management in the Public Services: Code of Practice and Cross-Sectoral Guidance Notes. This Council has adopted the Code will apply its principles to all investment activity.

In accordance with the Code, the Strategic Director of Finance & Customer Services has reviewed and prepared its treasury management practices. This part, TMP 1(5), covering investment counterparty policy requires approval each year.

2. Annual Investment Strategy

2.1 The key requirements of both the Code and the investment guidance are to set an annual investment strategy, as part of its annual treasury strategy for the following year, covering the identification and approval of the following:

- The guidelines for investment decision making, particularly non-specified investments.
- The principles to be used to determine the maximum periods for which investments can be made.
- The specified investments the Council may use.
- The non-specified investments the Council may use.

This strategy is to be approved by full Council.

The investment policy proposed for the Council is detailed in the paragraphs below (sections 2.3 and 2.4).

2.2 **Strategy Guidelines**

The main strategy guidelines are contained in the body of the treasury strategy statement.

2.3 **Specified Investments**

2.3.1 These investments are sterling investments of not more than one-year maturity. If they are for a longer period then the Council must have the right to be repaid within 12 months if it wishes.

These are low risk assets where the possibility of loss of principal or investment income is small.

2.3.2 These would include the following investment categories:

1. The UK Government Debt Management Office.

2. UK Single Tier & County Councils – (i.e. Metropolitans District, London Boroughs, County Councils, Unitary Authorities)

3. Money Market Funds that have been awarded AAA credit ratings by Standard and Poor's, Moody's or Fitch rating agencies and restricted to 20% of the overall investment portfolio

4. A bank or a building society that has been awarded a minimum short-term rating of F1 by Fitch, P-1 by Moody's and A-1 by Standard and Poor's rating agencies. For Building Societies investments will be restricted to 20% of the overall investment portfolio and:

   - a maximum of £5m for a period not exceeding 6 months if the society is ranked in the top 10 by asset size; or
   - a maximum of £1m and a period not exceeding 3 months if the society is ranked 11 to 20 by asset size.

2.4 **Non-Specified Investments**

2.4.1 Non-specified investments are any other type of investment not defined as specified above.

The criteria supporting the selection of these investments and the maximum limits to be applied are set out below.

2.4.2 Non specified investments would include any sterling investments with:

1. A bank that has been awarded a minimum long term credit rating of AA- by Fitch, Aa3 by Moody's and AA- by Standard & Poor's for deposits with a maturity of greater than 1 year.

2. The Council's own bank if ratings fall below the above minimum criteria.

3. A Building Society which is ranked in the top 20 by asset size. Investments will be restricted to 20% of the overall investment portfolio and:

   - a maximum of £5m for a period not exceeding 6 months if the Society is ranked in the top 10 by asset size; or
   - a maximum of £1m and a period not exceeding 3 months if the Society is ranked 11 to 20 by asset size.

3 The Monitoring of Investment Counterparties

3.1 The credit rating of counterparties will be monitored regularly. The Council receives credit rating information from the Council Treasury Management advisors on a daily basis, as and when ratings change, and counterparties are checked promptly.

On occasions ratings may be downgraded after the date on which an investment has been made. It would be expected that a minor downgrading would not affect the full receipt of the principal and interest.

3.2 Any counterparty failing to meet the minimum criteria will be removed from the list immediately by the (Interim) Strategic Director of Finance & Customer Services, and new counterparties will be added to the list if and when they meet the minimum criteria.

Appendix D

Security, Liquidity and Yield Benchmarking

These benchmarks are targets and so may be exceeded from time to time with any variation reported, with supporting reasons in Mid-Year & Annual Treasury Reports.

1. Security and liquidity

These benchmarks are already intrinsic to the approved treasury strategy through the counterparty selection criteria and some of the prudential indicators, e.g. the maximum funds which may be invested for more than 364 days, the limit on the use of Non-specified investments, etc.

1.1 Security

1.1.1 Security is currently evidenced by the application of minimum criteria to investment counterparties, primarily through the use of credit ratings supplied by the three main credit rating agencies. Whilst this approach embodies security considerations, benchmarking the levels of risk is more subjective and therefore problematic.

1.1.2 One method to benchmark security risk is to assess the historic level of default against the minimum criteria used in the Council's investment strategy. The default rates are little changed from last year.

Credit Rating	1 year	2 years	3 years	4 years	5 years
AAA	0.04%	0.10%	0.18%	0.27%	0.37%
AA	0.01%	0.02%	0.08%	0.16%	0.23%
A	0.07%	0.19%	0.36%	0.55%	0.77%
BBB	0.15%	0.46%	0.82%	1.26%	1.73%

1.1.3 The Council's minimum long term rating criteria (over one year) is "AAA" meaning the average expectation of default for a three year investment in a counterparty with a "AAA" long term rating would be 0.18% of the total investment (e.g. for a £1m investment the average potential loss would be £1,800).

The Council's minimum long term rating criteria (up to one year) is "BBB" and the average expectation of default for such an investment would be 0.15% (e.g. for a £1m investment the average loss would be £1,500).

These are only averages but do act as a benchmark for risk across the investment portfolio.

The Council's maximum security risk benchmark for the estimated maximum portfolio during 2017/18 is 0.091% which means that for every £1m invested the average potential loss would be £910. This position remains largely unchanged from 2016/17 (benchmark was 0.096% or £960).

1.1.4 The Council's Treasury advisers maintain a continuous review of the risk position by the inclusion the Council's daily investment position within their online model.

1.2 **Liquidity**

1.2.1 This is defined as "having adequate, though not excessive cash resources, borrowing arrangements, overdrafts or standby facilities to enable the Council at all times to have the level of funds available to it which are necessary for the achievement of its business/service objectives" (CIPFA Treasury Management Code of Practice). The Council seeks to maintain:

- Bank overdraft – on a day-to-day basis the Council works to an agreed overdraft limit of £100,000 with the Council's bankers. Whilst a short-term increase could be negotiated less expensive short-term borrowing is accessed through the financial markets to remain within the agreed overdraft.
- Liquid, short term deposits of at least £3m available with a week's notice.

1.2.2 The availability of liquidity and the inherent risks arising from the investment periods within the portfolio is monitored using the Weighted Average Life (WAL) of the portfolio. This measures the time period over which half the investment portfolio would have matured and become liquid

A shorter WAL generally represents less risk and in this respect the benchmark to be used for 2017/18 is:

- 0.08 years which means that at any point in time half the investment portfolio would be available within 28 days.

2. <u>Yield</u>

These benchmarks are currently widely used to assess investment performance and the Council's local measure of yield is:

- Internal returns above the 7 day London Interbank Bid rate (LIBID) which is the rate at which a bank is willing to borrow from other banks

Rotherham Metropolitan Borough Council

Public Report
Audit Committee Meeting

Summary Sheet

Council Report
Audit Committee – 8th February 2017

Title
Procurement and Appointment of External Auditors - 2018/19 onwards

Is this a Key Decision and has it been included on the Forward Plan?
This is not a key Decision on the basis that no approval is being sought to vary the Council's budget nor has any impact on local communities living.

Strategic Director Approving Submission of the Report
Judith Badger – Strategic Director for Finance & Customer Services

Report Author(s)
Stuart Booth (Assistant Director of Financial Services)
Finance & Customer Services Directorate
01709 822034 stuart.booth@rotherham.gov.uk

Ward(s) Affected
All

Executive Summary

The Local Audit and Accountability Act 2014 introduced new arrangements for the procurement and appointment of external auditors from 2018/19.

There are three options for meeting this objective – making a standalone appointment; making an appointment with one or more other authorities, or, opting in to a sector-led national scheme.

The preferred option is considered to be option 3 (opting into a sector led national scheme) as this will minimise the financial and administrative burden on the Council and likely secure a high quality audit at competitive fees. Under this arrangement, the procurement and appointment will be led by Public Sector Audit Appointments (PSAA) as the designated "appointing person".

Accordingly, Audit Committee is asked to commend this option to full Council so that a decision can be made at its meeting on 8 March 2017 thereby enabling the deadline for opting into the proposed sector-led national scheme by the 9th March 2017, to be met.

Recommendation

That Audit Committee:

- **supports the sector-led option for the procurement and appointment of external audit from 2018/19 onwards; and**

- **recommends to full Council that the opt in form (Appendix A) is completed and submitted to PSAA by the Council's Strategic Director of Finance and Customer Services by the deadline of the 9th March 2017.**

List of Appendices Included
Appendix A - PSAA opt in form

Background Papers
None

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No

Council Approval Required
Yes

Exempt from the Press and Public
No

Procurement and Appointment of External Auditors - 2018/19 onwards

1. Recommendation

That Audit Committee:

- **supports the sector led option for the procurement and appointment of external audit from 2018/19 onwards; and**

- **recommends to full Council that the opt in form (Appendix A) is completed and submitted to PSAA by the Council's Strategic Director of Finance and Customer Services by the deadline of the 9th March 2017.**

2. Background

2.1 The Local Audit and Accountability Act 2014 introduced new arrangements for the audit of authorities, superseding the previous arrangements in which the Audit Commission was responsible for making audit appointments. These new arrangements come into effect for 2018/19 when the existing contract expires. Statutorily, a decision on the appointment of the external auditor needs to be made by full Council no later than 31 December 2017. However, should the Council wish to take advantage of the sector led option to use Public Sector Audit Appointments Limited (PSAA) to make the appointment – the preferred option supported by the Local Government Association (LGA) – a much earlier decision is required. The deadline for opting into the PSAA sector led procurement and appointment is the 9th March 2017.

3. Key Issues

3.1 The Local Audit and Accountability Act 2014 transfers responsibility for the appointment of external auditors to the Council with effect from 2018/19.

3.2 There are three options on how an authority can discharge its responsibility set out below.

4. Options considered and recommended proposal

4.1 The three options available to appoint an external auditor are as follows:

- **Option 1** – undertake an individual auditor procurement and appointment exercise on a standalone basis.
- **Option 2** – undertake a joint auditor procurement and appointment exercise in collaboration with one or more other local authorities.
- **Option 3** – opt into the sector led national scheme arranged through PSAA for procuring and appointing external auditors to local councils - the Local Audit (Appointing Person) Regulations 2015 enables the Secretary

of State to specify an Appointing Person to appoint a local auditor to audit the accounts of an opted in authority, that organisation being the continuation of PSAA.

4.2 Under both Option 1 and Option 2, the Council would need to establish an Auditor Panel to advise it on:

- Selecting and appointing an auditor;
- Whether to adopt a policy on obtaining non-audit services from the auditor;
- Maintaining an independent relationship with its auditor; and
- The outcome of any investigation into an auditor's resignation or removal from office.

4.3 Members of the Auditor Panel would need to be wholly or by majority independent members, and an independent member must chair the Panel. Under Option 2 the Council could set up an Auditor Panel with one or more other authorities or ask another authority's Auditor Panel to carry out its functions.

4.4 Options 1 and 2 provide greater scope for the audit contract to be tailored but would incur higher costs from setting up and administering the Auditor Panel either in isolation or jointly and the staff time involved in the procurement exercise.

4.5 The preferred option (supported by the LGA) is Option 3. The benefits of opting into the sector led national scheme are that it:

- reduces the financial and administrative burden on the Council as there would, for example, be no requirement for an Auditor Panel.

- will enhance the procurement exercise by offering a high volume of work likely to be of greater interest to the main accountancy firms and therefore lead to more competitive audit fees. Audit fees, as is currently the case, will be linked to size, complexity and risk associated with each local council. PSAA have indicated that they will only contract with accountancy firms with a proven track record keeping the focus on audit quality and improving the likelihood of securing auditors with the necessary expertise in public sector audit. There may also be potential for efficiency savings through the appointment of the same auditor to public bodies involved in significant collaboration or joint working arrangements.

5. Consultation

5.1 The Council has contacted neighbouring authorities to see which option they intend to take, in particular, whether there is any appetite to undertake a joint procurement and appointment exercise under option 2. To the best of our knowledge all the authorities consulted have opted for option 3.

6. Timetable and Accountability for Implementing this Decision

6.1 Under option 3, the opt in form needs to be submitted to PSAA no later than 9 March 2017 for it to be effective.

6.2 The deadline to appoint an auditor under options 1 and 2 is 31 December 2017.

7. Financial and Procurement Implications

7.1 Under the PSAA sector led scheme (option 3), the procurement would be undertaken nationally by PSAA. Under options 1 and 2, local procurement arrangements would need to be put in place.

7.2 There has been no indication as yet what the 2018/19 audit fee scales for each type of local authority might be. Under the Council's current external audit arrangement, the cost to the Council in 2016/17 is £140,828 plus a fee for the certification of specific government grant claims and returns (c£15k).

8. Legal Implications

8.1 The Council will meet its statutory requirements provided it appoints an external auditor no later than 31 December 2017.

9. Human Resources Implications

9.1 There are no Human Resource implications arising from this report.

10. Implications for Children and Young People and Vulnerable Adults

10.1 There are no implications arising from the proposals to Children and Young People and Vulnerable Adults.

11. Equalities and Human Rights Implications

11.1 There are no implications arising from this report to Equalities and Human Rights.

12. Implications for Partners and Other Directorates

12.1 There are no implications arising from this report to Partners or other directorates.

13. Risks and Mitigation

13.1 None.

14. Accountable Officer(s)

Judith Badger - Strategic Director of Finance & Customer Services

Approvals Obtained from:-

Assistant Director of Financial Services - Stuart Booth

APPENDIX A

Form of notice of acceptance of the invitation to opt in

(Please use the details and text below to submit to PSAA your authority's formal notice of acceptance of the invitation to opt into the appointing person arrangements)

To: appointingperson@psaa.co.uk

Subject: [Name of authority] **Notice of acceptance of the invitation to become an opted-in authority**

This email is notice of the acceptance of your invitation dated 27 October 2016 to become an opted-in authority for the purposes of the appointment of our auditor under the provisions of the Local Audit and Accountability Act 2014 and the requirements of the Local Audit (Appointing Person) Regulations 2015.

I confirm that [name of authority] has made the decision to accept your invitation to become an opted-in authority in accordance with the decision making requirements of the Regulations and that I am authorised to sign this notice of acceptance on behalf of the authority.

Name: [Name of signatory]
Title: [Role title] (authorised officer)
For and on behalf of: [Name of authority]
Date:

Document is Restricted

Document is Restricted