Agenda

Audit Committee

Date	Thursday, 27 June 2013 at 6:15 pm
Venue	Town Hall, St Annes
Committee members	Councillor John Singleton JP (Chairman) Councillor Brenda Ackers (Vice-Chairman) Councillors Ben Aitken, Christine Akeroyd, Leonard Davies, Kath Harper, Howard Henshaw, Linda Nulty, Louis Rigby

Item		Page
1	**Declarations of Interest:** Any member needing advice on Declarations of Interest should contact the Monitoring Officer before the meeting.	1
2	**Confirmation of Minutes:** To confirm the minutes of the previous meeting held on 21 March 2013 as a correct record. As attached at the end of the agenda.	1
3	**Substitute Members:** Details of any substitute members notified in accordance with council procedure rule 24.3.	1
4	**Annual Governance Statement**	3 – 16
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6	**Internal Audit Annual Report 2012-13**	49 – 62
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8	**Effectiveness of Internal Audit**	72 – 93
9	**High Priority Actions (Update)**	94 – 97

The code of conduct for members can be found in the council's constitution at www.fylde.gov.uk/council-and-democracy/constitution

This document/publication is also available on our website at www.fylde.gov.uk

Any enquiries regarding this document/publication should be sent to us at the Town Hall, St Annes Road West, St Annes FY8 1LW, or to listening@fylde.gov.uk.

REPORT

REPORT OF	MEETING	DATE	ITEM NO
DIRECTOR OF RESOURCES	AUDIT COMMITTEE	27 JUNE 2013	4

ANNUAL GOVERNANCE STATEMENT

Public item

This item is for consideration in the public part of the meeting.

Summary

The report presents the Annual Governance Statement prepared under the CIPFA/SOLACE framework the lcoal code of corporate governance for approval.

Recommendation

1. Approve the Annual Governance Statement for signature by the chairman.

Cabinet portfolio

The item falls within the following cabinet portfolio: Finance and Resources – Councillor Karen Buckley

Summary of previous decisions

There have been no previous decisions regarding this report.

Continued....

Report

1. A sound system of corporate governance underpins the achievement of all the Council's corporate objectives.

2. The Council has adopted a code of corporate governance which is consistent with the principles of the CIPFA/SOLACE Framework *Delivering Good Governance in Local Government.* This statement explains how Fylde Borough Council has complied with the code and shows how the effectiveness of governance arrangements have been monitored during the year.

3. The preparation and publication of an annual governance statement is necessary to comply with Regulation 4(3) of the Accounts and Audit Regulations 2011, which requires authorities to prepare a statement of internal control in accordance with "proper practices". The CIPFA/SOLACE guidance identifies the production of an annual governance statement in accordance with the guidance as "proper practices".

Summary of the local code

4. According to the CIPFA/SOLACE guidance, "governance is about how local government bodies ensure that they are doing the right things, in the right way, for the right people, in a timely, inclusive, open, honest and accountable manner. It comprises the systems and processes, and cultures and values, by which local government bodies are directed and controlled and through which they account to, engage with and, where appropriate, lead their communities".

5. The council's code adopts the following six core principles from the CIPFA/SOLACE guidance which underpin the council's system of governance

    - Focusing on the purpose of the authority and on outcomes for the community including citizens and service users and creating and implementing a vision for the local area

    - Members and officers working together to achieve a common purpose with clearly defined functions and roles

    - Promoting the values of the authority and demonstrating the values of good governance through behaviour

    - Taking informed and transparent decisions which are subject to effective scrutiny and managing risk

    - Developing the capacity and capability of members to be effective and ensuring that officers – including the statutory officers - also have the capability and capacity to deliver effectively

    - Engaging with local people and other stakeholders to ensure robust local public accountability.

6. The code requires the Council to:

    - consider the extent to which it complies with the above six core principles and requirements of good governance set out in the Framework;

- identify systems, processes and documentation that provide evidence of compliance;
- identify the individuals and committees responsible for monitoring and reviewing the systems, processes and documentation identified;
- identify the issues that have not been addressed adequately in the authority and consider how they should be addressed;
- identify the individuals who would be responsible for undertaking the actions required and plan accordingly.

7. The Local Code describes the arrangements that have been or are being established within the Council to comply with the requirements and these are summarised below.

Annual Governance Statement

8. Under each core principle, the code identifies a series of sub-principles, which in total provide a 63-point checklist. The Corporate Governance Group, comprising the Monitoring Officer, Section 151 Officer, Head of Internal Audit and Head of Governance, has conducted a detailed self-assessment of the council's governance against this checklist. A further addendum to the checklist was issued in 2012 to keep the framework current. These additional tests have also been addressed.

9. The council must publish the results of this self-assessment, including any recommended areas for improvement in the forthcoming year, as part of its Annual Governance Statement alongside the annual accounts.

10. The governance statement is attached to this report and is presented for approval by the committee. It will, if approved, be signed by the council leader and the chief executive.

11. The Corporate Governance Group will draw up an action plan for future approval by the committee to meet the issue identified in the governance statement. Much work has been undertaken in recent years to strengthen governance. In 2013/14, the Corporate Governance Group's single recommendation centres on the Council's Code of Corporate Governance. This was last updated in 2008, and the Group feel a review in 2013/14 is required.

IMPLICATIONS	
Finance	The Code of Corporate Governance is a key component of the council's commitment to sound financial systems and practices. The Annual Governance Statement is an important requirement within the Code.
Legal	The preparation of a code of governance and an annual governance statement complying with the CIPFA/SOLACE guidance is effectively a legal requirement under the Accounts and Audit Regulations 2011.
Community Safety	None

Human Rights and Equalities	None
Sustainability and Environmental Impact	None
Health & Safety and Risk Management	Good risk management is crucial to proper corporate governance, as the code and the CIPFA/SOLACE guidance make clear.

REPORT AUTHOR	TEL	DATE	DOC ID
Tracy Morrison	(01253) 658521	4 June 2013	

LIST OF BACKGROUND PAPERS		
NAME OF DOCUMENT	DATE	WHERE AVAILABLE FOR INSPECTION
Code of Corporate Governance	April 2008	Town Hall, St Annes
Directorate assurance statements	2012/13	Town Hall, St Annes

Attached documents

Appendix 1 - Annual Governance Statement

APPENDIX 1

ANNUAL GOVERNANCE STATEMENT 2013

Scope of responsibility

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

In discharging this overall responsibility, the council is responsible for putting in place proper arrangements for the governance of its affairs and for ensuring that there is a sound system of internal control which facilitates the effective exercise of its functions and which includes arrangements for the management of risk.

The council has approved and adopted a code of corporate governance, which is consistent with the principles of the CIPFA/SOLACE Framework Good Governance in Local Government. A copy of the code is on our website at www.fylde.gov.uk or can be obtained from the Town Hall, St Annes Road West, St Annes. This statement explains how the council has complied with the code and also meets the requirements of regulation 4 (3) of the Accounts and Audit Regulations 2011 in relation to the publication of a statement on internal control.

The purpose of the governance framework

The governance framework comprises the systems and processes for the direction and control of the authority and its activities through which it accounts to, engages with and leads the community.

The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure to achieve policies, aims and objectives and can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Council's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. It enables the authority to monitor the achievement of its strategic objectives and to consider whether those objectives have led to the delivery of appropriate, cost-effective services.

APPENDIX 1

The governance framework has been in place at the Fylde Borough Council for the year ended 31 March 2013 and up to the date of approval of the annual report and statement of accounts.

The governance environment

Principles

The Council has adopted a code of corporate governance ("the Code") and recognises that effective governance is achieved through the core principles enshrined in it. These are:
1. Focusing on the purpose of the authority and on outcomes for the community and creating and implementing a vision for the local area.
2. Members and officers working together to achieve a common purpose with clearly defined functions and roles
3. Promoting values for the authority and demonstrating the values of good governance through upholding high standards of conduct and behaviour
4. Taking informed and transparent decisions which are subject to effective scrutiny and managing risk
5. Developing the capacity and capability of members to be effective and ensuring that officers - including the statutory officers - also have the capability and capacity to deliver effectively
6. Engaging with local people and other stakeholders to ensure robust accountability

CIPFA and SOLACE reviewed the Framework during 2012 to ensure it maintained 'fit for purpose' and issued the Guidance in late December 2012 with the key message for local authorities to review and report on the effectiveness of their governance arrangements and meet the government standard.

Other developments that impact on the Framework since its launch include:

- The Government's commitment to increasing transparency
- Localism Act 2011
- Revised guidance on the role of the Chief Finance Officer
- Revised guidance on the role of Head of Internal Audit
- Changes to Local Authority governance structures

The Council's corporate governance environment comprises a multitude of systems and processes designed to regulate, monitor and control the various activities of the authority in its pursuit of its vision and objectives. The following describes the key elements:

Constitution

APPENDIX 1

The Council's constitution sets out how the council operates, how decisions are made and the procedures which are followed to ensure that these are efficient, transparent and accountable to local people. The constitution also identifies the principal obligations and functions of the council.

The constitution and its appendices clearly explain how the different elements of the council interact and work together. It sets out procedure rules to which members and officers must adhere, codes of conduct and protocols.
The constitution builds on model constitutions and guidance maintained by the Department for Communities and Local Government.

The Monitoring Officer has a standing obligation to keep the operation of the constitution under review and recommend any changes to help better achieve its objectives. The constitution is also presented annually to the council for re-adoption and updating to ensure that it remains relevant to its purposes.

Political structure

The Council, meeting as a body, is responsible under the constitution and the Local Government Act 2000 for setting the policy framework and the budget for the authority. It also exercises certain other functions that are reserved to it. The Council appoints, and can remove, the Council Leader.

The Council meeting also acts as a channel for executive accountability through mechanisms such as notices of motion and Cabinet questions.

The authority operates a Leader and Cabinet form of executive comprising the Council Leader and six other Cabinet members. The role of the Cabinet, as set out in the constitution and relevant legislation, is to be responsible for those matters not expressly reserved to the council meeting.

Meetings of the Cabinet are open to the public, except where personal or confidential matters may be disclosed. Public platform allows members of the public to make a point and seek to have it addressed during the course of the meeting. Members of the Council who are not members of the Cabinet can ask questions at Cabinet meetings. This helps ensure robust accountability of Cabinet decisions.

Accountability of Cabinet decisions is also achieved through scrutiny mechanisms, including the ability of a scrutiny committee to call-in a Cabinet decision, and by the power of the full council meeting to remove the council leader.

In addition to the statutory Forward Plan of key decisions to be taken by the cabinet, the Council publishes forward plans showing non-key decisions to be taken by the Cabinet and business expected to be considered by Scrutiny

Committees, Audit Committee and the full Council. Each plan gives details of when decisions are expected to be made, who will take the decision, which will be consulted before the decision is made and how representations can be made.

The Council has established two overview and scrutiny committees to assist the Cabinet in policy development and review, to scrutinise decisions made by the Cabinet and analyse the performance of the Council in meeting its policy objectives and performance targets.

The Council's Standards Committee deals with all aspects of advice and guidance for Members on matters of conduct, ethics, propriety and declarations of interest. It also assesses, oversees and determines complaints made against Members under the Code of Conduct. The Council has access to a number of 'independent persons' who assist in upholding high standards.

The Standards Committee is a point of reference for the Monitoring Officer who investigates or arranges for the investigation of any allegations of misconduct in accordance with agreed procedures and statutory regulations.

The monitoring and performance of the Council's assurance and governance framework is led by the Council's Audit Committee. This is a committee independent of the executive and scrutiny processes and reports directly to Council. The committee has the responsibility to ensure that the monitoring and probity of the Council's governance framework is undertaken to the highest standard and in line with the Chartered Institute of Public Finance and Accountancy (CIPFA) guidelines.

Decisions on planning, licensing and other regulatory or quasi-judicial matters are taken by committees of the Council in accordance with the principles of fairness and natural justice and, where applicable, article 6 of the European Convention on Human Rights. Such committees always have access to legal and other professional advice.

Officer structure

The authority implements its priorities, objectives and decisions through officers, partnerships and other bodies. Officers can also make some decisions on behalf of the authority.

The Chief Executive is designated as the head of the authority's paid service. As such, legislation and the constitution make him responsible for the corporate and overall strategic management of the authority. He is responsible for establishing a framework for management direction, style and standards and for monitoring the performance of the organisation.

The Council has designated its Director of Resources as Monitoring Officer. The Monitoring Officer must ensure compliance with established policies, procedures, laws and regulations. She must report to the full Council or Cabinet as appropriate if she considers that any proposal, decision or omission would give rise to unlawfulness or maladministration. Such a report will have the effect of stopping the proposal or decision being implemented until the report has been considered.

The Council has designated the Chief Financial Officer as the officer responsible for the proper administration of its financial affairs in accordance with Section 151 of the Local Government Act 1972. The principal responsibilities of this officer include financial management, reporting and monitoring financial information, ensuring compliance with financial codes of practice including the Accounts and Audit Regulations 2011.

Both statutory officers referred to above have unfettered access to information, to the Chief Executive and to Councillors so they can discharge their responsibilities effectively. The functions of these officers and their roles are clearly set out in the Council's Constitution. In particular, the role of the Chief Financial Officer accords with the principles set out in the CIPFA Statement on the Role of the Chief Financial Officer.

Three directors report to the chief executive and collectively form the authority's management team together with the Chief Financial Officer who acts as a specialist advisor. The Management Team assists the Chief Executive with the strategic and overall management of the organisation. The constitution makes it responsible for overseeing and co-ordinating the management, performance and strategic priorities of the authority within the agreed policy framework and budget. Each member of the management team takes lead responsibility for major elements of the authority's business and manages a business unit.

The Management Team collectively and individually are responsible for securing the economical, effective and efficient use of resources as required by the duty of best value.

Powers delegated to each member of Management Team are documented in the constitution.

The Council maintains an independent Internal Audit Service, which in 2012/13 operated to the standards set out in the 'Code of Practice for Internal Audit in Local Government in the United Kingdom'. From 1 April 2013 the relevant code will be the Public Sector Internal Audit Standards 2012.

A Corporate Governance Group has been established to co-ordinate the receipt and actioning of reports from the various sources of audit and inspection. The

group also is responsible to the Audit Committee and Management Team and to compile, maintain and monitor the Code.

Operational

The Corporate Plan establishes Fylde Borough Council's corporate priorities and reflects the Council's principal statutory obligations. Performance against the plan is supported by a performance management system.

The financial management of the authority is conducted in accordance with the Financial Regulations set out in Appendix 4 of the Constitution. The Council has in place a Medium Term Financial Strategy, updated annually, to support the aims of the Corporate Plan.

The Council ensures continuous improvement in the economy, efficiency and effectiveness of services through the annual service and financial planning process. All services are reviewed annually to ensure that they meet the needs of customers and that performance targets for quality improvements are set and monitored. The Medium Term Financial Strategy includes targets for efficiency savings where appropriate, to be met across all service areas.

Annual budgets are set by the Council in the context of the Medium Term Financial Strategy, and each budget is allocated to a named budget holder. The responsibilities of budget holders in financial management are clearly set out within Financial Regulations.

A robust process of financial monitoring is in place. Budgets are regularly reviewed, the regularity and depth of attention is linked to the risks associated with each budget area. The financial position of the Council is reported on a regular basis to the Management Team, to Cabinet, and to full Council. Closer monitoring and appropriate action is taken where there is an indication of a likely variance against budget.

The Council has adopted a "Local Code of Corporate Governance" in accordance with the CIPFA/SOLACE Framework for Corporate Governance. The local code contains appropriate monitoring and reporting procedures, and can be found on the Council's website.

The Council had adopted and implemented a Corporate Risk Management Strategy, which incorporates the identification and management of existing risks to the achievement of corporate objectives in accordance with recognised standards of control assurance. A Corporate Risk Register is in place and is monitored and regularly reviewed, combined with action planning for risks identified. Appropriate employees have been trained in the assessment, management and monitoring of risks.

A corporate Risk Management Group (RMG) has been established with an effective monitoring and reporting mechanism. A member of Management Team is the nominated chair of the RMG and the executive portfolio-holder is invited to attend meetings.

The authority's risk management policy requires that officers understand and accept their responsibility for risk and for implementing appropriate controls to mitigate those risks. To this end, service managers are required to incorporate a register of risks relevant to their service area within each Directorate's service plan.

Internal Audit provides in its annual report an independent and objective opinion on the effectiveness and operation of the internal control framework during the year. The Internal Audit Team is subject to periodic assessment by the Council's external auditors, who place reliance on the work carried out by the team.

The Council has an objective and professional relationship with external auditors and statutory inspectors, as evidenced by the Annual Audit Letter.
Council services are delivered by trained and experienced people. All posts have a detailed job description and person specification and training needs are identified through the Personal Development Appraisal Scheme.
In addition the Council has comprehensive policies and procedures in place, which provide the framework for the operation of its services and ensure that its actions and decisions are undertaken within the framework of effective internal control.

The authority has a zero tolerance policy towards fraud and corruption. The Council's Whistleblowing Policy provides the opportunity for anyone to report their concerns confidentially and enable these to be investigated impartially. The authority is committed to working in partnership with public private and voluntary sector organisations where this will enhance its ability to achieve its identified aims.

Review of effectiveness

The authority supplements the mandatory external audit judgements by assessing itself against the good practice elsewhere. This, together with the authority's own Performance Management Framework, provides the evidence needed to ensure a culture of continuous performance improvement.

Inherent within the review of internal control arrangements is the need to assess the extent of compliance with statutory requirements and the authority's rules and regulations, which includes not only its Financial and Contract Procedure Rules but also its Scheme of Delegation, and Codes of Conduct. In addition, the Head of Internal Audit is required to produce an Annual Report and provide opinion on

the effectiveness of the authority's Audit Committee and the internal control function.
Fylde Borough Council has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The Corporate Governance Group, which comprises the Chief Executive, Section 151 Officer, Monitoring Officer, Head of Governance and the Head of Internal Audit, has been given the responsibility to annually review the Corporate Governance Framework and to report to Audit Committee on the adequacy and effectiveness of the Code and the extent of compliance with it.

The review of effectiveness is informed by the work of the Directors within the authority who have responsibility for the development and maintenance of the governance environment, the Head of Internal Audit's annual report, and also by comments made by the external auditors and other review agencies and inspectorates.

The Group also receives Directorate Assurance Statements on an annual basis from each of the authority's Directorates. These assurance statements show the extent of compliance within the Directorate concerned with key corporate procedures designed to embed good governance and internal control. In addition, the group has taken account of external assurance sources including the external auditor's Annual Audit Letter andISA 260 Report to those charged with Governance.

Internal Audit has carried out an annual programme of reviews as approved by the Audit Committee. The managers of the services and functions reviewed have each agreed actions and priorities arising from the review and the achievement of those actions is monitored on an ongoing basis by the authority's Internal Audit service. Any significant failure to achieve agreed actions is reported to the Audit Committee, who can require an explanation from the Director concerned.

The Strategic Risk Management Group meets regularly to review achievement of control measures in relation to strategic risks identified in the annual risk identification exercise. In addition, Internal Audit now carries out an annual review of the Risk Management Framework in accordance with the terms of the Risk Management Policy.

We have been advised on the implications of the result of the review of the effectiveness of the governance framework and system of internal control by the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is set out below.

Governance Issues

APPENDIX 1

The Council, via its Corporate Governance Group's recommendations, has identified a number of areas in recent years where it believed that corporate governance could be strengthened. In 2013/14, the Corporate Governance Group's single recommendation centres on the Council's Code of Corporate Governance.

Since 2007, the CIPFA/SOLACE Framework 'Delivering Good Governance in Local Government' has been used by the Council for the annual assessment of governance arrangements and the preparation of the Annual Governance Statement.

New guidance on Delivering Good Governance in Local Government was published in 2012 to assist local authorities in reviewing the effectiveness of their own governance arrangements through self assessment and reference to best practice.

The 2007 Framework is reflected in the Council's current Code of Corporate Governance, which was prepared in 2008. Following the new guidance the Council's Code of Corporate Governance will be updated to meet the new guidance in addition to reflect changes to the way the Council operates and undertakes service provision.

APPENDIX 1

On the basis of the work carried out, which has been reviewed by the Audit Committee, we are satisfied that the Governance Framework is effective. We propose over the coming year to address the above matters to further enhance our governance arrangements. We are satisfied that these actions will address the need for improvements that were identified in our review and will monitor their implementation and operation as part of our next annual review.

.....

Allan Oldfield, Chief Executive

.....

Councillor David Eaves, Leader of the Council

REPORT

REPORT OF	MEETING	DATE	ITEM NO
RESOURCES DIRECTORATE	AUDIT COMMITTEE	27 JUNE 2013	5

RISK MANAGEMENT ANNUAL REPORT

Public Item

This item is for consideration in the public part of the meeting.

Summary

The report summarises the year end report on the 2012-13 Strategic Risk Register Action Plans, and the work undertaken by the Council's Risk and Emergency Planning Officer in producing the Strategic Risk Register for 2013-14.

The report links principally to the Corporate Objective – "to meet the expectations of our customers".

Recommendations

1. It is recommended that the year end report of the progress on the 2012-23 Risk Action Plans be considered and appropriate comments made.
2. It is recommended that the Strategic Risk Register for 2013-14 is approved.
3. It is recommended that the Strategic Risk Register approved by the Audit Committee in September 2011, is re-approved for the year 2013-14.

Cabinet Portfolio

The item falls within the following Cabinet portfolio:
Finance & Resources (Cllr Karen Buckley)

Summary of previous decisions

1. The Strategic Risk Register for 2012-13 was approved by the Audit Committee at its meeting on 21 June 2012.

2. The Strategic Risk Management Strategy was approved by the Audit at its meeting on 22 September 2011.

Continued....

Report

Introduction

1. The current Risk Management Strategy adopted by the Council dates back to May 2003, when Zurich Municipal conducted the first risk management assessment of the Council's activities.
2. Since 2004, an annual review of the strategic risks faced by the Council has been undertaken by the Council's Risk & Emergency Planning Officer and Head of Internal Audit working together to identify the strategic risks facing the organisation over the next 12 months and prioritising these risks.
3. The audit commission requires strategic risks to be review on an annual basis and recommends that both Members and Officers are involvement in the identification of the risks. Taking this into account this year's risk identification exercise included; the Leader and Deputy Leader of the Council, the Chairman and Vice Chairman of the Audit Committee, the Chief Executive, Directors' of each of the 3 directorates and the Section 151 Officer (Chief Financial Officer).

Strategic Risk Register 2012-13

4. Following on from the risk identification & prioritisation stage of the risk process, a risk register is produced each year. This register identifies a number of actions required to minimise the likelihood of each risk occurring.
5. These actions are monitored throughout the year by the Strategic Risk Management Group (SRMG) using the Council's InPhase performance management system.
6. In the 2012-13 Strategic Risk Register there were 57 actions identified for monitoring, 55 of these were due for completion in 2012-13. The number of tasks completed in full was 42, representing 76% of the total number of actions due to be completed in 2012-13. Of the remaining 13 actions, 2 were partially completed. The implementation of the other 11 actions had been delayed. Table 1 below details the outstanding actions with the reason for the delay in completion.

Table 1 – Non-completed risks at 31/03/13

Risk Action Plan	Action	Reason for non-completion
Accommodation	Contract signed for Derby Rd	1. Initial highest bidder withdrew offer, Contract with new buyer due to be signed in the near future.
	Contract signed for Public Offices	2. Highest Bidder has not signed contract
	Completion of sale of Derby Rd	See 1 above
	Completion of sale of Public Offices	See 2 above
	Accommodation Working Group (AWG) agree to appoint project manager/QS	3. Progress on the refurbishment of the Town Hall is dependent on the proceeds of the sale of Derby Rd & Public Offices

Risk Action Plan	Action	Reason for non-completion
	Appointment of project manager/QS	4. Dependent on sales of assets and decision of AWG to proceed with refurbishments
	Procure temporary Office accommodation	See 3 above
	Let Contract for refurbishment works	See 3 above
	Decanting	See 3 above
	Commence refurbishment contract	See 3 above
Planning/LDF	Coast Protection Strategy – Strategic appraisal report accepted by National Review Group	Delayed due to further work necessary to rework the impact scenarios. .Appraisal Report due to be agreed late May 2013.
	Seek funding of PAR Project	Dependent on above
	Scope/Tender/Commence work on PAR	Dependent on above

Review of the Strategic Risk Management Strategy

7. A full scale review of the risk management strategy was carried out in 2011, as part of the recommendations of an internal audit review of Risk Management at Fylde. The revised Strategic Risk Management Strategy (SRMS) was approved by the Audit committee in September 2011. The SRMS was looked at again as part of the 2012, Internal Audit review of Risk Management, although there were no major changes recommended a few minor amendments to job titles/directorates have been made to reflect the 2012 establishment restructure. The SRMS is therefore presented to the committee again for adoption in its refreshed format (Appendix 1).

Strategic Risk Register 2013-14

8. The strategic risk register for 2013-14 is attached (Appendix 2). The strategic risks and risk champions are each risk are shown in table 2 below.

Table 2 – 2013-2014 Strategic Risk Action Plans

Strategic Risk Area	Risk Champion
Accommodation	Director of Development Services
Cost of Appeals (DM)	Chief Financial Officer
Local Plans	Director of Development Services
Performance	Chief Executive
Travellers	Director of Community Services

9. Each individual risk action plan identified in the risk register is recorded to enable it to be monitored via InPhase through to its successful completion. There are 38 actions included in the 5 risk action plans. Progress on the completion of the risk actions will be monitored during the year by the Strategic Risk Management Group.

IMPLICATIONS	
Finance	The Accounts and Audit Regulations 2003 require the Council to ensure that its financial management is adequate and effective including its arrangements for the management of risk. The use of resources judgement (assessment undertaken by External Audit) includes a section on Risk Management. Risk Management is included as a key part of the internal control assessment.
Legal	The annual risk review forms a key part of the council's corporate governance arrangements.
Community Safety	None arising from this report
Human Rights and Equalities	None arising from this report
Sustainability and Environmental Impact	None arising from this report
Health & Safety and Risk Management	Included in the report

Report Author	Tel	Date	Doc ID
Name of author – Andrew Wilsdon	(01253) 658412	Date of report – 20 May 2013	Annual Report Audit Cttee June 2013

List of Background Papers		
Name of document	Date	Where available for inspection
Document name		Council office or website address

Attached documents

1. Strategic Risk Register 2013-14
2. Strategic Risk Management Strategy

Risk Management Strategy 2013

Approved by Audit Committee June 2013

FOREWORD

Welcome to the Council's Strategic & Operational Risk Management Strategy, refreshed in June 2013. The aim of the Strategy is to improve strategic and operational risk management throughout the Council. Effective risk management allows the Council to:

- have increased confidence in achieving its corporate objectives
- mitigate threats to acceptable levels
- take informed decisions about exploiting opportunities
- ensure that it gets the right balance between rewards and risks
- improve its partnership working arrangements and corporate governance

Effective risk management will help to ensure the Council maximises its opportunities and minimises the impact of the risks it faces, thereby improving its ability to deliver its core objectives and improve outcomes for its residents.

This strategy explains Fylde Borough Council's approach to strategic and operational risk management, and the framework that it will operate to ensure that it arranges its risks effectively.

Cllr, Karen Buckley
Cabinet
Portfolio Holder
Finance & Resources

Allan Oldfield
Chief Executive Officer
Fylde Borough Council

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6. **HOW WILL IT FEED INTO OUR EXISTING PROCESSES** (page 10)

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8. **WHAT ARE THE DIFFERENT ROLES AND RESPONSIBILITIES** (page 12)

9. **HOW WILL THE MONITORING AND REPORTING OF RISK MANAGEMENT HAPPEN** (page 17)

10. **CONCLUSION** (page 17)

Appendix A. Risk Management Policy Statement (page 18)

Appendix B. Strategic & Operational Risk Management Groups Terms of Reference (page 19)

Information Box	
Title	Risk Management Strategy version 3.4 revised June 2013
Description	Fylde Borough Council's Risk Management Strategy
Primary audience	Members, Chief Executive, Corporate Management Team, Heads of Service and all Fylde Borough Council staff
Contact	Risk & Emergency Planning Officer Resources Directorate Tel. No.: 01253 658412
Last revised	June 2013

1. Introduction

This document forms Fylde Borough Council's Risk Management Strategy. It sets out:

- What is meant by risk management
- Why we need a risk management strategy
- The philosophy of our risk management
- An overview of the methodology to be adopted and its links with existing processes
- A summary of the implementation timetable
- An outline of the associated roles and responsibilities of members, chief officers and other employees.
- A summary of future monitoring and reporting lines for risk management

Aim:

The aim of this strategy is to improve the Council's ability to deliver its core objectives **(Places, People, Prosperity & Performance)** by managing its threats, enhancing its opportunities and creating an environment that adds value to ongoing operational activities.

Council's Objectives:

The Council has adopted a Corporate Plan that sets out the Council's Vision and identifies four key corporate objectives required to achieve it. The corporate vision is to work with partners to provide and maintain a welcoming, inclusive place with flourishing communities through four corporate objectives:

- (Places) The promotion and enhancement of the natural and built environment
- (People) The promotion of cohesive communities
- (Prosperity) The promotion of a thriving economy
- (Performance) Meeting the expectations of our customers

Risk Strategy Objectives:

- fully integrate strategic and operational risk management into the culture of the Council and into the Council's strategic planning processes
- ensure that the framework for identifying, analysing, prioritising, action planning, monitoring and monitoring and reviewing risks across the Council is implemented and understood by all relevant staff
- communicate the Council's approach to risk management to its stakeholders and partners
- promote the co-ordination of risk management activities across the Council
- ensure that the Executive, Corporate Management Team (CMT) and external regulators can obtain the necessary assurance that the Council is mitigating the risks of not achieving its objectives, and thus complying with good corporate governance practice.
- ensure consistency throughout the Council in the management of risk

This strategy outlines how Fylde Borough Council is taking on its responsibility to manage risks and opportunities using a structured and focused approach.

A policy statement is attached at Appendix A.

2. What is Risk Management?

Risk Management can be defined as:

> "The management of integrated or holistic business risk in a manner consistent with the virtues of economy, efficiency and effectiveness. In essence it is about making the most of opportunities (making the right decisions) and about achieving objectives once those decisions are made. The latter is achieved through controlling, transferring and living with risks"
> *ZMMS/SOLACE, Chance or choice?, July 2000.*

Risk management is a strategic tool and is an essential part of effective and efficient management and planning.

Fylde BC delivers a diversity of services that provides a vast potential for personal injury and loss or damage. Risk management will allow us to reduce that potential and in respect of strategic risk it will allow us to effectively manage the barriers to achievement of the Council's objectives.

3. Why do we need a Risk Management Strategy?

Risk management will strengthen the ability of the Council to achieve its objectives **(Places, People, Prosperity & Performance)** and enhance the value of services provided.

Strategic risk management is also an integral requirement of demonstrating continuous improvement.

Risk management is also an essential part of the CIPFA/SOLACE framework on Corporate Governance that was to be adopted by all Authorities in 2002/03. The CIPFA/SOLACE framework requires Fylde Borough Council to make a public assurance statement annually, on amongst other areas, the Council's risk management strategy, process and framework. The Framework requires the Council to establish and maintain a systematic strategy, framework and processes for managing risk. The assurance statement is disclosed in the Annual Statement of Accounts and referred to in the Performance Plan and is signed by the Leader of the Council and the Chief Executive.

4. What is our philosophy?

The Council will seek to embed risk management into its culture, processes and structure to ensure that opportunities are maximised. The council will seek to encourage managers to identify, understand and manage risks, and learn how to accept the right risks. Adoption of this strategy must result in a real difference in the Council's behaviour.

Risk management is something that everyone within Fylde Borough Council undertakes almost daily to varying degrees. Risk Management cuts across all areas of management and it is, therefore, difficult to draw clear boundaries around risk management. However, at Fylde Borough Council risk management falls within the following main areas:

- Health & Safety
- Emergency Planning
- Business Continuity Planning
- Projects
- Business Risks i.e. risks identified in the Corporate & Operational Risk Registers
- Partnerships/Shared Services

The risk management process contained in this strategy applies primarily to the Strategic Business and Project risk areas, however, the principle of the strategy can be applied to operational risk areas.

The main areas of risk identified above are managed by the following Directorates

Risk Area	Service Area with Lead Responsibility
Health & Safety Risks	Resources Directorate (Client) Blackpool Council Health & Safety (Contractor)
Emergency Planning	Resources Directorate
Business Continuity	Resources Directorate
Project Risks	Initiating Directorate
Business Risks	Resources Directorate
Partnership Risks	Initiating Directorate

Health & Safety and Emergency Planning

The Council has long established and effective processes for the management of risks falling within the Health & Safety and Emergency Planning areas of operation. The arrangements in place for these processes are not superseded by this strategy.

Business Continuity Management

Although there are clear inter-dependences between Business Continuity Planning and Strategic Risk Management, the Council's Business Continuity Planning arrangements are dealt with separately to this Strategy (Business Continuity Plan).

Project Risks

Projects risks can be managed using one, or a combination of the following risk management processes:

- Risk management techniques associated with the project management methodology used i.e. PRINCE2
- The Council's Strategic Risk Management Process

The size and scope of the project is likely to dictate the process best suited to managing the risks. However, all projects must undertake full risk assessments.

Business Risks

The risk management process outlined within this strategy should be used to identify and manage all risks to the Council's ability to deliver its priorities. This should cover both strategic priorities (delivery of the Council's core objectives and corporate plans) and operational activities (delivery of actions identified in directorate service plans)

Partnership Risks

Although there are clear inter-dependencies between Partnership Risks and Strategic Risk Management, the Council's partnership working arrangements are dealt with separately to this Strategy. (Partnership Protocol)

5. What is the Risk Management Process?

Implementing the strategy involves identifying, analysing, managing and monitoring risks.

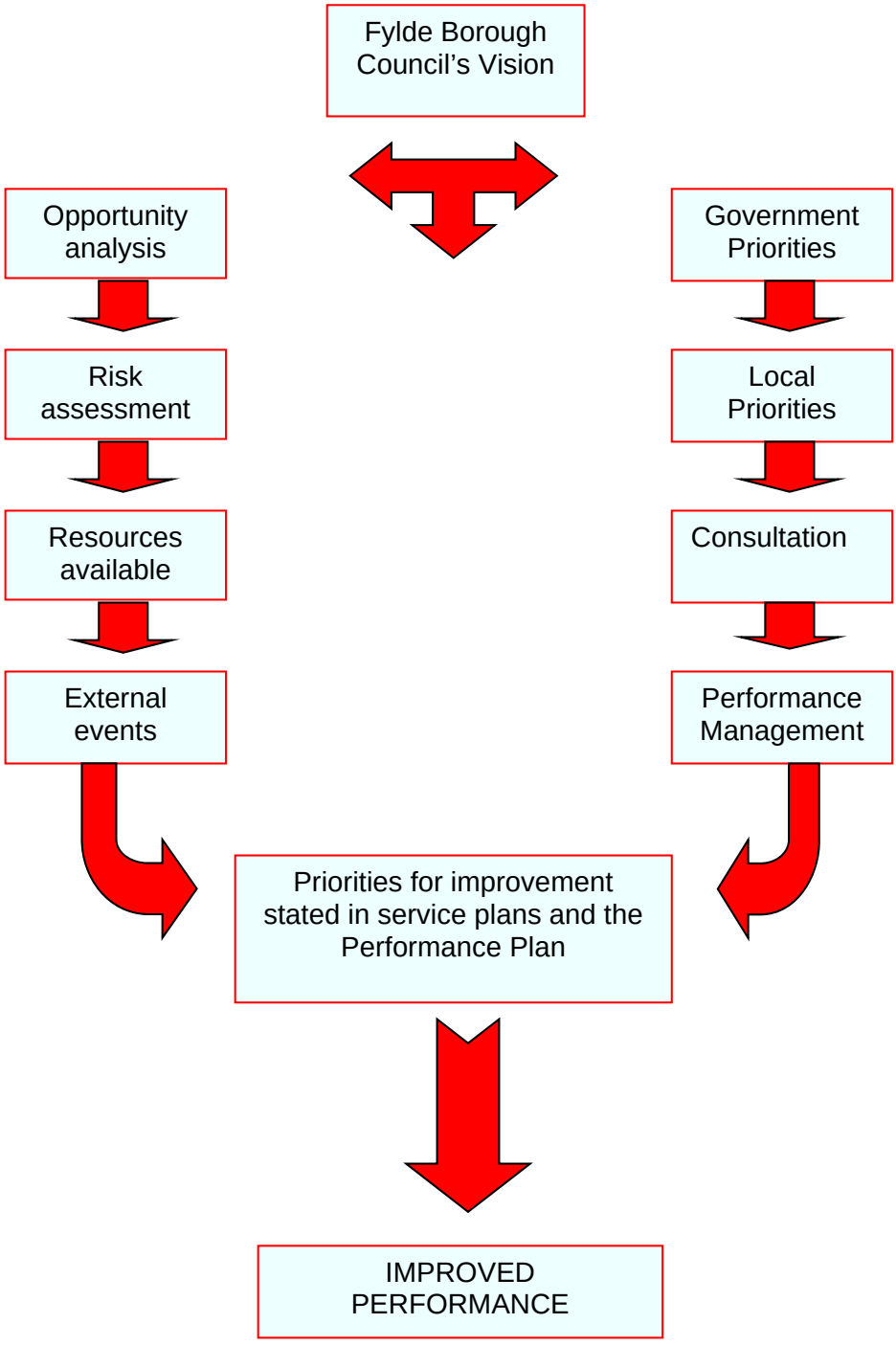
The identification of risks is derived from both a 'top down' (corporate) and a 'bottom up' (operational) process of risk assessment and analysis resulting in coverage of the whole Council. The process then prioritises the risks resulting in a focus on the key risks and priorities. The risks are then managed through the development of appropriate action plans and fed into overall service plans and the Corporate Plan. Relevant PI's are identified and then monitored through the developing performance management framework ensuring that the focus remains on achieving Fylde Borough Council's objectives (**Places, People, Prosperity & Performance**).

Step	Element	Activity Description
1	**Risk Identification**	Individual interviews are held in Dec / Jan each year with the Chief Executive, Directors, Council Leader/Deputy, Portfolio Holder and Chairman/Vice Chairman of the Audit Committee to identify strategic risks facing the Council over the next 12 months. Specific consideration is given to risks and opportunities associated with the Council's core objectives and priorities.
2	**Risk Analysis**	The risks identified in step 1 are analysed and clustered around common areas. These are then written into scenarios by the Risk & Emergency Planning Officer and Chief Internal Auditor that show the vulnerability, trigger and consequences of each risk type.
3	**Risk Priority**	The risk scenarios are presented to a Corporate Management Team workshop to decide if the risk presented is in fact valid, if it is it is prioritised on a 5x4 matrix measuring Likelihood against Impact. Once all the risks are plotted on the matrix the risk appetite line is added. All risks above the line are then actioned planned.
4	**Action Planning**	Each risk identified above the line is action planned. This process shows what action is already taken to mitigate the risk and identifies what further actions should be taken to reduce the risk to a more acceptable level by reducing the likelihood of the risk occurring or the impact if it does. Each risk is assigned to a Champion who oversees the implementation of the action plan

Step	Element	Activity Description
5	**Monitoring**	The strategic risk management group monitors progress on the implementation of the agreed action plans throughout the year to ensure that all actions are completed. If necessary it will recommend to the CMT that new risk are added to the Risk Register should the need arise during the year.
6	**Monitoring & Review**	The whole process is monitored and reviewed on an annual basis. Once the outcomes of the current years activities are known the cycle starts over with interviews to Identify the risks for the next years risks register
7	**Operational Risk**	The managing of operational risks is conducted using the same framework but within each directorate. Operational Risks Registers are set up in each directorate and they are monitored by the directorate Risk Champion. Reports on the progress of the individual directorate risk registers will be made to the operational risk management group twice yearly by the directorate risk champions

6. How will it feed into our existing processes?

The information resulting from the process acts as one of eight key pieces of information that will be incorporated into the development of the service and Best Value Performance Plans. Risk management will become an essential element to establishing policy, developing plans and enhancing operational management.



Effective risk management may also be integrated into the existing VFM guidance. It can help to narrow down the options for future service delivery. It can also be used as mechanism of identifying areas of service improvement.

The risk management methodology can also be adopted for individual projects and can be used to strengthen all decision-making processes.

Links to Corporate Governance

Risk Management is part of the Council's overall Corporate Governance arrangements:

Governance is the system by which the Council directs and controls its functions and relates to the Community. In other words, the way in which it manages its business, determines its strategy and objectives and how it goes about achieving its objectives. The fundamental principles are openness, integrity and accountability. The risk management strategy forms part of Fylde Borough Council's corporate governance arrangements. The other main elements are Internal Control, Performance Management, Health & Safety and Internal Audit.

Internal Controls are those elements of an organisation (including systems, resources, processes, culture, structure and tasks) that, taken together support people in the achievement of the Council's objectives. Internal financial control systems form part of the wider system of internal controls. The Council's internal controls forms part of its risk management process and have a key role to play in the management of significant risks to the fulfilment of its business objectives. For example all reports to non-regulatory committees where a decision is being recommended must have a risk assessment completed with the significant findings of the risk assessment included in the report. The report should also identify the risk register in which the risks and required risk mitigation actions will be entered and monitored. If it is considered that a risk assessment is not appropriate this information must be reported.

Performance Management and risk management are closely aligned. The Council's Performance Management process closely mirrors the Risk Management process.

The **Health & Safety** policy of the Council is a key component of the Council's structure of controls contributing to the management and effective control of risks affecting staff, contractors, volunteers, service users and the general public.

Internal Audit is a major component of the Council's system of controls protecting its financial and other physical assets. The risk management process in turn serves the Internal Audit function by enabling it to identify areas of high risk, and so target its resources more effectively.

7. How will this be implemented?

A detailed implementation plan has been developed to support the strategy. The following is a summary of the overall timetable:

Action	Timescale	Responsibility of
Corporate assessment and prioritisation of risks	Feb/Mar each year	Corporate Management Team
Develop strategy, report to CMT and recommend for approval by members. Report % achievement of pervious years Risk Actions	End of June each year	Risk & Emergency Planning Officer
Raise awareness of risk management as an effective management tool	ongoing	Risk & Emergency Planning Officer
Directorate service plans -assessment and prioritisation of risks	Feb/Mar each year	Directorate Risk Teams
Report to Audit Committee on progress on the current years Risk Actions contained in the Risk Register	Jan each year	Risk & Emergency Planning Officer

8. What are the different roles and responsibilities?

The following describes the roles and responsibilities that members and officers will play in introducing, embedding and owning the risk management process**: -**

Role	Responsibilities
The Audit Committee	➢ Overseeing effective risk management across the Council ➢ Agreeing Fylde Borough Council's Risk Management Strategy ➢ Ensuring that risk management is delivered by the Director of Governance & Partnerships on behalf of the Council ➢ Ensuring that a Strategic Risk Register, including details of actions taken to mitigate the risks identified, is established and regularly monitored ➢ Ensuring that the Risk Management Strategy and Strategic Risk Register are reviewed at least annually ➢ Seeking assurances that action is being taken on risk related issues identified ➢ Facilitating a risk management culture across the Council
Leader	➢ Appointing a Member with responsibility for Risk Management within the cabinet
Chief Executive & Corporate Management Team	➢ Leading risk management across the Council, with the Director of Governance & Partnerships as the designated CMT lead on Risk ➢ Advising members on effective risk management and ensuring that they receive regular monitoring reports ➢ Recommending a Risk Management Strategy to Members of the Audit Committee ➢ Identifying and managing the business risks and opportunities facing the Council ➢ Co-ordinating risk management across the Council ➢ Being responsible for ensuring that the Council fully complies will all corporate governance requirements, including the Annual Statement of Internal Control

Role	Responsibilities
Directors	Directors will demonstrate their commitment to risk management through: - ➢ Ensuring that risk management within their directorate is implemented in line with the Council's Risk Management Strategy and the Minimum Standard for Performance Management ➢ Ensuring partnerships initiated by their directorates are constituted in accordance with the Partnerships Protocol ➢ Appoint a risk champion who is authorised to progress effective risk management throughout their directorate that adheres to corporate guidelines ➢ Identifying, analysing, prioritising, and action planning risks arising from their business area. Identified risks to be recorder in a Directorate Operational Risk Register. DORR's to be kept up to date and reported on as required. ➢ Balancing an acceptable level of operational risk against programme and project objectives and business opportunity ➢ Reporting systematically and promptly to the Corporate Management Team any perceived new risk or failures of existing control measurers ➢ Attending the Strategic Risk Management Group
Risk Champions	➢ Acting as the main contact for their directorate on risk matters, and ensuring that corporate information and requirements are communicated to the directorate ➢ Progressing across their directorate effective risk management that adheres to corporate guidelines, including ensuring that all reporting requirements are met ➢ Representing their directorate at the Operational Risk Management Group when required and at the Strategic Risk Management Group in the absence of the Director ➢ Provide the ORMG with twice yearly reports on the status of their directorate's Risk Register and progress made on implementing the DORR risk action plan. ➢ Providing support on risk management to Directors and middle managers within their directorate ➢ Promoting the benefits of risk management across the directorate ➢ Maintaining, on behalf of Director an up to date DORR that complies with corporate guidelines.

Role	Responsibilities
Heads of Service / Service Managers	➢ Communicating to staff the corporate approach to risk management ➢ Identifying the risk management training needed by staff, and reporting this to the directorate Risk Champion ➢ Ensuring that they and their staff are aware of corporate requirements, seeking clarification from the risk champion when required
Staff	➢ Understanding their accountability for individual risks ➢ Reporting systematically and promptly to their managers any perceived new risks or failures of existing controls
Internal Audit	➢ Auditing the key elements of the Council's Risk Management Process ➢ Using the results of the Council's Risk Management Process to focus and inform the overall internal audit plan ➢ Ensuring that internal controls are robust and operating correctly
Risk Management Groups	The purpose of the risk management groups is to promote good practice on risk management across the Authority and act as a "Champion" on risk management issues. The Groups will also: ➢ Promote the "positive" effects that good risk management can have when embedded into all Council policies and procedures ➢ Ensure that risk management is seen as a tool to "make things happen" in a safe and beneficial way, not a process used to "stop things from progressing". ➢ Investigate issues referred to it by the Corporate Management Team and report back in a timely manner ➢ Standardise procedures and practices to reduce property and liability losses and claims ➢ Advise Corporate Management Team on risk management issues referred to it by individual directorates. ➢ Receive reports from the Risk & Emergency Planning Officer and Directorate Risk Champions on the status of the various Risk Registers and progress made on implementing the associated action plans.

Role	Responsibilities
Risk Management Groups	➢ Adopt SMART reporting techniques for all issues sent to the group from whatever source ➢ Introduce more sophisticated systems to analyse and forecast losses ➢ Investigate the feasibility of allocating risk costs in line with the risk features of each budget holder ➢ Use deductibles or self-insurance where financially beneficial to provide a vested interest in loss control. Dependence on insurance will be reduced and cover sought on a 'value for money' basis, seeking cover where financially prudent ➢ Wherever possible, improve risk management information and investigative procedures within the authority The terms of reference for the risk management group is attached at appendix B
Insurance, Risk Management, Business Continuity & Emergency Planning Officer	➢ Provide advice and guidance on insurable risks ➢ Provide strategic direction on the Council's approach to risk management ➢ Ensure effective liaison between risk areas (see table on page 6) ➢ Co-ordinating the Council's approach to risk management ➢ Provide advice to the Council on risks arising from partnership working, and possible mitigation actions such as use of Service Level Agreements ➢ Report on the status of the Council's Corporate Risk Register and the implementation of the associated action plans

9. How will the monitoring and reporting of risk management happen?

A framework of monitoring and reporting will be established that will allow: -

- An annual review of the risk management strategy by CMT approved by the Audit Committee
- Monitoring of the effective management of risks through developing performance management mechanisms including regular reporting on service and corporate performance indicators to CMT and members.
- An annual review of the overall process and a report to CMT and members on the effectiveness of risk management and internal control by Internal Audit.

An annual report to the Audit Committee outlining the effectiveness of the strategic and operational risk management actions undertaken as part of the Corporate and individual Directorate Risk Registers. The ultimate measure of effective risk management is that the Council:

- has resilience to deliver its services and core objectives
- is protected from the possibility of being impacted by an unforeseen risk
- is protected from the possibility of a foreseen risk having significantly greater impact than anticipated
- is able to take cost-effective measurers to reduce or eliminate the effects of negative risk
- is able to identify, and take maximum advantage of, the occurrence of positive risk.

10. Conclusion

The adoption of a sound risk management approach should achieve many benefits for the Council. It will assist in demonstrating that the Council is continuously improving and will go a long way to demonstrating effective corporate governance.

The challenge is to implement a comprehensive risk management process without significantly increasing workloads. This should be achieved in part by making risk management part of existing processes and reviews rather than treating it as a separate function.

Appendix A

Risk Management Policy Statement

The diversity of services offered by the Council presents a vast potential for personal injury, loss and damage. It is essential for the Council to develop Risk Management programmes which ensure that, in discharging its responsibilities to the citizens, the likelihood of personal injury and loss or damage to physical assets is minimised by means of anticipating and controlling our exposure to risk.

Accordingly it is the responsibility of every member of staff to identify, analyse, eliminate and control exposure to risk and to minimise such losses as they may occur. The purpose of the risk management policy is to achieve the following:

1. To support operating units in their efforts to appraise the risks to which they are exposed.
2. To provide advice through networks of specialists.
3. To provide guidance on best practice in loss control.
4. To motivate managers and others to manage risk effectively.
5. To provide incentives in order to increase the level of risk management.
6. To ensure that adequate risk financing is available.

The Council's Strategic and Operational Risk Management Groups are fundamental to this process. Elected Members, the Chief Executive, Directors and staff of all directorates must be fully supportive of the initiative.

It is the responsibility of every directorate to implement a sound Risk Management strategy. Management at directorate and cost centre level has the responsibility and accountability for managing the risks to which their area is exposed.

This philosophy has the support of the Council which recognises that any reduction in injury, illness or damage benefits the whole community.

Appendix B

Strategic & Operational Risk Management Groups – Terms of Reference

Meetings

The risk management groups will meet on a regular basis (minimum of 4 meetings per year); however the Chairman of either group may call extra meetings as necessary.

Chairmanship

The Chairmen of the Groups will normally appointed by the CMT.

Secretary

The Secretary of the Groups will normally be the Risk & Emergency Planning Officer.

Membership of the Groups

Every directorate will be represented on the each Group. Each directorate will nominate a senior member of the directorate to represent the directorate on the group. Directorate membership should, where possible, be rotated over a cycle of a number of meetings so that risk management is promoted to as many senior officers as possible. Additional staff members may attend the meeting where it is considered beneficial to have their input on matters being discussed.

Purpose, Focus and Scope of the Risk Management Group

- The purpose of the risk management group is to promote good practice on risk management across the Authority and act as a "Champion" on risk management issues.
- The group should promote the "positive" effects that good risk management can have when embedded into all Council policies and procedures.
- Risk management should be seen as a tool to "make things happen" in a safe and beneficial way, not a process used to "stop things from progressing".
- The risk management group should investigate issues referred to it by the Corporate Management Team and report back in a timely manner.
- The group should also advise Corporate Management Team on risk management issues referred to it by directorates.
- The group should adopt SMART reporting techniques for all issues sent to the group from whatever source.
- The Strategic Risk Management Group manages Corporate risks which affect the Council's ability to fulfil its Corporate Objectives and is concerned with major Business risk.
- The Operational Risk Management Group will manage Operational risks which affect the Council's ability to run its day to day services.

Minutes and Reports

Minutes of meetings should be kept and the Chairman of each Group should present these to the Corporate Management Team at the next available meeting. All reports issued by the groups should also be reported to CMT. Once minutes and reports are approved by the CMT they should be posted onto the risk management page of the Intranet.

Strategic Risk Register
2013-2014
Approved by Audit Committee 28 June 2013

2013/2014 Risk Register
Risk Management Action Plan No: 1
Champion – Director of Development Services

Issue: Accommodation	**Description: Working Towards The Completion of the Accommodation Project**
Council Objective	**Performance/People/Places**

Existing Controls in place
• Sold St David's Rd Depot
• Acquired operational depot – Snowden Rd
• Budget provision for operational depot
• Offers on Wesham Office site
• Offer on Public Offices - close to signing
• Regular reports to members
• Remedial works to existing buildings
• Staff kept up to date
• Working Group – regular meetings
• Draft refurbishment proposals agreed

Required management action/control	**Responsible for action**	**Critical success factors & KPI's**	**Review frequency**	**Key Dates**
Agree preferred bidder on Derby Road and move to exchange of contract	Gary Sams	Contract agreed and signed	N/A	May 2013
Public Offices – move to exchange of contract (1)	Gary Sams	Contract agreed and signed	N/A	Jul 2013
Process planning applications for Derby Road	Paul Rossington	Applications determined within 13 weeks	When contracts are exchanged	Submission dates anticipated: Jun 2013
Process planning applications for Public Offices	Paul Rossington	Applications determined within 13 weeks	When contracts are exchanged	Date dependent upon earlier actions being achieved (1)
To seek tenders and report to Cabinet to obtain approval for commencement of phase one of the Town Hall refurbishment works and secure fit for purpose depot facilities (subject of a separate detailed action plan if approved)	Andrew Dickson	• Works designed and let • Works completed	June 2013	Report to Cabinet – Jun 2013
Complete asset disposal contracts and receive monies	Gary Sams	Contracts completed and monies received	When planning applications are ready to be determined	Date dependent upon earlier actions being achieved

Required management action/control	Responsible for action	Critical success factors & KPI's	Review frequency	Key Dates
Accommodation WG - agree to make start on main Town Hall refurbishment works	Paul Walker/ AWG	Project manager and professional team appointed to work up the scheme	Keep reviewed at each meeting of the AWG	Date dependent upon earlier actions being achieved
Prepare for decanting of staff during refurbishment works	Gary Sams/ Andrew Dickson	Decanting solution agreed and costed	Linked to earlier actions being achieved	Date dependent upon earlier actions being achieved
Undertake main refurbishment works to the Town Hall	Andrew Dickson	• Scheme designed and let • Scheme completed	Linked to earlier actions being achieved	Date dependent upon earlier actions being achieved
Finalise and agree scheme at Snowden Rd depot to provide new operational facilities	Andrew Dickson	• Scheme designed and let • Scheme completed	Linked to earlier actions being achieved	Date dependent upon earlier actions being achieved

2013/2014 Risk Register
Risk Management Action Plan No: 2
Champion – Section 151 Officer

Issue: Appeals	**Description: Development Management - Cost of Planning Appeals**
Council Objective	**Performance/People/Places**

Existing Controls in place
• Member training and development
• Monthly reporting of appeal decisions to DM Committee
• Update reports to Development Management (DM) Committee of appeal decisions received

Required management action/control	**Responsible for action**	**Critical success factors & KPI's**	**Review frequency**	**Key Dates**
Further member development training sessions: General planning training for members	Lyndsey Lacey	Reduced resource implications & costs of planning appeals	Annually	Sep 2013
Further member development training sessions: Members of DM committee and Cabinet to review appeal decisions and lessons learned	Paul Rossington	Reduced resource implications & costs of planning appeals	Annually	Sep 2013
Raise risk with Cabinet via Management Board – major applications in the pipeline and recent decisions received	Paul Walker/ Mark Evans	Increased awareness of appeals	Annually	Oct 2013
Carry out a review of procedure for decisions which are made by DM committee contrary to officer recommendations	Paul Rossington	Completion of review of procedure	Annually	Dec 2013

2013/2014 Risk Register
Risk Management Action Plan No: 3
Champion – Director of Development Services

Issue: Local Plan	**Description: Working towards completion of the Fylde Local Plan: Part 1**
Council Objective	**Places/People**

Existing Controls in place
• Assistance from PAS to work up plan for adoption
• Plan partially completed
• Previous public consultation on Issues and Options
• Preferred Options circulated to LP Steering Group
• Clarification from Minister, PAS & PINS on future housing requirement
• Resources in place
• Greater knowledge in Cabinet

Required management action/control	**Responsible for action**	**Critical success factors & KPI's**	**Review frequency**	**Key Dates**
Agreement of draft Preferred Option by Local Plan Steering Group	Julie Glaister/ Mark Evans	Member backing for the Draft Preferred Option	N/A	Apr 2013
Undertake viability appraisals	Julie Glaister/ Mark Evans	Appraisals completed	When draft Preferred Option has been considered by Local Plan Steering Group	Jun 2013
Agreement of Preferred Option by Council	Julie Glaister/ Mark Evans	Member backing for the Draft Preferred Option	When draft Preferred Option has been considered by Local Plan Steering Group	Jun 2013
Undertake other technical assessments: • Viability Assessment, • Appropriate Assessment, • Health Impact Assessment, • Equalities Impact Assessment, • Rural Proofing • Infrastructure Delivery Plan	Julie Glaister/ Mark Evans	Assessments undertaken	When draft Preferred Option has been considered by Local Plan Steering Group	Jul 2013
Consultation on Preferred Option	Julie Glaister/ Mark Evans	Consultation commenced and positive engagement achieved	When draft Preferred Option has been considered by Council	Jul / Aug 2013
Evaluation of consultation responses received	Julie Glaister/ Mark Evans	Responses evaluated and plan revised where necessary	When Consultation on Preferred Option has commenced	Sep/Oct/ Nov 2013
Agreement of Published Local Plan by Council	Julie Glaister/ Mark Evans	Member backing for the Local Plan	When Consultation on Preferred Option has closed	Jan 2014
Publication	Julie Glaister/ Mark Evans	Local Plan Published	Linked to earlier actions being achieved	Mar 2014

Required management action/control	Responsible for action	Critical success factors & KPI's	Review frequency	Key Dates
Submission to the Secretary of State	Julie Glaister/ Mark Evans	Local Plan submitted to the Secretary of State	Linked to earlier actions being achieved	May/ Jun 2014
Adoption of Local Plan	Julie Glaister/ Mark Evans	Local Plan adopted	Linked to earlier actions being achieved	Dec 2014

2013/2014 Risk Register
Risk Management Action Plan No: 4
Champion – Chief Executive

Issue: Staff	**Description: Supporting performance to embed the new Corporate Culture**
Council Objective	**Performance**

Existing Controls in place
• Ambassadors Group
• Staff Appraisals
• Staff briefings
• Meeting with CEX/MT
• Staff Surveys
• PM Framework
• Suggestion Scheme
• Money saving expert
• Championing good performance
• Resident survey on staff performance
• Coaching programme
• Vocational training
• Compliments in grapevine/website
• Competency Framework
• Corporate cross team working

Required management action/control	**Responsible for action**	**Critical success factors & KPI's**	**Review frequency**	**Key Dates**
Even more people championing success	Allan Oldfield	The number of employees that are selling the success of the Council	Quarterly	Mar 2014
Revise Appraisal System on feedback received	Alex Scrivens / Allan Oldfield	Percentage of appraisals completed and % satisfaction	Annual	Oct 2013
Evolution of Competency Framework on feedback received	Alex Scrivens / Allan Oldfield	Increase in promotion and use of the competencies	Annual	Aug 2013
CEX to share feedback from Ambassadors Group	Allan Oldfield	Circulation of notes from feedback meetings	Quarterly	May 2013
Continual reinforcement of initiatives	Senior Management	Five Points, Grapevine, Team Briefs and staff briefs	Quarterly	May 2013
Identify and address poor performance	Senior & Middle Management	Mechanism for reporting poor performance and agreeing action in place	Six monthly	Jul 2013
Target and support poor performance	Senior & Middle Management	Number of successful interventions	Six Monthly	Oct 2013
Formal & Informal team building events	All Managers	Number of team building initiatives implemented	Annual	Mar 2014

2013/2014 Risk Register
Risk Management Action Plan No: 5
Champion – Director of Community Services

Issue: Travellers	**Description: Resources/costs involved in dealing with Travellers**
Council Objective	**Places/people**

Existing Controls in place
• Meetings/relationships with residents
• Following due legal process
• Support from Secretary of State in defence of the challenges
• Injunction in place controlling the development
• Regular visits to sites by staff – evidence gathering
• Existing GTAA in place
• Existing over provision

Required management action/control	**Responsible for action**	**Critical success factors & KPI's**	**Review frequency**	**Key Dates**
Liaise with Wyre	Mark Evans	Maintain communication with WBC officers to ensure joined up approach	Monthly	Apr 2013 Ongoing
Refresh Gypsy Travellers Accommodation Assessment	Mark Evans	Revised GTAA produced		Jun 2013
Refresh Gypsy Travellers Accommodation Assessment	Mark Evans	Revised GTAA agreed by Members		Aug 2013
Court of Appeal dates (18th or 19th July 2013)	Nicola Martin	Judgement to uphold the decision of the Secretary of State		Jul 2013
Prepare for evictions if required after end of legal process	Paul Walker	Establish officer working group re Hardhorn site		Jun 2013
Prepare for evictions if required after end of legal process	Paul Walker	Working group to develop action plan re management of site eviction		Jul 2013
Prepare for evictions if required after end of legal process	Paul Walker	Establish potential site(s) to evict to		Jul 2013
Test political appetite for Travellers site	Paul Walker	Member awareness raising session re need		Aug 2013
Test political appetite for Travellers site	Paul Walker	Formal report to Cabinet to agree way forward re site provision?		Sep 2013

Required management action/control	Responsible for action	Critical success factors & KPI's	Review frequency	Key Dates
Report to DM Committee following expiry of enforcement notice (29/7/13)	Mark Evans / Ian Curtis	Thorough and balanced report considered by members		Aug 2013
Make budget provision	Paul Walker	Estimate resource requirement		Aug 2013
Make budget provision	Paul Walker	Raise awareness of resource requirement to Cabinet		Sep 2013
Make budget provision	Paul O'Donoghue	Include estimate in MTFS update		Sep 2013
Manage Reputation of Council	Allan Oldfield	Regular updates to residents and media	Monthly	Apr 2013 Ongoing

REPORT

REPORT OF	MEETING	DATE	ITEM NO
INTERNAL AUDIT	AUDIT COMMITTEE	27 JUNE 2013	6

INTERNAL AUDIT ANNUAL REPORT 2012-13

Public Item

This item is for consideration in the public part of the meeting.

Summary

The report provides an opinion on the effectiveness of the Council's system of internal control in support of the Annual Governance Statement. It also summarises the work undertaken by internal audit from April 2012 to March 2013 and performance information for the same period.

The report meets the Head of Internal Audit's responsibility under the Code of Practice for Internal Audit in Local Government in the United Kingdom 2006, the prevailing code for the period.

Recommendation

1. To approve the annual report of the Head of Internal Audit

2. To note the Internal Audit opinion that reliance can be placed on the Council's control environment in terms of the overall adequacy and effectiveness of the controls and processes which are in place to achieve the objectives of the Council

Cabinet Portfolio

The item falls within the Finance & Resources portfolio (Councillor Karen Buckley)

Summary of previous decisions

There have been no previous decisions regarding this report.

Continued....

1 Introduction

1.1 The Role of Internal Audit

The role of internal audit is to provide management with an objective assessment of the adequacy and effectiveness of internal control, risk management and governance arrangements. Internal audit is therefore a key part of the Council's internal control system and integral to the framework of assurance that the Audit Committee can place reliance upon in its assessment of the internal control system.

1.2 Definition of Internal Audit

In 2012/13 internal audit operated in compliance with CIPFA's Code of Practice for Internal Audit in Local Government in the United Kingdom. The definition of internal audit, as described in the Code, is set out below:

- Internal Audit is an assurance function that primarily provides an independent and objective opinion to the organisation on the control environment comprising risk management, control and governance by evaluating its effectiveness in achieving the organisation's objectives. It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper, economic, efficient and effective use of resources.

- Whilst Internal Audit "primarily" provides an independent and objective opinion to the organisation on the control environment, it may also undertake other, non-assurance work at the request of the organisation subject to the availability of skills and resources. This can include consultancy work; indeed, Internal Audit intrinsically delivers consultancy services when making recommendations for improvement arising from assurance work, and fraud-related work.

1.3 Purposes of the Report

1.3.1 The Internal Audit Team is responsible to the Director of Resources for carrying out a continuous examination of the accounting, financial and other operations of the Council in accordance with Section 151 of the Local Government Act 1972 and the Accounts and Audit Regulations 2011. The latter states that *"the relevant body shall be responsible for ensuring that the financial management of the body is adequate and effective and that the body has a sound system of internal control which facilitates the effective exercise of that body's functions and which includes arrangements for the management of risk."*

1.3.2 The statutory Code of Practice for Internal Audit in Local Government in the United Kingdom requires that the Head of Internal Audit must provide a written report to those charged with governance, timed to support the Annual Governance Statement.

1.3.3 The Head of Internal Audit's annual report to the organisation must:

- Include an opinion on the overall adequacy and effectiveness of the organisation's control environment
- Disclose any qualifications to that opinion, together with the reasons for the qualification
- Present a summary of the audit work from which the opinion is derived, including reliance placed on work by other assurance bodies
- Draw attention to any issues the Head of Internal Audit judges particularly relevant to the preparation of the Annual Governance Statement
- Compare the work actually undertaken with the work that was planned and summarise the performance of the internal audit function against its performance measures and targets
- Comment on compliance with the standards (the Code of Practice) and communicate the results of the internal audit quality assurance programme

1.3.4 The report also summarises the activities of internal audit for the financial year 2012-13 to provide managers and members with the opportunity to review the service provided to the Council.

2 The Statement of Assurance

2.1 Context

2.1.1 The Council's internal auditors are required to provide the Audit Committee with assurance on the system of internal control. In giving our opinion it should be noted that assurance can never be absolute. The most that internal audit can provide to the Audit Committee is a reasonable assurance that there are no major weaknesses in risk management, governance and control processes.

2.1.3 The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

2.2 Internal Audit Opinion

2.2.1 We are satisfied that sufficient internal audit work has been undertaken to allow us to draw a reasonable conclusion as to the adequacy and effectiveness of the Council's risk management, internal control and governance processes.

2.2.2 In our opinion, based upon the work we have undertaken, for the 12 months ended 31 March 2013, reliance can be placed on the Council's control environment in terms of the overall adequacy and effectiveness of the controls and processes that are in place to achieve the objectives of the Council. There were no qualifications to the opinion.

2.2.3 The evidence to support the opinion is contained within this report.

2.3 Scope of the Internal Audit Opinion

2.3.1 In arriving at our opinion, we have taken into account:

- The results of all internal audits undertaken during the year ended 31 March 2013 (see Table Two for details of the opinions given during the year);
- The results of follow-up action taken in respect of audits completed;
- Whether or not any fundamental or significant recommendations have not been accepted or implemented by management and the consequent risks;
- The results of external audit work during the year and any concerns expressed by the External Auditor;
- The results of any other external inspection or assessment
- The effectiveness of the Council's risk management arrangements
- The effectiveness of the Council's governance arrangements, including internal audit

2.4 Basis of the Opinion

2.4.1 In reaching this opinion the following factors were taken into particular consideration:

<u>External Audit Work during 2012/13</u>

2.4.2 The main part of the external auditor's work relates to the Council's financial accounts. The external auditor's Report to Those Charged with Governance for 2011/12 which was reported to the meeting of the Audit Committee on 20 September 2012, concluded that having regard to the relevant criteria for principal authorities as published by the Audit Commission, the Council had secured economy, efficiency and

effectiveness. It also provided an opinion to verify that the Council has complied with all legal and regulatory frameworks with respect to its accounting arrangements resulting in an unqualified opinion.

2.4.3 The Annual Audit Letter, presented to the 14 November 2012 meeting, detailed the external auditor's view on performance and financial management. An unqualified value for money conclusion was issued meaning the Council was judged to have proper arrangements for securing both financial resilience and achieving economy, efficiency and effectiveness. An unqualified opinion was also issued on the financial statements meaning they gave a true and fair view of the Council's financial position.

2.4.4 The Certification of Grants and Returns Report, reported to the 30 January 2013 committee, summarised the outcomes of the external auditor's certification work. An unqualified certificate was issued for both grant claims reviewed.

Other External Inspection

2.4.5 There were no other external inspections during 2012-13 to take into account.

Risk Management

2.4.6 The Council's risk management framework is established by the Risk Management Strategy. It provides information on the approach, responsibilities, processes and procedures and sets the context in terms of how risks will be identified, profiled, managed and reviewed. The Strategic Risk Management Group is fundamental to the process and meets to ensure risk management remains high on the corporate agenda. There is also regular reporting to the Audit Committee, the elected member committee with responsibility for risk management.

2.4.7 An audit of the risk management process carried out during 2012-13 and an action plan with seven agreed actions was agreed and promptly implemented. The implementation of the audit recommendations means that substantial reliance can reasonably be placed on the effectiveness of the Council's risk management arrangements.

Governance

2.4.8 A self assessment exercise was undertaken by the Chair and Vice Chair of the Audit Committee in relation to the effectiveness of the Committee. The main conclusion drawn from the self assessment was that the Audit Committee had the framework in place to act effectively and did so in practice. There were no new issues arising from the review, which was presented to the committee on 21 June 2012.

2.4.9 The Head of Internal Audit is a member of the Corporate Governance Group, which is charged with the compilation of the annual governance statement and improvement plan. As part of standard internal audit work, the corporate governance framework was also reviewed against the CIPFA/Solace Good Governance Framework and the addendum to the framework and revised guidance note issued in 2012. There were no fundamental weaknesses or exceptions to report. One area for improvement or development is included in the 2013 Annual Governance Statement.

Internal Audit

2.4.10 The Accounts and Audit Regulations 2011 state that each local authority "must, at least once in each year, conduct a review of the effectiveness of its internal audit". The regulations go on to state that the findings of this review should be considered by a committee of the relevant body as part of the wider consideration of the Council's system of internal control.

2.4.11 The guidance relating to the assessment of internal audit allows for different methods of review. The expected understanding is that reviews of internal audit by external audit will take place triennially. In other years the spirit of the regulations points to an independent review conducted externally where

possible. However, this needs to be balanced against the practicalities either in terms of cost or the resources required to undertake a reciprocal external review each year.

2.4.12 From the 1 April 2013 'Public Sector Internal Audit Standards' (PSIAS) replaced the 'Code of Practice for Internal Audit in Local Government' as the mandatory standards for all principal local authorities subject to the Accounts and Audit Regulations 2011. However, this year's review of the effectiveness of internal audit continued to use the 2006 CIPFA checklist, which remains a useful tool for assessing the effectiveness of internal audit. This is the last year that this checklist will be used.

2.4.13 The Head of Internal Audit has assessed the effectiveness of Internal Audit using the recommended CIPFA Code of Practice checklist and no significant issues have been identified. A separate detailed report concerning this exercise forms part of the Committee's agenda. There were no exceptions of consequence to report.

Internal Control

2.4.14 The Accounts and Audit Regulations 2011 require local authorities to conduct a review at least once in a year of the effectiveness of its system of internal control. This section of the report provides an opportunity for the Committee to consider the work of Internal Audit and whether the outcomes provide evidence of a satisfactory level of internal control within the organisation.

2.4.15 During the financial year 2012-13 nineteen reports were issued including two that were substantially completed at year-end. All have been accepted by management and in all cases action plans are now in place. The agreed reports and action plans are available to view via the Audit Work page on the Intranet.

2.4.16 We categorise recommendations arising from audit work as high, medium or low priority. High indicates a significant control weakness that may lead to material loss, exposure to fraud or failure to meet regulatory requirements. Medium suggests a less important vulnerability not fundamental to system integrity. Low priorities relate to good practice improvements or enhancements to procedures that merit management attention.

2.4.17 We also measure the overall level of assurance based on the adequacy and effectiveness of internal control in a system on a five-point scale. Table One sets out the assurance levels and definitions as follows:

Table One: Levels of Assurance

Level		Definition
5	Full Assurance	There is a sound system of control designed to achieve the system objectives and manage the risks to achieving those objectives
4	Substantial Assurance	While there is basically a sound system of control, there are some minor weaknesses, which put some of the system objectives at risk
3	Moderate Assurance	While there is on the whole a sound system of control, there are some more significant weaknesses that may put some of the system objectives at risk
2	Limited Assurance	There are significant/serious weaknesses in key areas in the systems of control that put the system objectives at risk
1	No Assurance	The control framework is generally weak leaving the system open to significant error or abuse

2.4.18 Table Two shows the category of recommendations identified for each audit completed, together with the level of assurance for the system reviewed.

Table Two: Reports, Risk & Assurance

Audit Area	High Risks	Medium Risks	Low Risks	Assurance Level
Disabled Facilities Grants[1]	1	5	4	Moderate
FMS - Fuel & Payments[1]	-	4	10	Moderate
FMS - Fuel & Payments (Finance) [1/2]	-	2	-	-
Post Opening[1]	-	1	4	Substantial
FMS Cash Handling	-	10	1	Limited
Fraud Awareness	-	2	3	Substantial
Fraud Awareness (HR) [2]	-	-	1	-
Purchasing	-	5	3	Substantial
Procurement	1	3	7	Moderate
Creditors	-	2	4	Substantial
Housing Benefits	-	1	3	Substantial
Sundry Debtors	-	4	6	Substantial
Localised Support for CTax (Project Man)	-	5	5	Substantial
Localised Support for CTax (Consultation)	-	-	-	Full
Localised Support for CTax (Collection)	-	1	-	Substantial
Data Protection	-	12	8	Moderate
Data Protection (IT) [2]	-	1	1	-
Risk Management[3]	-	4	3	Substantial
Licensing[3]	2	6	4	Moderate
Total	**4**	**68**	**67**	

[1] Reviews from 2011/12 finalised in 2012/13
[2] Additional/Subsidiary action plan
[3] Finalised after year-end

2.4.19 Table Three shows both the average and main system assurance scores for those systems reviewed by Internal Audit over the last five years and the average for the same period:

Table Three: Assurance Ratings

Audit Area	2008/09	2009/10	2010/11	2011/12	2012/13	5 Year Average
All Reviews Average	3.1	3.5	3.3	3.7	**3.8**	**3.5**
Main Financial Systems:	3.4	3.8	4.2	4.2	**4.4**	**4.0**
Business Rates	*3.8*	*	*4.5*	*	~	*4.2*
Cash Collection	*3.5*	*3.8*	*3.8*	*3.8*	*	*3.7*
Council Tax	*3.8*	*4.0*	*	~	*4.5*	*4.1*
Creditors	*2.9*	*4.0*	*4.4*	*	*4.4*	*3.9*
Housing Benefits	*4.1*	*	*4.0*	*	*4.4*	*4.2*
Main Accounting	*3.5*	*3.5*	*	*4.3*	*	*3.8*
Payroll	*3.0*	*3.4*	*3.6*	*	*	*3.3*
Sundry Debtors	*3.3*	*4.0*	*4.6*	*	*4.3*	*4.1*
Treasury Management	*2.4*	*4.2*	*	*4.6*	*	*3.7*

* Not Undertaken
~ Reviewed via FCAT

2.4.20 For those systems reviewed during the year the average assurance score on the scale of 1 to 5 was 3.8. Main financial systems had a better average score of 4.4. The 'All Reviews' figure shows a further slight improvement compared to last year and is the highest average assurance score achieved in the five year period. The figure for 'Main Financial Systems' also represents the highest average score achieved.

2.4.21 Both the 'All Reviews' and 'Main Financial Systems' scores equate to substantial assurance. Taken together they indicate that overall there is a basically sound framework of control in place but some weaknesses may put certain system objectives at risk.

2.4.22 There were four important internal control weaknesses brought to the attention of management during the year and two brought forward from 2011/12. Five of these risks have been addressed in full. One action from the previous year in relation to car parking was reported as satisfied by internal audit but re-instated as outstanding by the Audit Committee.

2.4.23 Table Four sets out the issues, the responsible Directors and the current position or date for resolution.

Table Four: High Priority Risks Identified

	Risk	Director	Resolution Date
Previous Years' Risks			
1	Annual system upgrades and bug fixes were not carried out as required by contract terms	Resources	Completed
2	Arrangements for penalty notice administration will be reviewed and updated in a signed contract and retained	Development	Outstanding[1] Mar/Jun12
2012/13 Risks			
3	Two quotations from suitable contractors will be sought for housing grant work, except in the case of stair lift installations	Development	Completed
4	The link between the Fylde Council contract opportunities page and the Chest navigation page will be restored	Resources	Completed
5	Licensing - confidential item (charges)	Development	Completed[2]
6	Licensing - confidential item (safeguarding)	Development	Completed[2]

[1] Reported as satisfactorily implemented by IA but re-instated as outstanding by Audit Committee
[2] Completed during 2013/14 in accordance with agreed action plan

2.4.24 The present position in summary based on managers' advice and evidence available is as follows:

- One action has not been completed - number 2. The committee requested that the responsible manager should attend the next meeting of the Audit Committee to explain the reasons
- Five risks have been addressed in full - numbers 1, 3, 4, 5, 6

Follow Up

2.4.25 Follow-up reviews are performed to appraise management of post audit actions and provide assurance that audit recommendations have been implemented. Fifteen follow-up reviews were completed during the year. Table Five shows the total number of agreed recommendations that were implemented by managers.

Table Five: Agreed Recommendations Implemented

Audit Area	Recommendations

	Total Agreed	Number Implemented	% Implemented
Previous Years' Reports			
Main Accounting	2	2	100%
Penetration Testing	1	1	100%
FMS Fuel & Payments (Finance)	2	2	100%
Post Opening	5	5	100%
Cheque Receipting	1	1	100%
Risk Management	12	12	100%
Cash Collection (Remote)	3	3	100%
Fraud Awareness (HR)	1	1	100%
Treasury Management	2	2	100%
Cheque Production (Main)	9	7	78%
Cemetery/Crematorium	8	6	75%
Car Parking	20	17	85%
Purchasing[1]	8	8	100%
2012-13 Reports			
Localised Support for CTax (Project Man)	10	10	100%
Housing & Council Tax Benefits	5	5	100%
Total	89	82	92%

[1] Finalised after year-end

2.4.26 The overall implementation rate for all reports followed up in 2012/13 is 92.1% compared to last year's figure of 84.4%. This year's outcome is above the target of 90%.

2.4.27 In addition to the overall rate, the percentage of high and medium priority recommendations implemented is also measured. Table Six shows the total number of agreed high and medium recommendations that were implemented by managers. Those follow up reviews where no high or medium recommendations were made have been omitted from the table.

Table Six: High & Medium Recommendations Implemented

Audit Area	High Priority		Medium Priority		%
	Yes	No	Yes	No	Implemented
Previous Years' Reports					
Main Accounting	-	-	1	-	100%
FMS Fuel & Payments (Finance)	-	-	2	-	100%
Post Opening	-	-	1	-	100%
Cheque Receipting	-	-	1	-	100%
Risk Management	-	-	8	-	100%
Cash Collection (Remote)	-	-	2	-	100%
Treasury Management	-	-	2	-	100%
Cheque Production (Main)	1	-	3	1	80%
Cemetery/Crematorium	-	-	4	-	100%
Car Parking	2	1[1]	10	2	80%
Purchasing	-	-	6	-	100%
2012-13 Reports					
Housing & Council Tax Benefits	-	-	1	-	80%

Total	3	1	41	3	92%

[1] Reported as satisfactorily implemented by IA but re-instated as outstanding by Audit Committee

2.4.28 The classification of recommendations as 'high', 'medium' or 'low' priority indicates where resources might best be applied. The percentage of high and medium priority recommendations implemented in 2012/13 was 91.7% compared to last year's 84.3%. This result is a significant improvement on last year but still some way below the target of 95%.

2.4.29 Table Seven shows both the overall and 'high/medium' priority implementation rates for those reviews followed up by Internal Audit over the last five years and the average for the same period:

Table Seven: Annual Implementation Rates

Category	2008/09	2009/10	2010/11	2011/12	2012/13	Average
Overall Implementation %	78.5	92.0	94.9	84.4	92.1	88.4
High/Medium Implementation %	75.4	93.3	93.1	84.3	91.7	87.6

2.4.30 The rates of implementation by managers have recovered considerably following last year's decline but have not quite achieved the highest levels of 2010/11. For 2012/13 the annual overall rate of implementation was the second highest achieved, while the percentage of high and medium priority recommendations implemented ranked at the mid-point for the five year period. Both were above the five-year average score.

3 Other Internal Audit Work

3.1 Special Investigations and Counter Fraud Work

Investigations

3.1.1 During the year the audit team commenced three special investigations into allegations of fraud and corruption:

- One arose as a result of concerns expressed by a councillor but the investigation found no evidence to substantiate them. The responsible Director was made aware of the outcome.
- The second investigation was prompted by an unexplained cash discrepancy. The investigation was successfully concluded and the missing cash recovered from a third party. There was no malpractice by any member of the Council's staff.
- An employee's whistleblowing was the cause of the third investigation, which is still ongoing,

3.1.2 Table Eight summarises the results of the various special investigations during April to December compared with the outturn for previous years.

Table Eight: Results of Fraud Investigations

Outcome	2008-09	2009-10	2010-11	2011-12	2012-13
Disciplinary action	3	-	-	1	-
Employee Resigned prior to conclusion	-	-	-	-	-
Third party restitution	-	-	-	-	1
No evidence to support allegation	-	1	-	-	1
Inconclusive evidence	-	-	-	-	-

Investigation aborted	-	-	1	1	-
Investigation Ongoing	-	-	-	-	1
Total	3	1	1	2	3

3.1.3 Some 14 days were taken up dealing with reactive fraud work the year. The fact that the incidence of reported fraud remains at such a relatively low level suggests good standards of probity among Council employees, reinforced by the Council's zero tolerance commitment to fraud and corruption.

National Fraud Initiative

3.1.4 The Head of Internal Audit has acted as key contact for the National Fraud Initiative data matching exercise; nominating data download contacts and co-ordinating the production of housing benefit, payroll, council tax, creditor and licensing information for a data matching exercise.

3.1.5 The live data was extracted from the participant systems in accordance with the data specifications and uploaded to the NFI web application. The 2012/13 exercise matches are currently under investigation. Savings generated from the previous exercise totalled £53,000 most of which will be ongoing in future years.

Benefit Fraud

3.1.6 The Head of Internal Audit is responsible for overseeing the delivery of the benefit fraud service provided by Preston City Council. The shared benefit fraud service continued to deliver very good results in 2012-13. Fraudulent overpayments of £213,896 were discovered, significantly exceeding the target. The service also delivered 40 sanctions including 12 prosecutions, which was also above the agreed target.

Counter Fraud Work

3.1.7 In addition to the above, internal audit has undertaken the following counter fraud work, which is not an exhaustive list:

- developed a Post Opening/Cheque Handling Protocol to regulate internal procedures following incremental organisational changes
- reported on the 'fraud awareness' survey of employees, which showed high levels of knowledge and confidence in the Council's counter fraud arrangements providing substantial assurance
- prepared and submitted data and statistics to the National Fraud Survey 2012 of over 450 public sector bodies about a wide range of fraud and corruption issues, which seeks to asses the incidence of fraud and the effectiveness of responses to it
- performed a 'fitness for purpose' check and comprehensive refresh of the Council's Anti-fraud & Corruption, Whistleblowing, Money Laundering and Sanction & Prosecution policies
- prepared press releases highlighting benefit fraud prosecutions
- prepared articles for Grapevine highlighting whistleblowing and ethical conduct

3.2 Projects, Consultancy and Advice

3.2.1 This section summarises the range of services, beyond internal audit's assurance role. Such work is often requested by senior managers, rather than forming part of the risk-based audit function. Commonly, tasks will involve problem-solving issues as an aid to management for the enhancement of their service. The nature and scope of the work may include participation in projects, facilitation, process design, training, and advisory services, but this list is not exhaustive.

3.2.2 During the year internal audit has undertaken project work, provided advice or acted in a consultancy capacity in the following areas, which is not an exhaustive list:

- Corporate Governance - as part of the governance framework the Head of Internal Audit is a member of the Corporate Governance Group, which leads on the production of the Annual Governance Statement and the monitoring of the Corporate Governance Improvement Plan.
- Lowther Trust - commenced a review of governance arrangements to help ensure transparency and accountability
- Strategic Risk Management - jointly led the annual exercise to identify strategic risks facing the Council, set the corporate risk appetite and devise action plans to manage unacceptable risks. This work involved interviewing members of Management Team and senior councillors and facilitating a risk management day along with the Risk & Emergency Planning Officer.
- Responded to three Freedom of Information requests each of them concerned with the incidence of fraud and related statistics

4 Performance of Internal Audit

4.1 Internal Audit Plan

4.1.1 A risk assessed annual audit plan was prepared for 2012-13 based on the resources available. The plan was agreed by the Management Team and received approval from the Audit Committee. The total number of days in the plan was 655, not including time for things such as holidays, sickness and training.

4.1.2 In the event the outturn figure was 688 days, an increase of 33 days as a result of the low sickness rate for the audit team and less training days used than was envisaged. The results are set out in Table Nine.

Table Nine: Internal audit plan

Audit Activity	Plan days	% of total	Actual days	% of total
Main Financial systems	129	19.7	146	21.2
Planned Reviews	121	18.5	88	12.8
Corporate Governance	32	4.9	28	4.1
Computer audit*	37	5.7	20	2.9
Anti-fraud audit	21	3.2	10	1.5
Other audit	16	2.4	20	2.9
Reactive audit	50	7.6	54	7.9
Communication & Consultancy	46	7.0	58	8.4
Management & Admin	169	25.8	200	29.0
Non-Audit Work	34	5.2	64	9.3
Total	655	100%	688	100%

* Does not include bought-in days

4.1.3 The analysis of outturn days shows that rather more time was spent on main financial systems than was originally planned. This was largely caused by increased time spent on one of the audits undertaken – Housing and Council Tax Benefits, undertaken jointly with Blackpool internal audit team. There were several separate pieces of work related to benefits and one of these, a review of the project to introduce the new regime of localised Council Tax support, overran quite significantly. The time allowed for this one-off audit was a 'best estimate' that was ultimately inadequate for the work that was required. A second area that showed a substantial increase in days used was the Management & Administration category. In part this increase was caused by the unplanned but necessary work required to be undertaken with Fylde audit staff in advance of the proposed shared internal audit service with Blackpool Council. The increase in Non-Audit work was attributable partly to three unplanned office relocations for the audit team.

4.1.14 There were three main areas where actual days totalled significantly less than originally anticipated – planned reviews, computer audit and anti-fraud work. Less days were spent on the Planned Reviews mainly because the intended audit of Vehicle and Plant was not commenced but rolled forward into 2013/14. Three other reviews were not completed at 31 March but all will be concluded in the first quarter of this year. Possible changes to the delivery of the IT service resulted in the postponement of one of the planned computer audits, which now forms part of this year's plan. In terms of anti-fraud work, an allowance for the National Fraud Initiative was not fully required since most of the analysis work for the 2012/13 data extraction will take place in the 2013/14 year.

4.1.5 The percentage of the 2012/13 audit plan completed at 31 March was 88.4%, a little below the 90% target for the year. However, taking into account the completion of ongoing audit work slipped into 2013/14 the annual rate at 31 May stood at 90.4% and further slippage work is currently ongoing, anticipating a final outturn of 94.7%.

4.2 Client Satisfaction

4.2.1 All audit reports issued include a client feedback questionnaire for the auditee to give their views on the different aspects of the audit. The overall satisfaction rate was 91% just above the 90% target. Table Ten sets out the questions and the responses received.

Table Ten: Summary of Client Feedback Questionnaires

Question	Average Score	Excellent %	Good %	Satis %	Fair %	Poor %
Audit review covered key control risks	91	88	12	-	-	-
Review was carried out in a timely and efficient manner	93	88	12	-	-	-
Auditors were polite, positive and professional	92	89	11	-	-	-
Involvement of auditee in the process was appropriate	90	78	22	-	-	-
Well structured and clear audit reporting	90	78	22	-	-	-
Findings and recommendations were accurate and useful	89	78	22	-	-	-
Review provided assurance or resulted in beneficial change	90	78	22	-	-	-
Average	91	82	18	-	-	-

4.3 Performance Indicators

4.3.1 In 2009 an exercise was carried out to canvass the views of stakeholders about developing a suite of performance indicators for internal audit. Subsequently the Audit Committee adopted the seven indicators that had received the highest usefulness rating from stakeholders and established targets for achievement. Table Eleven sets out the targets for 2012/13, together with the actuals for the two most recent years.

Table Eleven: Performance Indicators for Internal Audit

Performance Indicator	Target	Actuals 2011/12	Actuals 2012/13
IA1 % of audit plan completed	90%	95.3%	90.4%
IA2 % satisfaction rating indicated by post-audit surveys	90%	90.8%	90.7%
IA3 % of audit recommendations agreed with management	95%	100%	100%
IA4 % of agreed actions implemented by management	90%	84.4%	92.1%

IA5 % of 'High Priority' actions implemented by management	100%	100%	75.0%[1]
IA6 % of 'High/Medium Priority' actions implemented by management	95%	84.3%	91.7%
IA7 % of recommendations implemented at initial follow up	75%	52.1%	77.5%

[1] Reported as satisfactorily implemented by IA but re-instated as outstanding by Audit Committee

4.3.3 The fist two performance indicators reflect specifically on the work and service of the internal audit team. The remaining indicators relate to the effectiveness of the audit service as a result of management's action or inaction.

Risk Assessment

This item is for information only and makes no active recommendations. Therefore there are no risks to address

Report Author	Tel	Date	Doc ID
Savile Sykes	(01253) 658413	27/06/13	

List of Background Papers		
Name of document	Date	Where available for inspection
Audit Plan 2012-13 Audit reports & documents	March 2012 Various	Internal Audit Office by arrangement

IMPLICATIONS	
Finance	The Accounts and Audit Regulations 2011 require the Council to ensure that its financial management is adequate and effective and that it has a sound system of internal control which facilitates the effective exercise of its functions and which includes arrangements for the management of risk. There is a statutory requirement for the Council to undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control (Accounts and Audit Regulations 2011) A number of audit projects carried out in 2012/13 related to finance, resource or property
Legal	The report also contributes towards the production of the Annual Governance Statement published each year by the Council. Effective audit and risk management enhance good governance and probity of Council action

Community Safety	None arising directly from this report
Human Rights and Equalities	None arising directly from this report
Sustainability and Environmental Impact	None arising directly from this report
Health & Safety and Risk Management	Internal audit work covers key areas of risk and should therefore strengthen the internal control framework. The Annual Internal Audit report arises from that work and is an important element of the assurance process for the effectiveness of the Council's systems of internal control.

REPORT

REPORT OF	MEETING	DATE	ITEM NO
HEAD OF AUDIT	AUDIT COMMITTEE	27 JUNE 2013	7

EFFECTIVENESS OF THE AUDIT COMMITTEE

Public Item

This item is for consideration in the public part of the meeting.

Summary

The report presents the findings of a self assessment exercise undertaken by the Head of Internal Audit in conjunction with the Chair and Vice Chair of the Committee in relation to the effectiveness of the Audit Committee. The self assessment compared existing arrangements with those advocated by the Chartered Institute of Public Finance and Accountancy (CIPFA) in their published advice.

Recommendations

1. The Committee agrees the findings of the self assessment of the effectiveness of the Audit Committee against the checklist provided by the CIPFA better governance forum in their publication 'A Toolkit for Local Authority Audit Committees' undertaken by the Chair and Vice Chair of the Committee.

Cabinet Portfolio

The item falls within the following executive portfolio[s]:
Finance & Resources (Councillor Karen Buckley)

Summary of previous decisions

There have been no previous decisions regarding this report.

Continued....

Report

1. The Audit Committee forms a part of the corporate governance and internal control framework that provides accountability to stakeholders on all areas of corporate activity. The effectiveness of the Council's Audit Committee forms part of the evidence used in preparing the Annual Governance Statement for 2013.

2. An effective audit committee helps to raise the profile of internal control, risk management and financial reporting within the Council, as well as providing a forum for the discussion of issues raised by both internal and external auditors. It also enhances public trust and confidence in the financial governance of the Council.

3. Best practice guidance set out by CIPFA in its toolkit for Local Authority Audit Committees, recommends that committees periodically review their own effectiveness in discharging their responsibilities. The guidance incorporates an effectiveness self-assessment checklist to permit benchmarking against good practice.

4. The Head of Internal Audit in conjunction with the Chair and Vice Chair of the Audit Committee carried out the self-assessment review against the checklist. The review will be re-performed annually to ensure the effectiveness of the committee is maintained.

5. The main conclusion that can be drawn from the self assessment is that the Audit Committee has the framework in place to act effectively and does so in practice.

6. There were two areas where partial divergence from the standard was noted. Both of these related to the independence of members in carrying out their functions as members of the Audit Committee.

7. Best practice guidance suggests that in order to preserve independence the Chair of the Audit Committee should not be a member of the Executive or be involved in the scrutiny function. Currently the Chair of Audit Committee is free of executive functions but serves on the Community Focus Scrutiny Committee although not as a Chair/Vice. This was not thought to impact seriously on the independence of the Chair.

8. In the case of other members of the Audit Committee, guidance suggests that none should be members of the Executive and ideally should be independent of other committees. Presently two members act as Vice Chairs of scrutiny committees, one is Chair of a regulatory committee and one is Vice Chair of a regulatory committee. However, there was no evidence that the independence of the Audit Committee was undermined.

9. The self assessment checklist is attached as an Appendix to this report.

Risk Assessment

This item is for information only and makes no active recommendations. Therefore there are no risks to address

Report Author	Tel	Date	Doc ID
Savile Sykes	(01253) 658413	27/06/2013	

List of Background Papers		
Name of document	Date	Where available for inspection
A Toolkit for Local Authority Audit Committees (CIPFA)		All background papers or copies can be obtained from Savile Sykes, Head of Internal Audit on 658413 or email saviles@fylde.gov.uk

IMPLICATIONS	
Finance	This will enhance good governance and probity
Legal	None arising directly from the report
Community Safety	None arising directly from the report
Human Rights and Equalities	None arising directly from the report
Sustainability and Environmental Impact	None arising directly from the report
Health & Safety and Risk Management	In completing a review of this nature the Council is compliant with best practice and the exercise demonstrates the effectiveness of the Audit Committee and forms part of the consideration of the system of internal control

Attached documents

1. Audit Committee Checklist.

AUDIT COMMITTEE – SELF ASSESSMENT CHECKLIST 2013 **Appendix 1**

ISSUE	SATISFIED YES	SATISFIED PARTLY	SATISFIED NO	Comments
Terms of Reference				
Have the committee's terms of reference been approved by full Council?	✓			The latest terms of reference for Audit Committee were confirmed by Council on 30th July 2012. They are reviewed and updated where necessary on an annual basis.
Do the terms of reference follow the CIPFA model?	✓			The Statement of Purpose and the full Terms of Reference recommended by CIPFA have been adopted in full.
Internal Audit Process				
Does the committee approve the strategic audit approach and the annual programme of work?	✓			Audit Committee approves the internal audit strategy and also receives the annual Internal Audit plan for comment and approval.
Is the work of internal audit reviewed regularly?	✓			Reports concerning the work of Internal Audit are presented to the Audit Committee by the Head of Audit twice yearly. The Audit Committee is provided with the percentage of agreed recommendations implemented both for each individual audit review and overall for the year in the annual report of the Head of Internal Audit. The Audit Committee has been proactive in seeking to increase the proportion of agreed recommendations implemented. The annual review of the effectiveness of the system of Internal Audit is also presented to the Audit Committee.
Are summaries of quality questionnaires from service managers reviewed?	✓			An analysis of the customer feedback survey forms is provided to Audit Committee as part of the Head of Internal Audit's annual report.
Is the annual report, from the Head of Audit, presented to the committee?	✓			The Annual report of the Head of Internal Audit is presented to the Audit Committee annually at the June meeting.

ISSUE	SATISFIED YES	SATISFIED PARTLY	SATISFIED NO	Comments
External Audit Process				
Are the reports on the work of external audit and other inspection agencies presented to the committee?	✓			Progress reports on the work of external audit are received by the Audit Committee. Other inspection agencies reports are reported to Audit Committee as appropriate.
Does the committee input into the external audit programme?	✓			The external audit programme is presented to the Audit Committee for information and comment. The Audit Committee does have the opportunity to suggest areas that they consider could be reviewed.
Does the committee ensure that officers are acting on and monitoring action taken to implement external audit recommendations?	✓			All external audit recommendations are formulated into action plans with responsible officers named and target implementation dates established. Progress against the action plans is monitored by the Audit Committee on a regular basis. The Committee can require any officers to attend to explain non-implementation of external audit actions.
Governance, Risk, Fraud				
Does the committee take a role in overseeing:				
◆ the annual governance statement	✓			The Audit Committee receives the Annual Governance Statement annually for comment and approval. Progress in implementing any resulting action plan of improvements is monitored by the Audit Committee periodically.
◆ risk management strategies	✓			The Risk Management Strategy is approved by the Audit Committee and the Strategic Risk Action Plans are presented to the committee annually for comment and approval. Progress against the action plans is monitored by Audit Committee on a regular basis.

ISSUE	SATISFIED YES	SATISFIED PARTLY	SATISFIED NO	Comments
Governance, Risk, Fraud				
Does the committee take a role in overseeing:				
◆ anti-fraud arrangements	✓			The Audit Committee approves the Anti-Fraud and Corruption strategy, and receives information on the outcomes of all fraud investigation work in the annual report of the Head of Internal Audit. There is an annual review and refresh of all anti-fraud policies which is reported to and approved by the Audit Committee.
◆ whistleblowing policy	✓			The Whistleblowing Policy is approved by the Audit Committee. The policy forms part of the annual review and refresh of anti-fraud policies that comes before the committee for approval.
Membership				
Has the membership of the committee been formally agreed and a quorum set?	✓			Audit Committee Terms of Reference have been approved by the Council. The quorum of Committees established in the Constitution is one-quarter of the whole number of the members of that Committee provided that the quorum is not less than 3 members. The quorum of the Audit Committee would therefore be 3.
Is the Chair free of executive or scrutiny functions?		✓		The Chair of Audit Committee is free of executive functions but serves on the Community Focus Scrutiny Committee although not as a Chair/Vice. The independence of the Chair was not thought to be compromised.

ISSUE	SATISFIED			Comments
	YES	PARTLY	NO	
Are members sufficiently independent of the other key committees of the Council?		✓		In the main yes but two Members act as Vice Chairs of scrutiny committees (Coun. Akeroyd & Coun. L Davies), one is Chair of a regulatory committee (Coun. B Aitken) and one is Vice Chair of a regulatory committee (Coun. Ackers). The independence of the Audit Committee was not thought to be compromised.
Have all members' skills and experiences been assessed and training given for identified gaps?	✓			The Council has in place a comprehensive elected member driven training and development programme. Fundamental to this is an embedded Strategy and PDP process. This help shapes both individual and corporate needs resulting in an on going tailored learning programme. In relation to Audit Committee members, the CIPFA document states that "to be effective, the members of an audit committee will require certain skills". These are listed as: a broad understanding of the financial, risk and control, and corporate governance issues facing local authorities generally and the council specifically. For new members of the Audit Committee specific training in advance of their first meeting is arranged based on the above skills to address the main potential gaps. (Specific training for the Audit Committee is considered below)
Can the committee access other committees as necessary?	✓			The Audit Committee is a committee of the Council and can access other Committees as necessary and appropriate.
Meetings				
Does the committee meet regularly?	✓			The Audit Committee meets at least four times a year in accordance with the committee's terms of reference, but in both 2012-13 and 2011-12 the committee actually on five occasions.

ISSUE	SATISFIED			Comments
	YES	PARTLY	NO	
Are separate, private meetings held with the external auditor and the internal auditor?	✓			Private meetings with external audit do not happen as a matter of course but if such meetings were required they could be arranged. Private meetings between the Chair and Vice Chair of the Audit Committee and the Head of Internal Audit occur a couple of times annually, once for the purpose of identifying strategic risks and once for the completion of the annual review of Audit Committee effectiveness. Other private meetings have taken place occasionally following committee briefings. In reality, the Chair of the Audit Committee or any member can meet with the Head of Internal Audit at any time.
Are meetings free and open without political influences being displayed?	✓			Yes – thorough discussion of items takes place without undue political influences being displayed.
Are decisions reached promptly?	✓			Decisions are reached promptly at each meeting.
Are agenda papers circulated in advance of meetings to allow adequate preparation by members?	✓			Agenda papers are circulated well in advance and are also available on the internet.
Does the committee have the benefit of appropriate officers at its meetings?	✓			The Section 151 Officer/Deputy, the Monitoring Officer and the Head of Internal Audit are regular attendees. Directors and other officers attend as required. Representatives of KPMG, the Council's external auditors also attend as necessary.

ISSUE	SATISFIED YES	SATISFIED PARTLY	SATISFIED NO	Comments
Training				
Is induction training provided to members?	✓			Yes – all new members receive corporate induction training. In terms of the Audit Committee new members of the committee will be offered specific relevant induction training.
Is more advanced training available as required?	✓			More specific training for the Audit Committee is regularly offered with sessions on the role of external audit, internal audit and the Audit Committee. Other training has been provided on Corporate Governance, Risk Management and the International Financial Reporting Standards.
Administration				
Does the authority's s151 officer or deputy attend all meetings?	✓			In 2012-13 five meetings of the Audit Committee took place. The Section 151 Officer or Deputy Section 151 Officer attended all of them.
Are the key officers available to support the committee?	✓			Yes – key officers are available to support the Committee with suitable administrative arrangements also in place.

REPORT

REPORT OF	MEETING	DATE	ITEM NO
INTERNAL AUDIT	AUDIT COMMITTEE	27 JUNE 2013	8

EFFECTIVENESS OF INTERNAL AUDIT

Public Item

This item is for consideration in the public part of the meeting.

Summary

The internal audit function is considered to be a key indicator in providing assurance on internal control. A review of internal audit effectiveness is required as part of satisfying the overall governance arrangements in local authorities and supports the Council's Annual Governance Statement. The report presents the findings of a self assessment exercise in relation to the effectiveness of internal audit.

Recommendations

1. The Committee notes the findings of the review on the effectiveness of internal audit and confirms the conclusion that the Council has an effective internal audit service.

Cabinet Portfolio

Finance & Resources Councillor Karen Buckley

Summary of previous decisions

There have been no previous decisions regarding this report.

Continued....

Report

1 Introduction

1.1 The Accounts and Audit Regulations 2011 state that each local authority, "must at least once a year, to conduct a review of the effectiveness of its system of internal audit". The regulations require that the findings of this review should be considered by a committee of the relevant body as part of the wider consideration of the Council's system of internal control

1.2 The purpose behind this is to ensure that the opinion in the annual audit report issued by the Head of Internal Audit can be relied upon as a key source of evidence in the Annual Governance Statement.

1.3 From the 1 April 2013 'Public Sector Internal Audit Standards' (PSIAS) replaced the 'Code of Practice for Internal Audit in Local Government' as the mandatory standards for all principal local authorities subject to the Accounts and Audit Regulations 2011. However, this year's review of the effectiveness of internal audit continues to use the 2006 CIPFA checklist, which remains a useful tool for assessing the effectiveness of internal audit. This is the last year that this checklist will be used

2 Findings of the Current Review of Internal Audit Effectiveness

2.1 The CIPFA Code of Practice for Internal Audit checklist contains 104 standards within 11 principles (Appendix A). It was completed by the Head of Internal Audit, indicating almost full compliance with the Code with 100 of the standards fully achieved.

2.2 There were three cases where "Partial" compliance was given. Caveats explaining the relevant circumstances have been provided and the areas concerned were not considered to materially detract from the effectiveness of the system of Internal Audit in the Council. Not all areas had to be ticked as "yes" to be rated as compliant with the Code.

2.3 There was one instance where the standard was not achieved. This standard requires that the Head of Internal Audit should be managed by a member of the corporate management team. The Internal Audit function forms part of the Governance Team managed by the Head of Governance. During 2012 the Head of Governance ceased to be a member of the corporate management team. However, the Head of Internal Audit reports on audit matters directly to a level within the Council that demonstrates both that internal audit is able to fulfil its responsibilities and that the organisational independence of internal audit is not compromised.

Risk Assessment

This item is for information only

Report Author	Tel	Date	Doc ID
Savile Sykes	(01253) 658413	Date of report	

List of Background Papers		
Name of document	Date	Where available for inspection
◆ The Accounts and Audit Regulations ◆ CIPFA Code of Practice for Internal Audit in Local Government (including effectiveness checklist)	2011 2006	All background papers or copies can be obtained from Savile Sykes – Head of Internal Audit on 01253 658413 or e-mail saviles@fylde.gov.uk

IMPLICATIONS	
Finance	The Accounts and Audit Regulations 2011 require the Council to ensure that its financial management is adequate and effective and that it has a sound system of internal control which facilitates the effective exercise of its functions and which includes arrangements for the management of risk. The report also contributes towards the production of the Annual Governance Statement which forms part of the Financial Statements of the Annual Accounts published each year by the Council.
Legal	No specific implications
Community Safety	No specific implications
Human Rights and Equalities	No specific implications
Sustainability and Environmental Impact	No specific implications
Health & Safety and Risk Management	Internal audit work covers key areas of risk and should therefore strengthen the internal control framework. This report reviews the effectiveness of internal audit's contribution.

Attached documents

1. Appendix - CIPFA Code of Practice for Internal Audit compliance checklist

Appendix 1

REVIEW OF THE EFFECTIVENESS OF INTERNAL AUDIT – JUNE 2013

Ref	Adherence to Standard	Y	P	N	Evidence
1	**Scope of Internal Audit**				
1.1	**Terms of Reference**				
1.1.1	Do terms of reference: (a) establish the responsibilities and objectives of Internal Audit? (b) establish the organisational independence of Internal Audit? (c) establish the accountability, reporting lines and relationships between the Head of Internal Audit (HIA) and: (i) those charged with governance? (ii) those parties to whom the Head of Internal Audit may report? (d) recognise that Internal Audit's remit extends to the entire control environment of the organisation? (e) identify Internal Audit's contribution to the review of the effectiveness of the control environment? (f) require and enable the Head of Internal Audit to deliver an annual audit opinion? (g) define the role of Internal Audit in any fraud-related or consultancy work (see also 1.3.2)? (h) explain how Internal Audit's resource requirements will be assessed? (i) establish Internal Audit's right of access to all records, assets, personnel and premises, including those of partner organisations, and its authority to obtain such information and explanations as it considers necessary to fulfil its responsibilities?	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓			Included in Financial Regulations and IA Terms of Reference
1.1.2	Does the Head of Internal Audit advise the organisation on the content and the need for subsequent review of the terms of reference?	✓			HIA advises the Audit Committee on any changes required to the terms of reference
1.1.3	Have the terms of reference been formally approved by the organisation?	✓			The most recent version of the Internal Audit Terms of Reference were adopted in September 2010 by the Audit Committee and refreshed annually.
1.1.4	Are the terms of reference regularly reviewed?	✓			Reviewed on an annual basis

1.2	**Scope of Work**				
1.2.1	Are the organisation's assurance, risk management arrangements and monitoring mechanisms taken into account when determining Internal Audit's work and where effort should be concentrated?	✓			Audit plan developed on a risk basis and conducts its own risk assessment. Account is taken of the Council's Strategic Risk Register but Operational Risk Registers are not yet fully reliable.
1.2.2	Where services are provided in partnership has the Head of Internal Audit identified: (a) how assurance will be sought? (b) Agreed access rights where appropriate?	n/a			Internal audit services provided by in-house team
1.3	**Other Work**				
1.3.1	Where Internal Audit undertakes consultancy and/or fraud and corruption work, does it have the: (a) skills, and (b) resources to do this?	✓ ✓			Internal audit has extensive experience in the area of fraud both proactively in terms of prevention and publicity and reactively in terms of investigation. Advice on a range of topics has been provided to management in a consultancy-style capacity. A contingency provision for reactive fraud and consultancy is allowed for in the annual plan
1.3.2	Do the terms of reference define Internal Audit's role in: (a) fraud and corruption? (b) consultancy work?	✓			The terms of reference cover both points
1.4	**Fraud and Corruption**				
1.4.1	Has the Head of Internal Audit made arrangements, within the organisation's anti-fraud and anti-corruption policies, to be notified of all suspected or detected fraud, corruption or impropriety?	✓			The Anti-fraud & corruption Policy & Strategy and the Whistleblowing Policy are on the Intranet and contain guidance on notifying internal audit of suspected fraud, corruption of impropriety.

2	**Independence**				
2.1	**Principles of Independence**				
2.1.1	Is Internal Audit: (a) independent of the activities it audits? (b) free from any non-audit [operational] duties?	✓			The HIA acts as liaison officer for the Benefit Fraud shared service with Preston but this does not impact on independence since the service is provided externally. Otherwise the service has no non-audit or operational duties.
2.1.2	Where internal audit staff have been consulted during system, policy or procedure development, are they precluded from reviewing and making comments during routine or future audits?	✓			IA offers all advice and consultation without prejudice to any later review of the area. HIA will review the situation and the decision to preclude or not will be based on the nature of the involvement with the issue. All auditors are mindful of the importance of independence in the conduct of their work.
2.2	**Organisational Independence**				
2.2.1	Does the status of Internal Audit allow it to demonstrate independence?	✓			The TOR stipulates this requirement. Also Internal audit has direct reporting lines to Chief Executive, Section 151 Officer and Audit Committee. All reports are in the name of HIA. Head of Internal Audit.
2.2.2	Does the Head of Internal Audit have direct access to: (a) officers? (b) members?	✓			As 2.2.1 above
2.2.3	Does the Head of Internal Audit report in his/her own name to members and officers?	✓			As 2.2.1 above
2.2.4	(a) Is there an assessment that the budget for Internal Audit is adequate? (b) Does any budget delegated to service areas ensure that: i) Internal Audit adherence to the Code is not compromised? ii) the scope of Internal Audit is not affected? iii) Internal Audit can continue to provide assurance for the Annual Governance Statement?	✓ n/a			Annual budgetary review Not applicable. Managers do not have delegated budgets to procure their own IA services. They have to utilise the corporate IA Service.

2.3	**Status of the Head of Internal Audit**				
2.3.1	Is the Head of Internal Audit managed by a member of the corporate management team?			✓	Reports to the Head of Governance who is not a member of CMT
2.4	**Declarations of Interest**				
2.4.1	Do audit staff make formal declarations of interest?	✓			Audit staff make annual declaration to abide by the IA Code of Ethics which requires declarations of interest
2.4.2	Does the planning process take account of the declarations of interest registered by staff?	✓			No declarations registered to date. If a significant conflict of interest was declared audit member concerned would not be allocated to that area.
3	**Ethics for Internal Auditors**				
3.1	**Purpose**				
3.1.1	Does the Head of Internal Audit regularly remind staff of their ethical responsibilities?	✓			As 2.4.1 above
3.2	**Integrity**				
3.2.1	Has the internal audit team established an environment of trust and confidence?	✓			Client satisfaction surveys indicate positive feedback regarding auditors' professionalism
3.2.2	Do internal auditors demonstrate integrity in all aspects of their work?	✓			All audit staff abide by the IA Code of Ethics which requires integrity, truthfulness and honesty. IA is regularly asked by management to participate in confidential matters requiring integrity

3.3	**Objectivity**				
3.3.1	Are internal auditors perceived as being objective and free from conflicts of interest?	✓			Acknowledged as undertaking an independent appraisal function
3.3.2	Is a time period set by the Head of Internal Audit for staff where they do not undertake an audit in an area where they have had previous operational roles?				This has not arisen to date. Arrangements are not formalised but if an auditor had had previous operational responsibility the HIA would take appropriate action to minimise the risk of conflict.
3.3.3	Are staff rotated on regular/annually audited areas?		✓		Limitations due to smallness of audit team also some jobs require a level of expertise gained from knowledge of the system. All audit work is subject to managerial review.
3.4	**Competence**				
3.4.1	Does the Head of Internal Audit ensure that staff have sufficient knowledge of: (a) the organisation's aims, objectives, risks and governance arrangements? (b) the purpose, risks and issues of the service area? (c) the scope of each audit assignment? (d) relevant legislation and other regulatory arrangements that relate to the audit?	✓ ✓ ✓ ✓			AGS and SRM Action Plans circulated to team IA Team meetings, pre-audit meetings, announcement letter, wash up sessions Audit programmes, checklists, assignment briefings
3.5	**Confidentiality**				
3.5.1	Do internal audit staff understand their obligations in respect to confidentiality?	✓			Audit staff make annual declaration to abide by the IA Code of Ethics which requires adherence to strict standards of confidentiality
4	**Audit Committees**				
4.1	**Purpose of the Audit Committee**				
4.1.1	Does the organisation have an independent audit committee?	✓			Full Audit Committee operational since October 2006

4.2	**Internal Audit's Relationship with the Audit Committee**				
4.2.1	Is there an effective working relationship between the audit committee and Internal Audit?	✓			Audit Committee workplan contains various internal audit agenda items. Audit training sessions hosted by HIA have been well received.
4.2.2	Does the committee approve the internal audit strategy and monitor progress?	✓			Internal Audit Strategy approved September 2010. Progress monitored via HIA's annual report.
4.2.3	Does the committee approve the annual internal audit plan and monitor progress?	✓			Internal Audit annual plan approved March 2013. Monitoring reports presented to Audit Committee.
4.2.4	Does the Head of Internal Audit: (a) attend the committee and contribute to its agenda? (b) participate in the committee's review of its own remit and effectiveness? (c) ensure that the committee receives and understands documents that describe how Internal Audit will fulfil its objectives? (d) report on the outcomes of internal audit work to the committee? (e) establish if anything arising from the work of the committee requires consideration of changes to the audit plan, or vice versa? (f) present the annual internal audit report to the committee?	✓ ✓ ✓ ✓ ✓ ✓			HIA attends most Audit Committee meetings HIA together with Chair and Vice Chair reviewed Audit Committee effectiveness HIA presents all documents explaining the role, remit, objectives and achievements of internal audit Outcomes of IA work presented to committee twice yearly Any changes to the audit plan arising from the work of the committee would be noted by HIA The HIA presents an annual report to the committee
4.2.5	Is there an opportunity for the Head of Internal Audit to meet privately with the committee?	✓			This has occurred when HIA briefed Chair and Vice concerning annual report, in performing review of Audit Committee effectiveness and during the annual Corporate Strategic Risk identification process
5	**Relationships**				
5.1	**Principles of Good Relationships**				
5.1.1	Is there a protocol that defines the working relationship for Internal Audit with: (a) management? (b) other internal auditors? (c) external auditors? (d) other regulators and inspectors? (e) elected members?	✓			The Internal Audit Terms of Reference defines the basis and nature of these relationships

5.2	**Relationships with Management**				
5.2.1	Does the Head of Internal Audit seek to maintain effective relationships between internal auditors and managers?	✓			Undertaken as part of the overall audit process, pre-closure and closure meetings, etc. Open Door policy of the team demonstrated by the level of requests for advice and guidance. Also by meetings between the Head of Internal Audit and Directors as part of the planning process and high levels of manager satisfaction as measured by feedback questionnaires
5.2.2	Is the timing of audit work planned in conjunction with management?	✓			The reviews within the Audit Plan are allocated across quarter periods in agreement with managers. Client Notification issued to managers prior to audit commencing and managers can request deferment for valid reasons
5.3	**Relationships with Other Internal Auditors**				
5.3.1	Do arrangements exist with other internal auditors that include joint working, access to working papers, respective roles and confidentiality?	✓			There is a joint approach to the audit of shared services with Blackpool Council Internal Audit in relation to council tax, business rates, housing benefits and payroll.
5.4	**Relationships with External Audit**				
5.4.1	Is it possible for Internal Audit and External Audit to rely on each other's work?	✓			Annual external audit inspection has consistently replaced reliance on Internal Audit work
5.4.2	Are there regular meetings between the Head of Internal Audit and the External Audit Manager?		✓		Not regular meetings - as and when required
5.4.3	Are the internal and external audit plans co-ordinated?		✓		The draft internal audit plan is shared with external audit to assist in co-ordination, but there is no formal arrangement.

5.5	**Relationships with Other Regulators and Inspectors**				
5.5.1	Has the Head of Internal Audit sought to establish a dialogue with the regulatory and inspection agencies that interact with the organisation?	✓			Dialogue established as and when considered necessary
5.6	**Relationships with Elected Members**				
5.6.1	Do the terms of reference for Internal Audit define the channels of communication with members and describe how such relationships should operate?	✓			The Terms of Reference define such channels of communications. Reports are submitted on a regular basis to the Audit Committee
5.6.2	Does the Head of Internal Audit maintain good working relationships with members?	✓			Comments in meetings of the Audit Committee generally reflect Member satisfaction with the work of Internal Audit
6	**Staffing, Training and Continuing Professional Development**				
6.1	**Staffing of Internal Audit**				
6.1.1	Is Internal Audit appropriately staffed (numbers, grades, qualifications, personal attributes and experience) to achieve its objectives and comply with these standards?	✓			The grades, qualifications, personal attributes and experience of the audit team are appropriate
6.1.2	Does the Head of Internal Audit have access to appropriate resources where the necessary skills and expertise are not available within the internal audit team?	✓			Arrangement with LCC for provision of IT Audit to supplement the expertise of the section
6.1.3	Is the Head of Internal Audit professionally qualified and experienced?	✓			HIA is CCAB qualified
6.1.4	Does the Head of Internal Audit have wide experience of internal audit and management?	✓			HIA has substantial experience in internal audit
6.1.5	(a) Do all internal audit staff have up-to-date job descriptions? (b) Are there person specifications that define the required qualifications, competencies, skills, experience and personal attributes for internal audit staff?	✓			All job descriptions and person specifications are up to date

6.2	**Training and Continuing Professional Development**				
6.2.1	(a) Has the Head of Internal Audit defined the skills and competencies for each level of auditor? (b) Are individual auditors periodically assessed against these predetermined skills and competencies? (c) Are training or development needs identified and included in an appropriate ongoing development programme? (d) Is the development programme recorded, regularly reviewed and monitored.	✓ ✓ ✓ ✓			Job descriptions define the skills and competencies required for each of the specific grades etc. Review of quality of work produced is undertaken on every assignment completed There are staff PDAs and Training Plans PDAs reviewed
6.2.2	Do individual auditors maintain a record of their professional training and development activities?	✓			Staff PDAs and training plans. Log for audit team accessible by all staff is maintained
7	**Audit Strategy and Planning**				
7.1	**Audit Strategy**				
7.1.1	(a) Is there an internal audit staff strategy for delivering the service? (b) Is it kept up to date with the organisation and its changing priorities?	✓			The Internal Audit Strategy was approved by the Audit Committee in September 2010. It is refreshed on a regular basis
7.1.2	Does the strategy include: (a) Internal Audit objectives and outcomes? (b) how the Head of Internal Audit will form and evidence his or her opinion on the control environment? (c) how Internal Audit's work will identify and address local and national issues and risks? (d) how the service will be provided, ie internally, externally, or a mix of the two? (e) the resources and skills required to deliver the strategy?	✓			All these points are included in the Audit Strategy
7.1.3	Has the strategy been approved by the audit committee?	✓			The Internal Audit Strategy was approved by the Audit Committee in September 2010

7.2	**Audit Planning**				
7.2.1	Is there a risk-based plan that is informed by the organisations risk management, performance management and other assurance processes?	✓			Audit Plan produced on a risk basis taking account of operational and strategic risk registers. The Internal Audit Universe comprising all auditable systems and processes is determined and incorporated into an indicative five year strategic plan from which the annual plan is derived.
7.2.2	Where the risk management process is not fully developed or reliable, does the Head of Internal Audit undertake his or her own risk assessment process?	✓			Audit plan based upon materiality, business risk, previous audit work, exposure to fraud and time since last audit
7.2.3	Are stakeholders consulted on the audit plan?	✓			CMT members consulted to identify issues in their services. S151 Officer reviews draft audit plan. Report to CMT and Audit Committee
7.2.4	Does the plan demonstrate a clear understanding of the organisation's functions?	✓			The audit planning process is comprehensive and covers all the Council's functions as well as stakeholder concerns. The plan is developed in consultation with members of CMT and the S151 Officer
7.2.5	Does the plan: (a) cover a fixed period of no longer than one year? (b) outline the assignments to be carried out? (c) prioritise assignments? (d) estimate the resources required? (e) differentiate between assurance and other work? (f) allow a degree of flexibility?	✓			The audit plan incorporates all these elements
7.2.6	If there is an imbalance between the resources available and resources needed to deliver the plan, is the audit committee informed of proposed solutions?	✓			If necessary a report would be presented to Audit Committee

7.2.7	Has the plan been approved by the audit committee?	✓			The audit plan is approved by the Audit Committee annually
7.2.8	If significant matters arise that jeopardise the delivery of the plan, are these addressed and reported to the audit committee?	✓			If necessary a report is presented to Audit Committee
8	**Undertaking Audit Work**				
8.1	**Planning**				
8.1.1	(a) Is a brief prepared for each audit? (b) Is the brief discussed and agreed with the relevant managers?	✓			A brief is prepared for each audit in conjunction with operational managers and/or staff. A copy is given to managers prior to audit taking place for comment as part of audit announcement process
8.1.2	Does the brief set out: (a) objectives? (b) scope? (c) timing? (d) resources? (e) reporting requirements?	✓			The audit brief covers all these aspects
8.2	**Approach**				
8.2.1	Is a risk-based audit approach used?	✓			Each system is audited against its principal risks and the adequacy of the key controls in place designed to mitigate such risks. Depending upon the findings, an assurance based opinion is given on the likelihood of the system achieving its objectives. Where possible previous audit work informs the approach, alternatively high risk areas would be identified at the planning phase for audit focus
8.2.2	Does the audit approach show when management should be informed of interim findings where key (serious) issues have arisen?	✓			Management is informed of interim findings where serious issues have arisen in accordance with the Audit Procedure Manual

8.2.3	Does the audit approach include a quality review process for each audit?	✓			All working papers and draft reports are reviewed for quality by the Head of Internal Audit or Senior Auditor
8.3	**Recording Audit Assignments**				
8.3.1	Has the Head of Internal Audit defined a standard for audit documentation and working papers?	✓			Audit files are compiled to a standard pattern. Auditors use standard formats and templates which, if changed or adapted, are subject to approval by the Head of Internal Audit
8.3.2	Do quality reviews ensure that the defined standard is followed consistently for all audit work?	✓			All working papers and draft reports are reviewed for quality by the Head of Internal Audit or Senior Auditor to ensure they conform to planned arrangements, fulfil the audit programme and adhere to defined internal audit standards
8.3.3	Are working papers such that an experienced auditor can easily: (a) identify the work that has been performed? (b) re-perform it if necessary? (c) see how the work supports the conclusions reached?	✓			Working papers inform and permit all these tasks
8.3.4	Is there a defined policy for the retention of all audit documentation, both paper and electronic?	✓			Audit documents retained for the two most recent audits undertaken in accordance with Audit Procedure Manual
8.3.5	Do all retention and access policies conform to appropriate legislation, i.e. Data Protection Act, Freedom of Information Act, etc and any organisational requirements?	✓			The Council's corporate policy applies
8.3.6	Is there an access policy for audit files and records?	✓			Access policy Included in Audit Procedure Manual Paper files and records are secured in locked filing cabinets and access to electronic files restricted to audit team

9	**Due Professional Care**				
9.1	**Responsibilities of the Individual Auditor**				
9.1.1	Are there documents that set out the requirements on all audit staff in terms of: (a) being fair and not allowing prejudice or bias to override objectivity? (b) declaring interests that could be perceived to be conflicting or could potentially lead to conflict? (c) receiving and giving gifts and hospitality from employees, clients, suppliers or third parties? (d) using all reasonable care in obtaining sufficient, relevant and reliable evidence on which to base conclusions? (e) being alert to the possibility of intentional wrongdoing, errors or omissions, poor value for money, failure to comply with management policy or conflict of interest? (f) having sufficient knowledge to identify indicators that fraud or corruption may have been committed? (g) disclosing all material facts known to them which, if not disclosed, could distort their reports or conceal unlawful practice? (h) disclosing any non-compliance with these standards? (i) not using information they gain in the course of their duties for personal use?	 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓			 Incuded in Internal Audit Code of Ethics Included in Internal Audit Code of Ethics Included in Internal Audit Code of Ethics Included in Audit Procedure Manual Included in Audit Procedure Manual Included in Audit Procedure Manual Included in Audit Procedure Manual Included in Internal Audit Code of Ethics Included in Audit Procedure Manual
9.1	**Responsibilities of the Head of Internal Audit**				
9.2.1	Has the Head of Internal Audit established a monitoring and review programme to ensure that due professional care is achieved and maintained?	✓			Quality review process on each audit performed. The Head of Internal Audit reviews all audit files and reports prior to their issue to management Annual declaration of adherence to Audit Code of Ethics by all internal auditors Annual appraisal process addresses performance issues
9.2.2	Are there systems in place for individual auditors to disclose any suspicions of fraud, corruption or improper conduct?	✓			Such issues would be raised with the Head of Internal Audit immediately at the time of discovery. Fortnightly team meetings also take place. Corporate Whistleblowing Policy also in place.

10	**Reporting**				
10.1	**Principles of Reporting**				
10.1.1	Is an opinion on the control environment and risk exposure given in each audit report?	✓			The audit provides 5 levels of assurance based opinion for the service area under review and all risks identified are prioritised H/M/L
10.1.2	Has the Head of Internal Audit determined the way in which Internal Audit will report?	✓			There is a standard template for reports which is sometimes adapted to suit a specific service or need
10.1.3	Has the Head of Internal Audit set out the standards for internal audit reporting?	✓			Reporting standards are established in the Audit Procedure Manual
10.1.4	Are there laid-down timescales for reports to be issued?	✓			Target reporting times for all stages of an audit including issuing the draft and final reports are included in the Audit Procedure Manual
10.2	**Reporting on Audit Work**				
10.2.1	Do the reporting standards include: (a) format of the reports? (b) quality assurance of reports? (c) the need to state the scope and purpose of the audit? (d) the requirement to give an opinion? (e) process for agreeing reports with the recipient? (f) an action plan or record of points arising from the audit and, where appropriate, of agreements reached with management together with appropriate timescales?	✓			Reporting standards established in the Audit Procedure Manual include all these points
10.2.2	Does the audit reporting process include discussion and agreement of reports?	✓			Pre-closure meetings with operational manager/s and end of audit closure meetings with service manager where agreed management action plans are finalised

10.2.3	Has the Head of Internal Audit determined a process for prioritising recommendations according to risk?	✓			Prioritised management action plans in accordance with Audit Procedure Manual, all risks identified are prioritised H/M/L
10.2.4	Are areas of disagreement recorded appropriately?	✓			Where matters raised are contentious, a record of the discussions and the points raised are retained on file in accordance with the Audit Procedure Manual
10.2.5	Are those weaknesses giving rise to significant risks that are not agreed drawn to the attention to senior management?	✓			If any issues are not accepted, management must explain the reasons why they wish to take no action. At this stage internal audit forms a judgement on whether no action presents an unacceptable level of risk. If this is the case, the matter is referred to the next level of senior management
10.2.6	Is the circulation of each audit report determined when preparing the audit brief?	✓			Protocol established in Audit Procedure Manual
10.2.7	a) Does the reporting process include details of circulation of that particular audit report? (b) Is this included in the brief for each individual audit?	✓ ✓			Protocol established in Audit Procedure Manual Report circulation details are included in the audit brief
10.2.8	Does the Head of Internal Audit have mechanisms in place to ensure that: (a) recommendations that have a wider impact are reported to the appropriate forums? (b) risk registers are updated?	✓ ✓			Particular high-priority recommendations may be reported to the Audit Committee and be considered by Governance Group for inclusion in AGS Risk Manager advised where the recommendation may have an impact on risk registers
10.3	**Follow-up Audits and Reporting**				
10.3.1	Has the Head of Internal Audit defined the need for and the form of any follow-up action?	✓			All audit recommendations are followed up in accordance with the Audit Procedure Manual

10.3.2	Has the Head of Internal Audit established appropriate escalation procedures for internal audit recommendations not implemented by the agreed date?	✓			High-priority recommendations not implemented are reported to the Audit Committee and escalated in accordance with protocol established in Audit Procedure Manual
10.3.3	Where appropriate, is a revised opinion given following a follow-up audit and reported to management?	✓			Where it is found that all of the high and medium priority recommendations have been implemented promptly, such that the arrangements and circumstances relating to the audit are unlikely to have changed significantly, the original assurance level placed on the system may be increased by one level
10.3.4	Are the findings of audits and follow-ups used to inform the planning of future audit work?	✓			Findings are used to inform the planning process. Audit plan is produced on a risk basis including the findings from previous audit work and follow ups
10.4	**Annual Reporting and Presentation of Audit Opinion**				
10.4.1	Does the Head of Internal Audit provide an annual report to support the Corporate Governance Statement?	✓			Head Of Internal Audit's Annual Report presented to Audit Committee and taken into account by Governance Group for AGS purposes
10.4.2	Does the Head of Internal Audit's annual report: (a) include an opinion on the overall adequacy and effectiveness of the organisation's control environment? (b) disclose any qualifications to that opinion, together with the reasons for the qualification? (c) present as summary of the audit work from which the opinion was derived, including reliance placed on work by other assurance bodies? (d) draw attention to any issues the Head of Internal Audit judges particularly relevant to the preparation of the Corporate Governance Statement? (e) compare the actual work undertaken with the planned work and summarise the performance of the internal audit function against its performance measures and targets? (f) comment on compliance with the standards of the Code? (g) communicate the results of the internal audit quality assurance programme?	✓			Head Of Internal Audit's Annual Report meets all the points

10.4.3	Has the Head of Internal Audit made provision for interim reporting to the organisation during the year?	✓			Head of Internal Audit reports at least twice annually to the Audit Committee
11	**Performance, Quality and Effectiveness**				
11.1	**Principles of Performance, Quality and Effectiveness**				
11.1.1	Is there an audit manual?	✓			Audit Performance Manual in place
11.1.2	Does the audit manual provide guidance on: (a) carrying out day-to-day audit work? (b) complying with the Code?	✓ ✓			Audit Performance Manual includes guidance on carrying out day-to-day audit work Audit Performance Manual refers to the Code and provides guidance on compliance
11.1.3	Is the audit manual reviewed regularly and updated to reflect changes in working practices and standards?	✓			Last reviewed in 2010 – some updating has taken place to reflect minor changes in working practices
11.1.4	Does the Head of Internal Audit have arrangements in place to assess the performance and effectiveness of: (a) each individual audit? (b) the internal audit service as a whole?	✓ ✓			File review arrangements and documents Performance indicators, audit standards, effectiveness review
11.2	**Quality Assurance of Audit Work**				
11.2.1	Does the Head of Internal Audit have a process in place to ensure that work is allocated to auditors who have the appropriate skills, experience and competence?	✓			As far as possible within a small team of auditors, work is allocated according to the skills and experience required and so that there is adequate supervision
11.2.2	Does the Head of Internal Audit have a process in place to ensure that all staff are supervised appropriately throughout all audits?	✓			Ongoing supervision and assistance in place Fortnightly team meetings used to monitor progress and highlight problems/issues arising Quality review process on each audit performed

11.2.3	Does the supervisory process cover: (a) monitoring progress? (b) assessing quality of audit work? (c) coaching staff?	✓ ✓ ✓			Fortnightly team meetings used to monitor progress and highlight problems/issues arising Quality review process on each audit performed Staff appraisals and probation arrangements for newly recruited staff
11.3	**Performance and Effectiveness of the Internal Audit Service**				
11.3.1	Does the Head of Internal Audit have a performance management and quality assurance programme in place?	✓			Individual audit reports and supporting documentation are reviewed, staff performance appraisals are conducted annually and audit satisfaction surveys are issued with each final audit report. The results are analysed and reported to the Audit Committee
11.3.2	Does the performance management and quality assurance framework include as a minimum: (a) a comprehensive set of targets to measure performance: (i) which are developed in consultation with appropriate parties? (ii) which are included in service level agreements, where appropriate? (iii) against which the Head of Internal Audit measures, monitors and reports appropriately on progress? (b) user feedback obtained for each individual audit and periodically for the whole service? (c) a periodic review of the service against the strategy and the achievement of its aims and objectives, the results of which are used to inform the future strategy? (d) Internal quality reviews to be undertaken periodically to ensure compliance with this Code and the audit manual? (e) an action plan to implement improvements?	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓			Several targets following 2009 stakeholder survey were established and approved by Audit Committee Input from Directors, Heads of Service and Chair/Vice of Audit Committee in developing targets Not applicable at present Measured and monitored by HIA; reported to Audit Committee Audit satisfaction surveys are issued with each final audit report Service is reviewed against strategy annually to inform objectives for the next year Self-assessment via the checklist reported to Audit Committee Action Plan presented to Audit Committee if necessary
11.3.3	Does the Head of Internal Audit compare the performance and the effectiveness of the service over time, in terms of both the achievement of targets and the quality of the service provided to the user?	✓			Annual internal audit report and opinion Comparisons are undertaken with previous years' performances. Any under achievements against measures are investigated

11.3.4	Do the results of the performance management and quality assurance programme evidence that the internal audit service is: (a) meeting its aims and objectives? (b) compliant with the Code? (c) meeting internal quality standards? (d) effective, efficient, continuously improving? (e) adding value and assisting the organisation in achieving its objectives?	✓			Internal audit service is generally achieving the standards listed Compliance with the Code evidenced by external audits review of internal audit Adding value element is evidenced via consultancy projects and investigations undertaken at the request of management and client satisfaction surveys
11.3.5	Does the Head of Internal Audit report on the results of the performance management and quality assurance programme in the annual audit report?	✓			Performance results against a number of indicators are included in the Head of Internal Audit's annual report. An analysis of internal audit customer feedback is also provided
11.3.6	Does the Head of Internal Audit provide evidence from his or her review of the performance and quality of the internal audit service to the organisation for consideration as part of the annual review of the effectiveness of the system of internal audit?	✓			Report to Audit Committee

REPORT

REPORT OF	MEETING	DATE	ITEM NO
HEAD OF INTERNAL AUDIT	AUDIT COMMITTEE	27 JUNE 2013	9

HIGH PRIORITY ACTIONS (UPDATE)

Public Item

This item is for consideration in the public part of the meeting.

Summary

At its meeting in January 2013 the Committee considered the Internal Audit Interim Report for 2012/13 and the Head of Internal Audit was requested provide a further report concerning the outstanding high priority actions identified. The Head of Internal Audit reported further to the March 2013 meeting of the Committee. This report sets out the current position.

Recommendations

The Committee notes the latest position with regard to each of the high priority actions agreed by management but not implemented as previously reported.

Cabinet Portfolio

The item falls within the Finance & Resources portfolio (Councillor Karen Buckley)

Summary of previous decisions

Audit Committee - 21 March 2013

It was RESOLVED subject to (1), (2) and (3) below, the report be noted

(1) An update report on the high priority action with regard to the ICT upgrades as referred to in paragraph 4 of the report, be presented to the next meeting.

Continued....

(2) In relation to the administration and management of penalty notices at this Council's car parks as referred to in paragraph 5 of the report, the Council's responsible officer be requested to attend the next meeting to explain in the form of a report, the history, issues and why the contract document has not been signed.

(3) With regard to the nominated contractor issue concerning non specialist work in relation to housing grants as referred to in paragraph 6 of the report, an update be presented to the next meeting.

Background

1. At the January 2013 meeting of the Audit Committee, the Internal Audit Interim Report outlined the position with regard to high priority action agreed by managers. The Committee noted that three issues remained unresolved - one concerning IT system upgrades, the second in relation to car park penalty notice arrangements and the third relating to quotations for housing grants work. At the time of the committee meeting the revised implementation dates for the first and third actions had not been passed.

2. A further report by the Head of Internal Audit to the Committee at the March 2013 meeting provided the latest position with regard to these matters. The table below sets out the issues, the responsible Directorates and the position or date for resolution as indicated at the March meeting.

Table: High Priority Risks Identified

	Risk	Director	Resolution Date
Previous Years' Risks			
1	Annual system upgrades and bug fixes were not carried out as required by contract terms	Resources	Jan 11 Feb 13
2	Arrangements for penalty notice administration will be reviewed and updated in a signed contract and retained	Development	Completed[1]
2012/13 Risks			
3	Two quotations from suitable contractors will be sought for housing grant work, except in the case of stair lift installations	Development	Jul 12 Jan 13

[1] Reported as satisfactorily implemented by IA but re-instated as outstanding by Audit Committee

3. In relation to the car parking issue the Committee continued to express concerns in spite of the reassurance of the Head of Internal Audit and asked for the responsible manager to attend the next meeting to explain the background to the issue and, in particular, why the service contract for the administration of penalty notices had not been signed.

4. The Committee requested the Head of Internal Audit to provide a further report outlining the current position in relation to the remaining two issues. This report set out the present situation.

Current Position

<u>IT Upgrades</u>

5. The first of the issues in relation to IT upgrades was originally reported as implemented subject to evidential review several months ago, but additional verification work undertaken suggested this was not the case. It was reported in January that a revised approach to IT system upgrades was being developed and a revised date for implementation was agreed with the newly responsible manager.

6. At the March meeting the Head of Internal Audit was relatively content that all the necessary arrangements were in place but advised that before final assurance on this matter could be given a final confirmation that the proposed procedures were operating robustly would be undertaken. This confirmation has taken place and the findings are set out in the following paragraph.

7. The roles and responsibilities of Information Asset Owners and Administrators (IAOs & IAAs) have been communicated, together with standard arrangements for the upgrading and updating of software systems. The first meeting of the IAA Group has been held and quarterly meetings have been set up to allow regular dialogue and planning between IT and IAAs. The IAAs have been charged with obtaining either a roadmap of developments from their particular software suppliers or where this is not available to get dates for the next scheduled system releases and updates. The first upgrade is currently being carried out in accordance with the agreed arrangements and all others will follow the same process. On this basis the action is considered to be completed.

Housing Grants

8. The concern in relation to housing grants work was the need for competitive quotations to be obtained from contractors except in the case of specialist work, such as the installation of chair-lifts. It has been confirmed that a second attempt to identify a further contractor for work on housing association properties has been successful and competitive quotations will be used as appropriate. The first work has recently been awarded to the new contractor in accordance with the schedule of rates. On this basis the action is considered to be completed.

Risk Assessment

This item is for information only and makes no recommendations. Therefore there are no risks to address arising from it. The implementation of agreed high priority actions will address system risks already identified to management.

Report Author	Tel	Date	Doc ID
Savile Sykes	(01253) 658413	27/06/13	

List of Background Papers		
Name of document	Date	Where available for inspection

Internal Audit Interim Report	30/01/13	All background papers or copies can be obtained from Savile Sykes – Head of Internal Audit on 01253 658413 or e-mail saviles@fylde.gov.uk
Internal Audit Annual Report	27/06/13	

IMPLICATIONS	
Finance	The Accounts and Audit Regulations 2003 require the Council to ensure that its financial management is adequate and effective and that it has a sound system of internal control which facilitates the effective exercise of its functions and which includes arrangements for the management of risk.
Legal	No specific implications
Community Safety	No specific implications
Human Rights and Equalities	No specific implications
Sustainability and Environmental Impact	No specific implications
Health & Safety and Risk Management	Internal audit work covers key areas of risk and should therefore strengthen the internal control framework.

Audit Committee

Date:	Thursday, 21 March 2013
Venue:	Town Hall, St. Annes
Committee members:	Councillor John Singleton (Chairman) Councillor Brenda Ackers (Vice Chairman) Councillors Christine Akeroyd, Kath Harper, Howard Henshaw, Linda Nulty, Richard Redcliffe, Louis Rigby
Other Councillors:	None
Officers:	Tracy Morrison, Paul O'Donoghue, Ian Curtis, Savile Sykes and Paul Rogers
Other Attendees:	None

1. Declarations of interest

Members were reminded that any interests should be declared as required by the Council's Code of Conduct adopted in accordance with the Localism Act 2011. No declarations were made.

2. Confirmation of minutes

RESOLVED: To approve the minutes of the Audit Committee meeting held on 30 January 2012 as a correct record for signature by the Chairman.

3. Substitute members

The following substitutions were reported under Council procedure rule 25:

Councillor Richard Redcliffe for Councillor Ben Aitken.

4. Planning Code

Councillor John Singleton, Chairman, referred members to paragraph 4 of the report before them and informed the committee that one of those members who had been consulted had not seen the revised protocol for planning. Ian Curtis, Head of Governance confirmed that the members referred to in paragraph 4 of the report had been consulted via email at the end of last year and one member had not responded. He reminded members that Audit committee would be making recommendations to Council for final approval.

Following discussion, it was RESOLVED that consideration of the report be deferred until the next available Audit committee meeting to enable consultation with members of the regarding the proposed revised protocol for planning.

5. Corporate Governance Improvement Plan 2012/13

Tracy Morrison, Director of Resources, presented a report relating to the Corporate Governance Improvement Plan actions which had been reported to the last meeting and the request of the committee to report back on the status of objectives AGS 2 and AGS 7.

Ms Morrison referred to the action in respect of AGS 2 which read 'Develop and deliver a targeted programme of equalities training and guidance for all staff'. She informed members although the equality act starter kit had been rolled out to managers, it would need to be cascaded down amongst their teams. In the strictest sense, she advised that the status should read 'Substantially Complete' with the anticipation that this would be completed by June this year. Regarding objective AGS 5 relating to the review and upgrading of the Corporate and Communications Strategy, she advised that this had now been reviewed and upgraded in line with the action described in the report and that the draft would now be presented to Management Team. On a point of clarification in respect of objective AGS 7 relating to Business Continuity arrangements, she suggested that the final paragraph in the comment would be better worded to say 'Review completed and Plan refreshed including the reflection of the new management structure'.

Councillor John Singleton, Chairman, thanked Ms Morrison for the report and updates on the objectives. He requested that the Committee be further updated on objective AGS 2 at the next meeting.

It was RESOLVED that the committee notes the latest position and that an update be presented on objective AGS 2 to the Audit committee meeting in June.

6. Constitution

Tracy Morrison, Director of Resources, reminded members that the Audit Committee's terms of reference included responsibility for advising Council on changes to the constitution.

In presenting the report, Ms Morrison informed members that for the budget Council meeting held on the 4 March 2013, the Council meeting was run in line with a local convention which had been used for the last few years for those meetings. She informed the committee that those procedures were a deviation from the constitution and she advised that in order to provide clarity in the future, that the constitution be amended to include the local convention. She informed the committee that the convention had been agreed by the political groups and the convention procedure was outlined in Appendix 1 attached to the report.

Councillor Howard Henshaw asked why non aligned members were not mentioned in the proposed procedure relating to alternative budget amendments. Ms Morrison advised that even though it was not set out in the note in the Appendix to the report, the two non aligned members would be offered the same courtesy in debate as the main political groups. She agreed with members that an amendment to the note on that procedure would strengthen the rule.

Following discussion, it was RESOLVED that Council adopts the attached procedure as set out in Appendix 1 to the report for its budget Council meetings as part of its constitution subject to non aligned members being included in the note relating to the presentation of alternative budget amendments.

7. Internal Audit Plan 2013/14

Savile Sykes, Head of Internal Audit, presented a report which outlined the Internal Audit Plan for the financial year 2013/14 and briefly described the methodology used in its production.

In taking members through the various sections in the report, Mr Sykes emphasised that those risks which had been identified by key managers via consultation together with those areas which were already included in the audit universe were then risk assessed on the basis of the considerations set out in paragraph 3 in the report. The risks were then scored and prioritised for inclusion in the Audit Plan. He drew members' attention to the other elements of the plan referred to on page 13 of the report such as key financial systems that are audited on an ongoing basis and other areas reviewed annually, such as corporate governance and anti-fraud activities. He also emphasised that the Plan needed to be flexible to allow for changes in circumstances after the completion of the risk assessment and pointed out that a contingency element had been included. Any significant changes during the year would be reported to the next Audit committee meeting.

Mr Sykes referred to the proposed Audit Plan for 2013-14 at Appendix 1 to the report. He took members through the various sections and emphasised that the number of days allocated to each audit area was based on knowledge of the work involved and professional judgement. He informed the committee that some day totals could fluctuate due to various unforeseen circumstances.

Councillor Linda Nulty asked whether the Local Plan would be eligible to be included in the audit plan as it was taking a long time to finalise it. Mr Sykes informed the committee that the local plan issue had not been raised as a potential issue during his consultations. He advised members that the annual Risk Management Workshop took place on 22 March where the local plan issue would be discussed and that an action plan would be considered at that meeting. Tracy Morrison, Director of Resources, confirmed that the local plan issue would be discussed when considering the Annual Risk Management report which was scheduled for the next Audit committee meeting.

After discussion it was RESOLVED that the Annual Internal Audit Plan 2013-14 be approved.

8. High Priority Actions (Update)

Savile Sykes, Head of Internal Audit, presented a report which, in accordance with a request from the last meeting of the committee, updated members on the current position with regard to the high priority actions identified at the last meeting.

Mr Sykes referred to paragraph 4 of the report regarding IT upgrades and bug fixes and informed members that once the proposed procedure note to support the new process has been agreed, he was relatively content that all the necessary arrangements would be in place. He advised that he would like to ensure that the procedures were operating robustly before he gave his final assurance.

Councillor John Singleton, Chairman, referred to a communication he had received from Andrew Cain, Customer, ICT and Service Improvement Manager, which was as follows:

'ICT and the Information Asset Administrators (IAA) have greed a procedure for updating systems to minimise the risk of system failure. The procedure has been circulated to middle managers and the IAA. A quarterly meeting has been scheduled in to allow regular dialogue between ICT and IAA. Both of these actions address the outstanding high priority action around ICT'.

Councillor Singleton suggested that the proposed update regarding how the system is operating be presented to the June committee meeting.

Mr Sykes referred to paragraph 5 in the report and reminded members that a contract that had been entered into for the administration and management of penalty notices issued at car parks. He advised that the Council's officers and the company that was supplying the service were operating in accordance with the terms and conditions of the contract document even though the contract had not been signed. Also, he had been advised by the Council's legal services that because the Council and the company were operating within the terms of the contract, the contract was legally binding despite not being signed. He informed the committee that the amount being charged by the company for its services was in accordance with the originally agreed terms. In the light of the advice received Mr Sykes indicated that he was minded not to pursue the issue further.

Councillor Linda Nulty and several other members expressed the view that because the contract had not been signed, the situation could leave the Council open to potential problems.

In response to a member's question, Mr Sykes informed the committee that he had not spoken to the other local authorities named in the contract about the current situation.

Mr Sykes referred to paragraph 6 of the report regarding the non specialist work in respect housing grants and the fact that New Fylde Housing had only one external approved contractor for which quotations for work were received instead of two quotations which was the norm for private sector dwellings. He informed members that an agreed schedule of prices had been agreed for repair work 3 years ago and they had not increased to date. Since the last committee meeting, he had contacted New Fylde Housing officers who had indicated that they had nominated two approved contractors for this work which, if correct, would address the issue.

In response to a member's question, Mr Sykes informed members that it was New Fylde Housing as owners of the properties that commissioned the work. However, in practice it was this Council's officers who obtained the prices on behalf of New Fylde Housing.

It was RESOLVED subject to (1), (2) and (3) below, the report be noted

(1) An update report on the high priority action with regard to the ICT upgrades as referred to in paragraph 4 of the report, be presented to the next meeting.

(2) In relation to the administration and management of penalty notices at this Council's car parks as referred to in paragraph 5 of the report, the Council's responsible officer be requested to attend the next meeting to explain in the form of a report, the history, issues and why the contract document has not been signed.

(3) With regard to the nominated contractor issue concerning non specialist work in relation to housing grants as referred to in paragraph 6 of the report, an update be presented to the next meeting.

9. Annual Review of Counter Fraud Policies

Savile Sykes, Head of Internal Audit, presented a report which requested the adoption and approval of the Anti-fraud & Corruption Policy and Strategy, the Whistleblowing Policy, the

Anti-Money Laundering Policy, Anti-Bribery Policy, and the Forensic Readiness Policy. He informed members that those policies had been refreshed to reflect changes to legislation and corporate arrangements and the changes were set out in the report. He advised that the policies referred to above created an integrated approach to tackling fraud.

After discussion, it was RESOLVED that the policy documents attached as Appendices to the report and amendments described be approved.