Argyll and Bute Council
Comhairle Earra-Ghàidheal Agus Bhòid

Customer Services
Executive Director: Douglas Hendry

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27 November 2015

NOTICE OF MEETING

A meeting of the **AUDIT COMMITTEE** will be held in the **COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD** on **FRIDAY, 4 DECEMBER 2015** at **11:15 AM**, which you are requested to attend.

Douglas Hendry
Executive Director of Customer Services

BUSINESS

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST**

3. **MINUTES** (Pages 1 - 6)
   Audit Committee Minutes 25 September 2015.

4. **EXTERNAL AUDIT PROGRESS REPORT**
   Verbal report by Audit Scotland, External Auditors.

5. **INTERNAL AUDIT SUMMARY OF ACTIVITIES** (Pages 7 - 14)
   Report by Chief Internal Auditor.

6. **INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE 2015 - 2016** (Pages 15 - 106)
   Report by Chief Internal Auditor.

7. **EXTERNAL & INTERNAL AUDIT REPORT FOLLOW UP 2014 - 2015** (Pages 107 - 112)
   Report by Chief Internal Auditor.

8. **DRAFT ANNUAL AUDIT PLAN 2016/17** (Pages 113 - 118)
   Report by Chief Internal Auditor.

9. **RISK MANAGEMENT OVERVIEW** (Pages 119 - 150)
   Report by Head of Strategic Finance.

10. **STRATEGIC RISK ASSURANCE MAPPING EXERCISE** (Pages 151 - 162)
    Report by External Auditors.

11. **AUDIT COMMITTEE DEVELOPMENT PLAN** (Pages 163 - 166)
    Report by Vice –Chair Audit Committee.

12. **AUDIT COMMITTEE WORKPLAN** (Pages 167 - 172)
    Audit Committee Workplan 2015 – 2016.

Audit Committee

Martin Caldwell (Chair)
Councillor Michael Breslin
Councillor Iain MacDonald
Councillor Iain MacLean
Sheila Hill (Vice-Chair)
Councillor Maurice Corry
Councillor Richard Trail

Contact: Shona Marshall Tel. No. 01546 604407

Agenda Item 3

MINUTES of MEETING of AUDIT COMMITTEE held in the COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD on FRIDAY, 25 SEPTEMBER 2015

Present: Martin Caldwell (Chair)

Councillor Michael Breslin
Councillor Maurice Corry
Councillor Richard Trail
Sheila Hill

Attending: Steve Barrett, Interim Head of Strategic Finance
Kevin Anderson, Chief Internal Auditor
Peter Cupples, Finance Manager
Douglas Hendry, Executive Director – Customer Services
Graeme Forrester, Area Committee Manager
Jane Fowler, Head of Improvement and HR
Rona Gold, Community Planning Manager
Samantha Quarton, Community Planning Officer
Fiona Mitchell-Knight, Audit Scotland
Russell Smith, Audit Scotland
David Jamieson, Audit Scotland

Prior to the start of the meeting the Chair took the opportunity to thank Steve Barrett for his contribution in the work of the Audit Committee and Council as Interim Head of Strategic Finance and wished him all the best for the future. It was noted that Kirsty Flanagan would take up the post of Head of Strategic Finance from 1 October 2015.

1. APOLOGIES FOR ABSENCE

An apology for absence was intimated on behalf of Councillor Iain S MacLean.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

3. MINUTES

The Minutes of the Audit Committee of 19 June 2015 were approved as a correct record.

Councillor Michael Breslin sought clarification on the decision of the committee to note Item 4: Progress Report on ADP Partnership. The Chairman provided clarification.

It was brought to Members attention that under Item 10 “Feedback Analysis – Audit Committee Effectiveness Session/Audit Committee Development Plan 15 – 16” that a combined report by the Chairs of the Audit Committee and Performance Review and Scrutiny Committee (PRS) on the protocols for forwarding/co-ordinating Audit reports to PRS would now be brought to the December meeting of the Committee.

Also under Item 17 “National Fraud Initiative in Scotland” members were informed that the 2015 NFI report would be available in June 2016.

Decision

The Committee noted the position.

4. PERFORMANCE MANAGEMENT REPORTING - UPDATE

The Committee considered a report which provided the Audit Committee with an annual update on progress against the process for scrutiny of the council’s performance management processes and procedures previously agreed by the Audit Committee in June 2013.

Decision

The Audit Committee noted progress against the agreed scrutiny process for the council’s performance management system and procedures.

(Reference: Report by Executive Director – Customer Services dated 25 September 2015, submitted)

5. REVIEW OF COMMUNITY PLANNING PARTNERSHIP GOVERNANCE

The Committee considered a report which informed the Audit Committee of the 2014/15 review of governance arrangements for the Argyll and Bute Community Planning Partnership (CPP).

Members praised the progress being made on CPP Management Committee membership and improvements in reporting of meeting highlights.

Decision

The Audit Committee noted the contents of the report.

(Reference: Report by Executive Director – Community Services dated 25 September 2015, submitted)

6. REVIEW OF CHORD ACTION PLAN

The Committee considered a report which updated Members on progress of the action plan agreed after the Internal Audit Review of CHORD 2014 / 15.

Discussion took place on Prince 2 methodology and the role of project boards.

Decision

The Audit Committee;

(i) noted the successful completion of the actions taken under the action plan agreed after the Internal Audit Review of CHORD 2014/15; and

(ii) agreed to remove the item Review of CHORD Action Plan from the Committee Work Plan 2015 – 16.

(Reference: Report by Executive Director – Customer Services dated 25 September 2015, submitted)

7. TREASURY MANAGEMENT ASSURANCE REPORT

The Committee considered a report which outlined the management arrangements and audit activities in place relating to the Councils treasury function to provide assurance to the Audit Committee that the risks and controls related to the Council's treasury activities were properly managed.

It was noted that a training course was being arranged for Members on Treasury Management, and details on this would be provided in due course.

Decision

The Committee noted the report.

(Reference: Report by Interim Head of Strategic Finance dated 25 September 2015, submitted)

8. AUDITED FINANCIAL ACCOUNTS

The Committee considered a report which set out the outcome of the External Auditors, Audit Scotland audit of the Council's financial statements for 2014 – 15.

Decision

The Committee approved the Annual Accounts for signature and that they be submitted to Council for approval.

(Reference: Report by Interim Head of Strategic Finance dated 25 September 2015, submitted)

9. EXTERNAL AUDIT ANNUAL REPORT

The Committee considered: the proposed annual audit report to Members and the Controller of Audit in accordance with ISA260 International Standard on Auditing; and a draft letter of representation under ISA 580 to be signed and returned by the Accountable Officer with signed financial statements prior to the independent auditor's opinion being certified.

External Auditors gave Members an overview of each of the main subject areas within the report, being;

- audit of the 14/15 financial statements
- financial management and sustainability
- governance and transparency
- best value; and
- outook

No issues of substantive concern were raised. Members noted that the annual audit report would be issued in final form after the financial statements had been certified.

Consideration was also given to a separate ISA260 report in relation to the audit of Charitable Trusts administered by Argyll and Bute Council.

Decision

The Audit Committee noted the contents of the reports and the draft letters of representation under ISA 580.

(Reference: Reports by Audit Scotland dated 25 September 2015, submitted)

10. INTERNAL AUDIT SUMMARY OF ACTIVITIES

The Committee considered a report which provided a summary of Internal Audit activity and progress during Quarter 2.

Members were given an update on the number of National Fraud Initiative Matches as being 315 matches completed with 141 in progress. These are to be completed by 30 September 2015.

Decision

The Committee noted the content of the report.

(Reference: Report by Chief Internal Auditor dated 25 September 2015, submitted)

11. INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE 2015 - 2016

The Committee considered a report which provided executive summaries and details on 8 audits that had been undertaken by Internal Audit and the recommendations that had been identified as a result of these audits.

In depth discussion took place on the Health and Social Care Integration internal audit and the workload which required to be completed by 1 April 2016.

Decision

The Committee noted the content of the summary report and detail within each individual report in respect of the following audits;

- Airports
- LEADER
- FLAG
- Education
- Electronic Signatures
- Health and Social Care Governance
- Planning Enforcement
- Single Outcome Agreement

(Reference: Report by Chief Internal Auditor dated 25 September 2015, submitted)

12. EXTERNAL & INTERNAL AUDIT REPORT FOLLOW UP 2014 - 2015

The Committee considered an Internal Audit document on the progress made by departmental management in implementing the recommendations made by both External Audit and Internal Audit. The report and attached appendices were the results of a review performed by Internal Audit for recommendations due to be implemented by 31 July 2015.

Discussion took place in relation to an instance of non-compliance in respect of a previous audit finding which was referenced within the report. The Executive Director of Customer Services provided Members with a management response in respect of the issues raised.

Decision

The Committee noted the content of the report.

(Reference: Report by Chief Internal Auditor dated 25 September 2015, submitted)

13. AUDIT COMMITTEE DEVELOPMENT PLAN

The Committee considered a report which provided a summary and update of progress with Development Plan action points.

Decision

The Committee noted the report and content of 15/16 Audit Committee development plan.

(Reference: Report by Vice Chair Audit Committee dated 25 September 2015, submitted)

14. AUDIT COMMITTEE WORKPLAN

The Committee considered the outline workplan to facilitate forward planning of reports to the Audit Committee.

Members were informed that the Risk Management Annual Assurance Report would be brought to the December meeting of the Audit Committee.

Decision

The Committee noted the workplan.

(Reference: Report by Executive Director – Customer Services dated 25 September 2015, submitted)

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ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **04 DECEMBER 2015**

INTERNAL AUDIT SUMMARY OF ACTIVITIES

1. EXECUTIVE SUMMARY

1.1 The objective of the report is to provide a summary of Internal Audit activity and progress during Quarter 3.

1.2 Core activities together with a progress update statement are shown below.

- **15/16 Audit Plan progress**: Audit plan is currently on track.
- **Individual Audits undertaken**: 8 individual audits have been completed during the period. Of these 8 audits, 7 are rated substantial and 1 is rated Limited.
- **Continuous Monitoring Programme Testing**: A number of auditable units are subject to continuous testing. Reporting is by exception. Management have responded to previous quarter notifications and there are no outstanding issues.
- **National Fraud Initiative**: Good progress has been made in completing matches. A new release of Council Tax matches has taken place and work has commenced.
- **Development Plan**: Progress continues to be made against revised development plan action points. All items are currently on track.
- **Performance indicators**: Revised indicators are in place and current status is on track / green.

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **04 DECEMBER 2015**

INTERNAL AUDIT SUMMARY OF ACTIVITIES

2. INTRODUCTION

2.1 The objective of the report is to provide an update on Internal Audit activity during Quarter 3 against a number of areas;

- 15/16 Audit Plan progress
- Individual Audits undertaken
- Continuous Monitoring Programme Testing
- National Fraud Initiative
- Internal Audit Development Plan
- Performance indicators

3. RECOMMENDATIONS

3.1 The Audit Committee is asked to note the content of the report.

4. DETAIL

4.1 The Audit Plan is currently on track. All Audits planned for completion during quarter 3 are anticipated to be complete by close of the period. A reduced number of reports are being submitted this cycle as a consequence of the early scheduling of the December meeting.

4.2 There is an emerging risk in respect of potential long term absence which may impact the timely completion of the 15/16 Audit Plan. Management are currently discussing mitigating actions.

4.3 Audits completed to November are detailed in Table 1.

Table 1: Summary of Audits performed in Quarter 2 2015/16:

Audit Name	Level of Assurance	No. of recommendations	High Recommendations
Early Years – Compliance with Young People Bill (600 hrs)	Substantial	5	1
Education – Equality of Provision Looked After Children	Substantial	4	0
Performance Management	Substantial	8	1
Procurement (PECOS)	Limited	11	1
Procurement - Tendering	Substantial	7	2
Risk Management	Substantial	2	0
Taxi Licencing	Substantial	2	0

4.4 Audits planned for the Quarter 4 15/16 are shown in the table below.

Quarter 4
Welfare Reform
Exclusions and Truancy
Economic Development Action Plans
Piers and Harbours
Capital Projects – Scoping and Design protocols
Homelessness
Town Heritage Initiative (THI)
Homecare (Resource Allocation System)
Children's Hostels
Disposal of Equipment <10k

4.5 A number of areas which were previously subject to individual audits now form part of our continuous monitoring programme. These areas are tested on a regular basis and detailed reporting will be by exception to Audit Committee. Standard audit tests are applied relevant to each auditable unit. A follow up process is in place whereby management are advised of findings and where appropriate, requested to take remedial actions. There are currently no outstanding follow-up points arising from previous quarters testing. Table 2 below summarises activity to date outlining issues arising and provides a level of assurance together with follow up detail.

Table 2: Continuous monitoring programme results:

Audit Unit	Areas Tested	Issues Arising	Assurance Level	Follow up
Payroll and Overtime	• Excessive & Regular Overtime • Ghost Employees • Duplicate Employees	• Excessive overtime payments • None • None	Substantial	Management are currently reviewing findings.
Creditors	• Sample of cheque requests tested for appropriate authorisation	• Individuals not on the signatory list authorising cheque requests	Substantial	Signatory List Updated.
Budgeting	• Ensure budget covers all areas of income and expenditure	None	High	N/A
Debtors	• Security controls/User access • Accuracy in posting to general ledger	None	High	N/A

Audit Unit	Areas Tested	Issues Arising	Assurance Level	Follow up
Establishments	• Oban High School	• Adhering to own constitution with regards to approval limits of transactions as opposed to those set out in circular 1.10. • School Fund committee does not follow a formal structure and no formal election is held.	Substantial	Compliance issues identified do not present any significant risk. Education Management to review circular 1.10 and update accordingly.
Imprest	• Municipal Buildings-Sinclair Street Helensburgh	A number of key weaknesses were identified with residual risk above an acceptable. Key weaknesses include failure to have appropriate authorisation, reconciliation and record keeping arrangements in place. A discrepancy was also identified in respect of the balance held.	Very Limited	Management are reviewing findings and an update in respect of any further action will be given in due course.
Council Tax	• Procedural instructions are issued and followed by staff • Ensure regular reconciliations in place between valuation list and the billing system • Relevant data from valuation list is promptly and correctly transferred to the billing system • Regular inspections of void properties are carried out and recorded.	None	High	N/A

4.6 National Fraud Initiative (NFI). Data matching involves comparing computer records held by one body against other computer records held by the same or another body to see how far they match. This is usually personal information. Computerised data matching allows potentially fraudulent claims and payments to be identified but the inclusion of personal data within a data matching exercise does not mean that any specific individual is under suspicion. Where a match is found it indicates that there may be an inconsistency which requires further investigation. No assumption can be made as to whether there is fraud, error or other explanation until an investigation is carried out

4.7 Good progress has been made with data matches scheduled for completion by September deadline. In respect of payroll, outstanding key matches are noted as being in progress. All requests for further information from partner organisations have been dealt with. *Insurance matches are being progressed via Zurich Municipal, our Insurance Partners.

Table 3.1 – Further release of National Fraud Initiative Matches:

Datasets	NFI Key Filter Matches	Matches Complete	Responsible Officer	Completion
Payroll	420	315	Payroll Supervisor	Sept 2015
Housing Benefit	178	177	Counter Fraud Manager	Sept 2015
Personal Budgets	4	4	Finance Officer (Income Max)	Sept 2015
Care Homes	7	7	Finance Officer (Income Max)	Sept 2015
Insurance	37	*	Insurance Assistant	Sept 2015
Total	**646**	**399**		

4.9 This section highlights progress made against the actions points in our rolling 14/15 Internal Audit development plan. These include improvements identified as a result of our review against the Public Sector Internal Audit Standards. An additional action has been added in respect of Assurance Level review.

Table 4: Internal Audit Development Key Actions:

Area For Improvement	Agreed Action	Progress Update	Timescale
Training and CPD	Formalise our plans for internal audit training, including continuing professional development (CPD)	On Track: Senior Audit Assistants are signed up to complete IIA Diploma qualification. Participation in Strategic Finance Training programme	Complete
Audit Plan Preparation	2016/17 Draft Plan submitted to December Audit Committee	Submitted to December Committee	Complete
SharePoint site	Upload Audit stage tracker information.	Base Sharepoint site developed and now in use by Internal Audit and Auditees.	Complete
Assurance Levels	Review Assurance Levels.	Internal Audit Team are reviewing options for assurance levels.	31 March 2016

4.10 Internal Audit scorecard data is available on pyramid. The indicators are currently showing as on track. The undernoted table is an extract of the key information.

Internal Audit Team Scorecard 2015 – 16 FQ 2 15/16			
TEAM RESOURCES			
PRDs IA Team G ➡	TARGET	Percentage of PRDs complete	
	90%	100%	
	Number of eligible employees FTE	Number of PRDs complete FTE	
	5	5	
Financial			
Revenue Finance	ACTUAL	BUDGET	G ➡
Year to date	£99,048	£101,117	
Year end	£253,277	£253,277	
SF02 Assurance…that financial and management controls are operating effectively		**Links to Enablers ABC 7**	G ➡
Audit risk assessment prepared by 31 January	Status	On Track	G ➡
	Target		
Annual Audit Plan	Status	On Track	G

	Target	On track	
Annual audit plan approved by 31 March	Status	On track	G ⇨
	Target		
% of audit recommendations accepted	Actual	100%	G ⇨
	Target	100%	
	Benchmark	100%	
% Recommendations followed up	Actual	100%	G ⇨
	Target	100%	
Annual report on risk management	Status	Complete	G ⇧
	Target	Complete	

Percentage qualified staff	Actual	60%	G →
	Target	60%	
	Benchmark		
% satisfaction rates from post audit surveys	Actual	100%	G →
	Target	80%	
	Benchmark		
% customer satisfaction with audit reports	Actual	89%	G ↑
	Target	80%	
	Benchmark		
Internal Audit Training hours	Actual	25 days	R ↑
	Target	30 days	
	Benchmark		

5. CONCLUSION

5.1 The 15/16 Audit Plan is currently on track. Continuous monitoring testing has provided an overall substantial level of assurance. There is an emerging risk in respect of potential long term absence which may impact the timely completion of the 15/16 Audit Plan.

6. IMPLICATIONS

6.1 Policy - Internal Audit continues to adopt a risk based approach

6.2 Financial -None

6.3 Legal -None

6.4 HR - None

6.5 Equalities - None

6.6 Risk – None

6.7 Customer Service - None

Kevin Anderson,
Chief Internal Auditor
4 DECEMBER 2015

For further information contact:
Kevin Anderson, Chief Internal Auditor (01369 708505)

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **4 DECEMBER 2015**

INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE 2015 - 2016

1. EXECUTIVE SUMMARY

1.1 There are 7 audits being reported to the Audit Committee, 6 have substantial assurance and one has a limited assurance opinion.

1.2 Internal Audit provides a level of assurance upon completion of audit work, this is evaluated as follows:

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

1.3 The attached reports contain the action plans which detail those recommendations where Internal Audit in agreement with management has classified the findings either high or medium. Recommendations classified as low have been removed.

1.4 A high level summary of each report is noted below:

- **PROCUREMENT (PECOS):** This audit has a Limited level of assurance. A number of key control weaknesses were identified. These were in relation to authorisation controls whereby approved signatory list did not match the PECOS approval groups. No evidence of prescribed approval limits. Evidence of manual input leading to double entry. A failure to maintain an appropriate audit trail and general housekeeping issues.

- **TAXI LICENCING:** This audit provided a substantial level of assurance. The Audit tested compliance with Taxi and Private Hire Car Licensing Best Practice Guidance for Licensing Authorities, April 2012 which provides information on issues that officials within licensing authorities should take into account when designing and implementing their local licensing procedures. It was evidenced that Argyll & Bute Council has policies and procedures in place in respect of Taxi Licensing arrangements which are generally in line with the Civic Government (Scotland) Act 1982 and best practice guidelines. Some minor issues were identified in relation to data recording /record keeping.

- **TENDERING:** This audit provided a substantial level of assurance with general good practice and adherence to comprehensive guidance which is in place. There are however elements of residual risk which are slightly above an acceptable level and these relate to incomplete records, records management, authorisation protocols, use of available checklists and mobilisation timescale periods.

- **PERFORMANCE MANAGEMENT:** This audit provided a substantial level of assurance. The design and accuracy of the 7 outcomes from the Council Scorecard were tested down through the levels to 298 sub-measures. Results provided assurance of little residual risk in respect of controls in place. Some issues were identified, which although not demonstrating a general trend require to be addressed. These were in relation to clarity of base data information /calculation, missing data, manual input and housekeeping controls.

- **RISK MANAGEMENT:** This audit provided a substantial level of assurance. This audit was undertaken by Grant Thornton, Internal Audit partners. Overall they have reported that internal controls in place to support risk management are generally well designed and operating in practice. Recommendations include ensuring actions within the Strategic Risk Registers are framed in SMART terms and a revised operational risk register review process is considered.

- **EDUCATION ATTAINMENT – LOOKED AFTER CHILDREN:** This audit provided a substantial level of assurance. The Education service has a Service Plan in place that includes service outcomes with improvement and performance measures to support the educational additional support needs of children and young people. A Corporate Parenting Board has been set up and a Corporate Parenting Policy and Strategy is in place. There are a number of initiatives in secondary schools aimed at improving attainment levels of Looked After Children (LAC). There are also a number of guidance documents and procedures available for staff, however, it was not evidenced that there is an overarching document or policy statement in place. Named person contact arrangements are identified as a potential issue however management assurance is in place in respect of on-going discussions.

- **EARLY YEARS:** This audit provided a substantial level of assurance. Adequate arrangements are in place in respect of identifying children eligible for childcare. Service activity is in line with the relevant guidance. A commissioning strategy is in place and adequate arrangements are in place in respect of payment controls. Although not a general trend some control weaknesses were identified in relation to Segregation of duties, formal documenting of the system or process and security of data.

2. RECOMMENDATIONS

2.1 Audit Committee note the content of this summary report and detail within each individual report.

3. CONCLUSION

3.1 Management has accepted each of the reports submitted and have agreed responses and timescales in the respective action plans. The total number of recommendations made within the 7 audits was 39, with 5 of these being rated high.

4. IMPLICATIONS

4.1 Policy - None

4.2 Financial - None

4.3 Legal - None

4.4 HR - None

4.5 Equalities - None

4.6 Risk - None

4.7 Customer Service – None

Kevin Anderson, Chief Internal Auditor
4 December 2015
For further information contact: Kevin Anderson, Chief Internal Auditor
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Governance
Assurance
Risk
Control

ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**PROCUREMENT - PECOS**
AUDIT DATE	**NOVEMBER 2015**

2015/2016

1. BACKGROUND

A review of Procurement and Commissioning within Customer Services has been planned as part of the 2015/16 Internal Audit programme.

The Professional Electronic Commerce Online System (PECOS) is an electronic purchasing system used throughout the Council. During financial year 14/15 26,828 orders were processed with a value of approx. £35 million. There are approx. 1000 users set up on the system across all the service departments.

PECOS is a system that enables the Council to make their purchasing processes while generating efficiencies in respect of reduced paper based systems in relation to ordering and invoicing.

PECOS is a collaborative buying system used throughout the public sector in Scotland. It is a cloud based system that is hosted outwith the Council's server environment, however, PECOS users, can access the system from anywhere within the Council and also through the weblink from any non-Council PC as long as access has been granted.

PECOS is an application for ordering all goods and services needed to run day-to-day business. PECOS provides facilities to order via electronic catalogues or non-catalogue items, through approval routing, to receipting and financial settlement.

The PECOS system operates workflows which manages transactions and approvals, and supports interfaces into the Oracle system. Purchase information and general ledgers are updated via the interface routines. The system also produces reports providing management information such as Spend Analysis.

2. AUDIT SCOPE AND OBJECTIVES

The scope and objectives of the audit were limited to a review of the following:

- User procedures, authorisation roles and responsibilities.
- Housekeeping procedures, archiving and reconciliation processes.
- Reporting and year-end processes and procedures.
- System user manual and guidance.
- Volume of use of PECOS system against other procurement methods and associated risk comparison.

A sample of orders was selected from a cross section of services and walkthrough testing was carried out.

3. RISKS CONSIDERED

- The procurement system does not meet statutory, professional, best practice, requirements and standards.
- The system's accuracy and effectiveness have not been assessed.
- The system, data and activities are not up to date.
- The system is not documented leading to a lack of awareness of processes and requirements.
- Authorities, roles and responsibilities have not been identified and assigned.

4. AUDIT OPINION

The level of assurance given for this report is Limited

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

AUTHORISATION ROLES AND RESPONSIBILITIES

- It was evidenced that approval groups are set up within the system, these groups link members of staff who are able to request orders within PECOS (requisitioner's) and those who are able to approve the orders (approvers). The groups distinguish the roles and the teams within the council that staff can order on behalf of.

- The Council has an Authorised Signatory list on the Hub which provides details of members of staff and management who are able to authorise invoices and other services within the Council. Within the list there is a section for Requisition approval which relates to the PECOS system. A number of discrepancies were evidenced between the Authorised Signatory list and PECOS approval groups, with variations in approval limits and some approvers not present.

- There are approximately 190 approval groups of which only 9 have prescribed authorisation limits. It was also noted that some of these approval groups are either not in use or redundant, however it is not known exactly how many fall into these categories.

- There is no set protocol or indicative matrix for setting approval limits.

- It was evidenced that the PECOS User Application Form includes an upper authorisation limit field, however this is not being used.

- It was evidenced that manual authorisation processes in the form of signed request documents from service staff to the construction purchasing team are being combined with electronic ordering which results in additional administration, increases the risk of error and does not maximise the functionality of the PECOS system. There is currently an exercise underway establishing an Education procurement team who will implement processes entirely based within the PECOS system, once established and if proved successful this should be used as a guide to best practise for the construction team. Internal Audit will review at a later date.

- The travel and accommodation team only use PECOS in limited circumstances. The majority of transactions are off contract due to their nature and the availability of more advantageous rates.

HOUSE KEEPING PROCEDURES

- From a population of 16,000 records entered onto the PECOS system from 1/1/15 – 31/7/15, a sample of 1% = 160 records was taken. From the records reviewed, 58 of the 160 orders remained open despite goods and services having been received and invoices paid, the remainder were complete. The procurement team have provided evidence of measures put in place to ensure that all orders are closed on a timely basis.

- Contained within the approval group information provided for review, there were a number of users who remain on the system despite having left the employment of the Council or changed roles and no longer required access to PECOS.

- The process in relation to ordering goods and services via the construction team and telephone requisition part of ICT is part manual and part electronic. In respect of the manual paper based element we were unable to evidence a full audit trail within the PECOS system. The majority of forms are not attached onto the PECOS system for review purposes.

- Where orders are entered onto the PECOS system retrospectively, descriptions were limited and referred only to the invoice number with no description of goods or services purchased.

- It was evidenced that the PECOS system was being used to facilitate minor utility payments made on a monthly basis. This involves timely manual input to adjust for variances and fails to utilise discounts offered via other payment methods.

- It was evidenced that purchase of ferry tickets did not require receipting as a separate process has been agreed. The controls in respect of this process are adequate, however, outwith PECOS, there is an issue regarding staff re-using old PECOS order numbers for purchase of further ferry tickets, this causes mis-matches within the PECOS system resulting in administrative requirements to process new orders retrospectively.

- PECOS is used as a form of contract monitoring in respect of a council-wide contract for multi-function devices (copiers). The process is very complex and difficult to reconcile with a number of cancellations, updates and adjustments resulting in a less than clear audit trail.

- A reconciliation process is in place which uses a “match-all” button, however, the use of this field is not restricted to the originator/approver of orders and was evidenced as being used in error by other staff.

REPORTING AND YEAR-END PROCESSES

- Housekeeping weaknesses have resulted in a number of issues in relation to accuracy of information produced from PECOS in relation to year-end accrual figures which has resulted in a manual work around process being developed by strategic finance. Measures have recently been put in place to improve housekeeping and increase accuracy of year-end reports.

MANUAL AND GUIDANCE

- A review of the PECOS manual showed comprehensive guidance on how to work the system and online training modules that can be accessed at any time to refresh knowledge.

- The process to request new users is currently a form completed by staff, which requires to be authorised by their line manager and forwarded on to the eProcurement team. This process does not make use of current workflow technology which would also allow for free flow of information for the maintenance of the authorised signatory list, however after discussion with management it is recognised that the team do not have the expertise or resource to implement this level of technology at the present time.

VOLUME OF USE

- Information provided by Customer and Support Services confirms that manual keying of invoices remains the most common method of purchasing and payment of goods and services. The following table highlights the volume and value of use of PECOS in comparison with other methods of purchasing for quarters one and two 2015/16:

SYSTEM	VOLUME	% by Volume	VALUE £	% by Value
PECOS	12,870	25.32	12,312,872	25.89
CareFirst	2,114	4.16	5,717,598	12.02
Tranman	3,598	7.08	981,557	2.06
NATWEST (purchase cards)	2,729	5.37	290,089	0.61
Manual	29,520	58.07	28,258,532	59.42
Total	50,831	100	47,560,648	100

SURVEY RESULTS

- A survey was issued to a cross section of both authoriser and requisition users of the system, 50 surveys were issued and 14 returned, a further 2 indicated that they have moved posts and no longer use the system and one auto reply was received indicating that the user had left the Council. Of the 14 returned 6 were from requisitioners, 7 were from authorisers and 1 had read only access.

- The results of the survey are summarised at Appendix 3, some of the additional comments received included a desire for some additional training and that it would be useful for authorisers to be able to see the items available.

- The variations and multiple boxes ticked for the questions regarding problems finding items or items that are unavailable on PECOS showed the majority of users are aware of alternative methods and the support available from both purchasing team and the eProcurement team.

- An issue was highlighted within the survey regarding coding errors arising from users of the system correcting coding errors on PECOS after the invoice has been received and not completing a corresponding journal entry within the Oracle Financial Management System.

6. CONCLUSION

This audit has provided a Limited level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There were 3 high and 5 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There are 7 low recommendations which are not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the procurement staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Authorisations		**High/ Medium or Low**		
The Authorised Signatories list does not match the PECOS approval groups. There are no standard templates of authorisation limits indicating approval levels.	Increased risk of unauthorised purchasing leading to error and/or ineffective use of resources.	High	**An authorisation limit template will be developed & issued to management for completion, thereafter, passed to both Creditors and Procurement for implementation and subsequent update of approval groups and individual limits. The user limits will be used to set limits within the approval groups on PECOS.**	**Procurement & Commissioning Manager** **31 July 2016**
2. System Functionality				**High/ Medium or Low**
The PECOS User Application Form includes an upper authorisation limit field, however this is not being used	System functionality not being maximised leading to control weaknesses resulting in unauthorised purchasing.	Medium	**PECOS User Application Form will be updated to enforce selection of authorisation values**	**Head of Customer and Support Services** **30 November 2015**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
3. Ordering Processes				**High/ Medium or Low**
Manual authorisation processes are being combined with electronic ordering which results in additional administration, increases the risk of error and does not maximise the functionality of the PECOS system.	Double entry of orders increases risk of error resulting in ineffective use of resources.	Medium	**Senior management to encourage further use of PECOS system**	**Head of Customer and Support Services** **31 December 2015**
4. Housekeeping				**High/ Medium or Low**
The approval group information contained users who have left the employment of the Council or changed roles and no longer required access to PECOS.	Failure to maintain accurate user records leads to unauthorised purchasing	Medium	**An Exercise will be undertaken to remove all inactive users**	**Procurement and Commissioning Manager** **30 November 2015**
5. Housekeeping				**High/ Medium or Low**
The PECOS system was being used to facilitate minor utility payments made on a monthly basis. This involves timely manual input to adjust for variances and fails to utilise discounts offered via other payment methods	Failure to maximise discounts available resulting in ineffective use of resources.	Medium	**User manual will be updated and users advised to ensure most appropriate payment options are utilised to achieve best value**	**Procurement and Commissioning Manager** **30 November 2015**

APPENDIX 2 SURVEY RESULTS

Question	Yes	NO
I am aware of the council's code of conduct for employees'	**10**	**4**
I am aware of the council's code of corporate governance	**6**	**8**
I am aware of the council's Whistleblowing Policy	**5**	**9**
I am aware of the council's Standing Orders and Financial Regulations	**9**	**5**
I am aware of and have received training regarding the Data Protection Act and Freedom of Information Act	**10***	**4**
I am aware your departments records management and document retention procedures	**13**	**1**

	Strongly agree	Agree	Disagree	Strongly disagree
I receive sufficient training and user support to assist me in the use of PECOS	**2**	**10**	**1**	**1**
I have access to the Procurement Policy and PECOS Manual	**3**	**9**	**2**	
I receive written guidance and notification of changes to PECOS	**2**	**10**	**1**	**1**

	Strongly agree	Agree	Disagree	Strongly disagree
I am aware of how to report problems with the system	**2**	**13**		
The information I require is easily located within the system.	**2**	**10**		**2**
Overall I think that the PECOS system is user friendly	**2**	**10**		**2**
Authorisers Only				
I am aware of my responsibility to check orders prior to authorisation.	**5**	**2**		
I am aware of other authorisers who are able to authorise in my absence and they are appropriate	**4**	**3**		
Requisitioners only				

I am aware of the various methods of procurement within PECOS	**2**	**5**		**1**
	Find an alternative item which will do the same job	**Seek support from the Purchasing team**	**Seek support from eProcurement team**	**Use an alternative method of procurement e.g. Purchase card etc.**
If I have any problems finding items within the system, I will.	**3**	**7**	**3**	**2**
If the item required is not available on PECOS, I will.	**2**	**8**	**2**	**3**

- **One of which aware but no training**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**Taxi Licensing**
AUDIT DATE	**October 2015**

2015/2016

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Taxi Licensing within Governance and Law as part of the 2015/2016 Internal Audit programme.

The Civic Government (Scotland) Act 1982 (referred to throughout as the Act) allows for local authorities to license taxis. Within the Act there are specific roles for both the local licensing authority and the police in administering and enforcing the local licensing regime. A Taxi Best Practice Guidance for Licensing Authorities was issued in 2012 by Scottish Government.

Taxis play an essential part in local transport networks, filling gaps in overall public transport provision, particularly for those without access to a car. In Argyll & Bute they are an invaluable service for both residents and visitors. Taking account of the importance of the taxi sector, it is essential that it is regulated to the highest standards, that the public is protected from harm while using the service and the industry is protected from infiltration and targeting by organised crime groups and individuals.

Local licensing authorities, working with the police, are responsible for ensuring that we have in place a licensing system that not only serves local communities, but ensures that in doing so, only fit and proper persons are involved within the management, ownership and operation of taxi businesses.

2. AUDIT SCOPE AND OBJECTIVES

The audit focussed on the adoption and/or compliance with best practice guidance in respect of the undernoted:

- Vehicles including specification, testing, identification, restrictions on quantity of taxi licences and return of plates;
- Taxi Fares and licensing of booking offices procedures;
- Drivers including duration of licenses, criminal record checks, age limits, medical fitness, driving experience, driving proficiency, training and topographical knowledge.

3. RISKS CONSIDERED

- Failure to adopt best practice guidance and timely provision of Taxi Licences to the public;
- Policies and Protocols are not clearly defined leading to potential non-compliance with legislative requirement;
- Failure to adhere to set down procedures and protocols.

4. AUDIT OPINION

The level of assurance given for this report is Substantial. Argyll & Bute Council has policies and procedures in place to meet the legislative obligations set out in the Civic Government (Scotland) Act 1982 and where appropriate have followed the best practice guidance set out in the Taxi Best Practice Guidance for Licensing Authorities issued in 2012.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

5.1 Taxi and Private Hire Car Licensing: Best Practice Guidance for Licensing Authorities, April 2012 provides information on issues that officials within licensing authorities should take into account when designing and implementing their local licensing procedures. It was evidenced that Argyll & Bute Council has policies and procedures in place in respect of Taxi Licensing arrangements which are generally in line with the Civic Government (Scotland) Act 1982 and best practice guidelines.

Policies and Procedures

5.2 It was evidenced that information relating to taxi licence fees, eligibility criteria, procedures regarding applications for taxi licences, and conditions of applying for a taxi licence were available on the Council's website.

5.3 It was evidenced that the Council hold annual meetings with taxi operators on an area basis. This allows the Council to discuss any current issues, including any appropriate police issues. It also provides a forum for taxi operators to raise any concerns or issues they may have.

5.4 It was evidenced that a register of taxi drivers is held, maintained and up to date.

Vehicles

5.5 The Act requires that a licensing authority should not grant or renew a taxi licence unless they are satisfied that the vehicle to which the licence relates is suitable in type, size and design for use as a taxi and is safe for that use. It was evidenced that as part of the application and renewal process, applicants are required to provide documentary evidence of ownership of vehicle (log book) and MOT certificate (where applicable).

5.6 The legislation gives local authorities a wide range of discretion over the types of vehicle that they can license as taxis. It was evidenced that Argyll & Bute have considered allowing new vehicle types to be considered for a Taxi Licence. An example of this would be consideration has been given to including tuk vehicles and trikes on the list of vehicles approved for use as taxis.

5.7 The holder of a taxi licence in terms of the Act is required to present the vehicle for inspection. The legal requirement for taxis requires that they should be subject to an MOT test or its equivalent one year after first registration and annually thereafter. Notwithstanding MOT requirements, best practice indicates that authorities undertake inspection of taxis at first licensing and annually or more frequently thereafter. It was evidenced that annual inspections of taxis are undertaken at various Council depots throughout Argyll.

5.8 Good practice indicates that local authorities should consider having more than one testing station. It was found that Argyll & Bute have 8 depots throughout Argyll & Bute that offer taxi vehicle testing.

5.9 Best practice suggests that as taxis provide a service to the public, it is also appropriate to set criteria for the internal condition of the vehicle, requiring for example the internal passenger accommodation, upholstery and fittings to be maintained in a serviceable condition. It was evidenced that the Argyll & Bute Schedule of Conditions for Taxis require that the holder of a Taxi Licence shall ensure that the taxi, including all bodywork, upholstery and fittings is in a good safe and serviceable condition and that subject to prevailing road conditions in a clean condition. It was further evidenced that the annual inspection carried out looks at the general standard of the vehicle to ascertain if the vehicle complies with the conditions.

5.10 Tranman (Roads & Transportation Data Management System) procedures require that on completion of the inspection a member of staff at the depot is required to scan a number of documents including the MOT and Insurance on to Tranman. After completion of the inspection the pass/fail certificate requires to be scanned in. Also entered into Tranman is the MOT Date and the Insurance expiry date. It was evidenced that there are inconsistencies in the information being recorded on Tranman and it was found that not all information is being recorded as required in the procedures.

5.11 The Act requires that there is an insurance policy in place relating to the vehicle. It was evidenced that as part of the application and renewal process applicants are required to provide documentary evidence of insurance policy for vehicles. It was further evidenced that vehicle insurance is checked as part of the annual inspection process.

5.12 A taxi licence extends to the operation of a vehicle substituted for the vehicle in respect of which the licence was granted or, as the case may be, last renewed. It was evidenced that procedures are in place in respect of notification for substitute vehicles and that notifications are being recorded.

5.13 The holder of a taxi licence is required within 28 days of selling or otherwise disposing of a vehicle to which the licence relates to deliver to the licensing authority his licence and any licence plate or other item which has been issued by the licensing authority for the purpose of indicating that the vehicle is a taxi. Taxi licence plates must be returned to the Council if the licence holder ceases to operate, the Council has procedures in place for the return of licence plates and as part of those procedures failure to return a licence plate would result in referring the matter to the police.

5.14 The present legal provision on quantity restrictions for taxis is set out in section 10(3) of the Act. This provides that: the grant of a taxi licence may be refused by a licensing authority for the purpose of limiting the number of taxis in respect of which licences are granted by them if, but only if, they are satisfied that there is no significant demand for the services of taxis in their area which is unmet. The quantity of taxi licences is not restricted within Argyll & Bute and each application for a new licence is considered on an individual basis. An unmet need survey was undertaken in 2014, this report is presented to members alongside applications in order to inform their decision.

5.15 Best practice suggests that Licensing authorities should actively promote and facilitate good links between the taxi and private hire car trades and the local police force, including active participation in any crime reduction initiatives. Informal discussions are held with the Community Liaison Officer and Argyll & Bute hold meeting with licence holders providing an opportunity to discuss any areas of concern which can be followed up in discussions with the police. It was evidenced that there is partnership working with the police. The police are a consultee on applications, the Head of Governance and Law also meets with police and meets with taxi operators at annual meetings.

5.16 Best practice recommends licensing authorities consider sympathetically, or indeed actively encourage, the installation of security measures which could include a screen between driver and passenger or CCTV. All Taxi drivers were written to and were asked for their views. This has been considered but is not currently considered an issue. It was evidenced that Taxi licence holders were made aware of this recommendation in a letter from the Authority dated 2012.

5.17 Best practice indicates that licensing authorities should consider how far their vehicle licensing policies can and should support any local environmental policies that may be adopted. It was not evidenced that this has currently been considered within Argyll & Bute policies.

Taxi Fares/Tariffs & Licence Application Fees

5.18 Licensing authorities are required to set maximum fares and other charges for taxis operating in their areas. The tariffs set by councils are maximum charges and operators may charge less at their own discretion. Argyll and Bute Council, in terms of the Civic Government (Scotland) Act 1982, have fixed a fare scale as the maximum fares and other charges in connection with the hire of taxis in public places within Argyll and Bute. Taxi fare scales are available on the Council's website.

5.19 Licensing authorities can charge fees in respect of taxi licences and applications for taxi licences. The Authority must ensure that the total amount of the fees is sufficient to meet the expenses incurred by them in carrying out their functions. It was evidenced that Legal services work with Strategic Finance staff in relation to setting taxi licence fees.

5.20 The Civic Government (Scotland) Act 1982 Licensing and Regulation requires that they consult with operators of taxis. It was evidenced that annual meetings are held with taxi operators in each of the areas as part of the consultation process. These meetings provide a forum to discuss any taxi related issues in terms of information from the Council and any concerns of taxi operators. The Head of Governance and Law attends these meetings.

Booking Offices

5.21 The Civic Government (Scotland) Act 1982 (Licensing of Booking Offices) Order provides that booking offices (those which take bookings for 4 or more relevant vehicles) must hold a booking office licence issued by the local authority in which area the premises are located. The Authority is required to send a copy of any application to the Chief Constable. The result is that those responsible for the operation of booking offices (the licence holder) are subject to police criminal record checks. It was evidenced that procedures are in place with regards to booking offices and that applications are sent to Police Scotland for comment.

5.22 The Order prescribes several licensing conditions which authorities are required to attach to the grant or renewal of a booking office licence. These conditions require that a record is kept of all bookings taken and that that record should include the registration number of the vehicle and the name of the driver fulfilling the hire. The licence holder is also required to take all reasonable steps to ensure that any vehicle and driver used to fulfil a hire is appropriately licensed under the 1982 Act. It was evidenced that Booking Office Licence holders are made aware for their responsibilities to hold appropriate records.

Drivers

5.23 The Act requires that a licensing authority should not grant a licence to any person unless the person has held a licence authorising them to drive a motor vehicle during any continuous period of 12 months prior to the date of his application. It was evidenced that drivers are required to submit a copy of their drivers licence as part of the application and renewal process. This is checked for compliance to the 12 month requirement.

5.24 Best practice suggests that, subject to no cause for concern licences should be granted for a 3 year period. However, licensing authorities have discretion to issue annual licences for new applicants where they feel a more frequent level of scrutiny is required. It was evidenced that licences are currently renewed on a three yearly basis in Argyll & Bute.

5.25 Applications for grant or renewal of taxi driver licences are required in terms of schedule 1 of the Act to be copied to the Chief Constable. Any objection or representation relating to an application for the grant or renewal of a licence will be refused if the applicant is disqualified or is not a fit and proper person to be a holder of the licence. It was evidenced that as part of the application process a criminal conviction declaration form requires to be completed by the applicant, it was further evidenced that the application is referred to Police Scotland for comment. Any objection or representation from Police Scotland is referred to the members in order that they can make an informed decision on whether to grant the licence.

5.26 Best practice recommends that where appropriate, local licensing authorities will want to consider a policy on applicants from other EU and non-EU countries. One approach is to require a certificate of good conduct authenticated by the relevant embassy. Where appropriate, Argyll & Bute require applicants from other EU and non-EU countries are required to submit a certificate of good conduct authenticated by the relevant embassy. It was evidenced that Argyll & Bute Council request a certificate of good conduct where applicable.

5.27 Best practice indicates that the licensing authority may, at any time, for the purposes of satisfying themselves that the licence holder is physically fit to drive a taxi, require them (an applicant for or holder of a taxi driver's licence) to submit to medical examination, at their expense, by a medical practitioner nominated by them. Argyll & Bute Council require a medical declaration to be completed for all applicants and once age 65 is reached a medical report requires to be completed by a health professional. It was evidenced that officers of the Council and members are provided with necessary medical information in order that they can make an informed decision on whether to grant a taxi licence.

5.28 A number of Scottish licensing authorities have, or are developing, minimum training requirements for taxi drivers which require to be met at first grant of a licence or at renewal. In addition the Scottish Government commends as best practice the importance of such vocational training for drivers and would encourage authorities to adopt a positive approach to vocational training. It was not evidenced that Argyll & Bute Council offers vocational training for taxi drivers at this stage, however consideration has been given to providing disability awareness training.

5.29 A licensing authority may require an applicant for a taxi driver's licence to take a test of his knowledge of the area (Argyll & Bute), of the layout of roads in that area. The authority may refuse to grant a licence to a person who does not satisfy them that he has adequate knowledge of any of these matters. The Council do not currently require taxi licence applicants to undertake a topographical knowledge test. It has been considered and a paper was presented to Committee in 2003. It is not considered necessary as the circumstances and geography of Argyll & Bute remain the same.

6. CONCLUSION

This audit has provided a substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There is one medium recommendation set out in Appendix 1 which will be reported to the Audit Committee. There is 1 low recommendation which is not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Legal Service staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Data Recording		**High/ Medium or Low**		
Inconsistencies in the information being recorded on Tranman, it was found that not all information records are available for review.	Failure to accurately record information leads to increased risk of error resulting in non-compliance with agreed policy	Medium	Governance and Law will make contact with depots to ensure compliance with scanning requirement and put in place arrangements to monitor	**Heads of Governance and Law/Roads and Amenity services** **March 2016**

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ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**Tendering Processes**
AUDIT DATE	**September 2015**

2015/2016

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Procurement processes within Customer Services as part of the 2015/16 Internal Audit programme.

Public procurement is the process by which public bodies acquire goods, services and works from third parties to meet customer and service user needs.

The Council's Procurement Strategy for 2012–2015 details strategic procurement arrangements. Effective procurement arrangements can make significant contributions to a wide range of Council objectives including a successful local economy, a thriving voluntary sector, community involvement and environmental issues as well as delivering value for money. It is essential that procurement decisions are taken with a focus on the outcomes that the Council is seeking to achieve.

All purchasing must take place in accordance with the Council's statutory duty to secure best value under the Local Government in (Scotland) Act 2003. This requires the Council to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance, having regard to economy, efficiency, effectiveness, and equal opportunities requirements and to contribute to the achievement of sustainable development.

The Council has a Procurement Strategy in place that covers the procurement aims and goals of the Council for 2012-2015. These aims and goals reflect both national and local policies and priorities.

The Council operates with a small procurement team, with the combination of Purchasing Officers working on corporate contracts (those that are for the purchase of goods, services and works that are common across the Council) and Purchasing Officers embedded within service departments, working on contracts that are largely specific to the activities of those services. The 2014/15 budget for the procurement team is £433k which represents 18.1 full time equivalents.

2. AUDIT SCOPE AND OBJECTIVES

The audit scope will be limited to:

Review a sample of supplies and services /works procured covering the following areas:

- Procurement Sourcing strategy has been outlined and agreed ,
- Pre-qualification has been properly carried out where the sourcing strategy has determined that this is appropriate.
- Invitation to Tenders (ITT) documents have been properly submitted in accordance with guidance
- Invitation to Tenders documents have been properly evaluated as per guidance
- The contract has been properly awarded and the recommendation report (CARR) has been properly prepared in line with guidance

Control objectives will include Authority, Occurrence, Completeness, Measurement, Timeliness and Regularity.

3. RISKS CONSIDERED

- Non-compliance with legislation requirements
- Non-compliance with operational policy
- Reputational damage to the Council
- Failure to secure best value

4. AUDIT OPINION

The level of assurance given for this report is substantial.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

- It was evidenced that the Council has a procurement manual which outlines the steps in order to achieve effective procurement by detailing the processes and procedures that should be carried out. The manual covers :

    - Planning, procurement and strategy
    - Advertising on Public Scotland Contract website and /or the office journal of the EU
    - Pre-qualification to establish the capability and capacity of the tenderers
    - Invitation to tenders
    - Submission of tenders
    - Evaluation of bids
    - Award decision
    - Standstill
    - Completion of contract
    - Contract Award Recommendation Report
    - Management of Contract

- A sample of 21 tenders was chosen from the procurement database. The sample was chosen covered a range of values and various procurement routes that a tender may follow. The Scottish Government has published guidance for Councils on Procurement routes and these are defined as under noted:

    <u>Route 1</u>

    Route one has been designed to be used by staff across the public sector who have a requirement and are authorised by their organisation to conduct low value/low risk/non repetitive procurement for goods or services. It is not necessary for staff using these processes to have extensive purchasing training; however it is assumed that individuals who are authorised to procure for their organisation have an awareness of EU Regulations and any applicable local procurement policies, guidelines and governance arrangements.

Route 2

This Route of the Procurement Journey is for the procurement of moderate value and risk procurements and is designed for use by Procurement officers and it is assumed that individuals will have been trained in EU regulations. Consideration must be given to planning and risk and records should be kept for audit purposes

Route 3

This Route of the Procurement Journey provides guidance for high value/high risk/strategic procurements and is designed for use by Procurement officers and it is assumed that individuals will have been trained in EU regulations. Consideration must be given to planning and risk and records should be kept for audit purposes

- Of the 21 tenders chosen, 8 related to "route 1" journey where the procurement is of relatively low risk and is of a non-repetitive nature. Of the remaining 13 tenders, 7 related to "route 2" journey and 6 related to "route 3" journey where services are openly advertised and the risk is deemed medium to high.

- In respect of the 21 tenders chosen for the various routes it was evidenced that for all routes personnel involved had the appropriate training and knowledge.

Scope 1: Procurement Sourcing Strategy has been outlined and agreed

- It is the policy of the Council that a Sourcing Strategy should be prepared to ensure that the Council's approach to a particular procurement has been fully thought out prior to embarking on the selection process. As per the procurement manual "it is not necessary to devise a sourcing strategy for each individual procurement exercise, advice is to be taken from the purchasing officer as to when it is appropriate to use / compile a sourcing strategy" i.e. when an existing framework is in place. The council procurement manual details the various requirements that the sourcing strategy should cover namely :

- Executive summary
- Stakeholder and User Intelligence Group (route 2 and 3 only)
- Internal Research
- Market Research and Analysis
- Risks and Issues
- Opportunity Assessment
- Options Appraisal
- Procurement Approach
- Project Plan
- Conclusion

A summary of the findings concerning sourcing strategy is outlined below:

	No of Tenders Reviewed	Comprehensive Sourcing Strategy in Place or framework adopted	Draft comprehensive Sourcing Strategy	No evidence of a Comprehensive Sourcing Strategy in place	Evidence of Management approval of Sourcing Strategies	No evidence of Management approval
Route 1	8	5	1	2	5	3
Route 2	7	6	0	1	6	1
Route 3	6	5	1	0	2	4

Route 1 tenders

- A review of the "route 1" tenders showed that for one of the tenders a comprehensive sourcing "draft" sourcing strategy was completed as per the procurement manual guidelines though no evidence could be found of a "final" sourcing strategy which had been approved.

- As regards the remaining 7 tenders it was evidenced that 5 of the tenders either had a comprehensive sourcing strategy in place or that the service/commodity had been acquired via a framework agreement, and therefore as per the procurement manual there was no requirement to produce a sourcing strategy. For the remaining 2 no evidence of a sourcing strategy was in place.

Route 2 tenders

- Of the 7 "route 2" tenders which were reviewed 6 were evidenced as having a comprehensive strategy in place. Of these 7 tenders 6 had appropriate authorisation controls in place.

- As regarding the 7th tender reviewed, it was evidenced that a summarised sourcing strategy had been prepared in the form of an executive summary but no evidence could be found of a comprehensive sourcing strategy as prescribed in the Procurement Manual, also no evidence of sign off authorisation control.

Route 3 tenders

- Of the 6 "route 3" tenders which were reviewed it was evidenced that 5 had a comprehensive sourcing strategy. It was evidenced that the 6th strategy was in a "draft" stage and no evidence could be found of the completed version.

- For 4 of the 6 "route 3 "tenders reviewed there was no evidence of appropriate authorisation control.

- It was noted for a number of tenders undertaken via framework agreement; explanations of the reasons as to why the route was chosen were given but these reasons are not formally documented.

Scope 2:Pre-qualification has been properly carried out where the sourcing strategy has determined that this is appropriate.

- Where it was deemed appropriate that a pre-qualification exercise should be carried it was evidenced that actions adhered to prescribed guidance. It was noted that for one tender where a Pre-Qualification Questionnaire (PQQ) had been required no sourcing strategy was prepared, however it was evidenced from e-mails which sets out the rationale for a PQQ, that a PQQ would be required for this tender.

- It was evidenced that a PQQ had been prepared and that an evaluation of each of the PQQ returns had been carried out via a scoring mechanism. It was also evidenced that a PQQ model answer document had been prepared that sets out the responses that would be expected from respondents to aid scoring. The purpose of this document is to ensure that there is an objective benchmark available when scoring candidates responses.

- It was evidenced that scoring sheets had been properly evaluated and that a score had been given awarded on the responses required per the PQQ.

- It was evidenced that the candidates invited to the Invitation to tender stage were appropriately selected having achieved the highest scores.

Scope 3: Invitation to Tender (ITT) documents have been properly submitted in accordance with manual

- Tenders were reviewed to assess compliance with procedures stipulated in the Procurement Manual as regards submission of ITT's namely:

    - Opening of tenders is only carried out by the Procurement and Commissioning Team.
    - ITT are submitted within the deadlines stipulated.

- It was evidenced that for all tenders reviewed that the procedures outlined above had been adhered to.

Scope 4: Invitation to Tenders documents have been properly evaluated as per manual

- Tenders were reviewed to ensure compliance with procedures stipulated in the Procurement Manual namely :
    - Panel member involved in evaluating the tender have been involved in PQQ and/or ITT.
    - There is a minimum of 2 panel members who demonstrate technical ability to evaluate tenders , one of which may be from the procurement team
    - Evaluation and scoring methodology has been determined.
    - Each panel has completed a scoring sheet which contains strengths/weaknesses for each question.
    - Price scoring has been carried out by the Procurement Contract team only.
    - Scoring sheets have been properly completed.

- Of the tenders evaluated it was noted that 4 consisted of 2 panel members of whom one included the procurement officer which complies with the 2014 manual. It is noted that the new guidelines for 2015 state that there will normally be a minimum of 3 evaluation panel members and a representative from Procurement Contract Team acting as Chairperson.

- It was evidenced that an audit trail was available with scoring sheets properly evaluated and that a score had been given awarded on the responses required per the tender documents. It was also evidenced that each panel member had recorded their scores/reasoning on to an electronic scoring matrix and that comments had been inserted where appropriate.

Scope 5: The contract has been properly awarded and the recommendation report has been properly prepared.

- The Procurement Manual stipulates that a Contract Award Recommendation Report (CARR) should be prepared by the Procurement Officer for approval by the prescribed signatories. The CARR is an internal mechanism to record the decision making process for contract award and provides an audit trail to enable the authorised signatories to approve the recommendation based on all available information.

- Once the CARR has been prepared and signed off the manual stipulates that the successful and unsuccessful tenderers should be notified by the Procurement team as soon as possible after the award.

- The Procurement Manual contains a template which states the headings that should be elaborated on when completing the CARR namely :

    - Purpose of report
    - Summary of requirements
    - Details and results of PQQ if appropriate
    - Price/quality ratio results
    - Details of any bid clarifications
    - Details of any interviews carried out
    - Details of any presentations
    - Details of any post tender negotiations
    - Sustainability considerations
    - Final recommendations
    - Evidence of sign off by relevant personnel

- CARR's were reviewed in order to evidence actions as specified in the headings listed above had been carried out in order for management to approve the recommendation on all information available. It was noted that 6 of the CARR'S reviewed did not reference the following areas, interviews, presentations, post tender negotiations and sustainability.

- It was noted that for 2 of the CARR'S reviewed detailed information relating to the sourcing strategy was included in the CARR. This requirement is not prescribed in the manual but nevertheless gives assurance to management that the sourcing strategy had been addressed.

- For CARR's reviewed appropriate authorisation controls were in place however it was noted that for one tender it had not been formally signed and the head of service name had been typed in the relevant box.

- It was evidenced that all successful and unsuccessful tenderers had been properly notified as prescribed in the manual.

- It was noted that the template for each of the CARR'S has a section at the bottom entitled for "Procurement Officer Use only" where the various stages of the Procurement route are outlined and where a date of completion should be entered. The stages being :

    - Notification issued to preferred bidder
    - Notification issued to unsuccessful bidder
    - Standstill period commenced
    - Contract Award letter issued
    - Copy of Award letter passed to appropriate finance manager
    - Contract award noticed placed
    - Confirm that contract award has been uploaded into spikes

    It was noted that none of the CARR's reviewed had this table completed.

- Included in the manual for "routes 2 and 3" tenders is the pre contract Award checklist requirement where a yes/no answer is required for the following :

    - Can all information provided to a supplier be justified in the event of a formal complaint and/or legal action?
    - Was the standstill notice sent to all tenderers and candidates?
    - Has the standstill period actually passed? Note the standstill period should not end on weekends or public holidays.

    There was no evidence from the "routes 2 and 3" tenders reviewed that this checklist had been completed.

- It was noted that mobilisation timescales for contract implementation was specified in only 6 of the CARR's reviewed and involved a period of between 2 and 4 weeks.

- Whilst undertaking the audit it was noted that record management arrangements were inconsistent.

6. CONCLUSION

This audit has provided a substantial level of assurance however elements of residual risk are slightly above an acceptable level and need to be addressed in a reasonable time scale. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There were 2 high and 4 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There is one low recommendation which is not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Customer Services staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Incomplete Documentation		**High/ Medium or Low**		
During the audit it was noted that Sourcing Strategy documentation was incomplete and/or unavailable.	Failure to have complete documentation may result in ineffective decision making leading to failure to achieve best value and/or legal challenge.	High	**Where documentation was incomplete and /or unavailable sourcing strategies had been approved via the CARR process. Ensure guidance is provided to all services and staff to ensure that Sourcing Strategies are complete prior to passing to appropriate signatory for sign off when these are required.**	**Procurement Commissioning Manager** **30th November 2015**
2. Authorisation Protocols				**High/ Medium or Low**
Authorisation control weaknesses were identified in respect of Management signing off Sourcing Strategy	Failure to adhere to authorisation control results in ineffective purchasing which does not reflect value for	High	**Where there was no management sign off of sourcing strategy this was covered via the CARR process.**	**Procurement Commissioning Manager**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
	money or operational efficiency		**Ensure guidance is provided to all services and staff to ensure appropriate authorised signatory signs off Sourcing strategy**	**30th November 2015**
3. Contract Award Recommendation Report				**High/ Medium or Low**
Inconsistences exist in respect of content of reports specifically in regard to interviews, post tender negotiations, presentations and sustainability .	Reports are produced which do not provide all available information potentially leading to ineffective decision making.	Medium	**In the CARRs where headings were removed, this was due to the fact that this particular procurement process did not occur hence the removal of these headings.** **Ensure all headings in CARR remain and are not deleted and if they are not appropriate for the specific contract officers to state this i.e. not applicable**	**Procurement Commissioning Manager** **30th November 2015**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
4 Completion Stages				**High/ Medium or Low**
Documentation includes completion checklist however from the tenders reviewed it was evidenced that none of these had been completed.	Failure to complete checklist increases potential for omission /error resulting in inefficient use of resources.	Medium	**Remove checklist from CARR and include within tender sub folder filing structure which has end to end process and will evidence completion stages.**	**Procurement Commissioning Manager** **30th November 2015**
5. Records Management				**High/ Medium or Low**
Whilst undertaking the audit it was noted that record management arrangements were inconsistent.	Failure to have adequate records management arrangement adversely impact on transparency resulting in further scrutiny.	Medium	**Review of file structure has been implemented and proposed tender sub folder filing structure agreed at team meeting on 27th October**	**Procurement Commissioning Manager** **30th November 2015**
6. Mobilisation periods				**High/ Medium or Low**
Mobilisation timescale is not always specified or may be insufficient in length.	Mobilisation timescale is insufficient to allow tenderer to make necessary arrangements and meet specified	Medium	Mobilisation period not always relevant i.e. contract can start immediately on start date. When mobilisation	**Procurement Commissioning Manager**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
	requirements.		appropriate, this is dealt with in CARR and in sourcing strategy. Management arrangements are in place to give consideration to nature of contract/tender and potential mobilisation time required.	**30th November 2015**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**PERFORMANCE MANAGEMENT**
AUDIT DATE	**NOVEMBER 2015**

2015/2016

1. BACKGROUND

A review of Performance Management within the Improvement and Organisational Development (IOD) section of the Improvement and HR Service has been planned as part of the 2015/16 Internal Audit programme.

The Council has a Planning and Performance Management Framework (PPMF) which describes how it plans and manages performance. The Framework is designed to enable alignment between the Council's available resources and corporate objectives. The balanced scorecard ensures the focus of the organisation remains firmly fixed on its Strategic Objectives.

Pyramid is the Council's Performance Management System, providing up to date information on levels of performance across the broad range of services that we provide. The system includes Council, Department, Service and Area Scorecards to provide the key management information required at all levels in the organisation. The Corporate, Area and Single Outcome Agreement (SOA) scorecards contain Red, Amber and Green (RAG) indicators to allow management to easily identify areas of concern.

There is a wide range of success measures which are monitored through service scorecards. These are analysed on an ongoing basis to show progress against targets. Quarterly performance reports including council and departmental scorecards are presented to the Performance Review and Scrutiny Committee. The reports outline performance during the period including a review of successes, key challenges and improvement actions for the coming period.

2. AUDIT SCOPE AND OBJECTIVES

To assess performance information in terms of relevance, accuracy and consistency across all services.

The scope of the audit will include:

- Review scorecard hierarchy and test the integrity of roll up of data.
- Review sample of outcomes/measures to assess whether compliant with relevant guidance.
- Review the process for RAG tolerance level setting.
- Review the process in relation to manual override of data provided by other council systems.

Control objectives will include Authority, Occurrence, Completeness, Measurement, Timeliness and Regularity.

3. RISKS CONSIDERED

SRR: Ineffective management of services leading to failure to achieve agreed performance levels and as a result services not contributing fully to Council objectives.

Roles and responsibilities have not been defined leading to inconsistencies within the system resulting in ineffective management.

Performance information is inaccurate and there is a lack of supporting documentation leading to misreporting resulting in internal and external criticism.

4. AUDIT OPINION

The level of assurance given for this report is Substantial.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

SCORECARD HIERARCHY AND ROLL UP OF DATA

The design and accuracy of the 7 outcomes from the Council Scorecard were tested down through the levels to 298 sub-measures. Of these sub-measures, several underwent further investigation to eliminate apparent inconsistencies and errors. This exercise resulted in 15 sub-measures remaining with anomalies or issues to be addressed.

One Service success measure was found to have variations in the base level calculation which resulted in inconsistent roll up of the data. The level of detail and design of the measure did not allow for transparent and clear interpretation.

Where measures show as a percentage, the underlying data is not available in all cases and values have been directly input to the Pyramid system.

It was evidenced that some measures are pulling the base data for their calculation from other areas within Pyramid. These measures have other information showing below them which is not used for their calculation, although it does relate to the measure. It is unclear as to which set of data underpins the calculation and there are no descriptions of where the data is pulled from.

It was evidenced during testing that where data is missing in sub-measures the roll up to higher level scorecards is still taking place and has the potential to provide a misleading value.

There were instances where data had been input for a period when no activity had taken place; in these circumstances agreed practice is for the target to be reduced to zero. There were inconsistencies in the application of this process which resulted in red indicators that would have been green.

During testing it was noted that one of the Governance and Law outcomes rolls up to an outcome within "Education, skills and training maximises opportunities for all" to which it has no direct link and would appear to be more relevant to another area within the scorecard. This anomaly is currently being addressed.

In relation to comments which are linked to particular measures, the information dates back more than 3 years and there is no evidence of data cleansing or housekeeping having taken place.

BENCHMARKING OF OUTCOMES/MEASURES

It was evidenced during testing that where outcomes/measures are required for benchmarking purposes, they are appropriately flagged and details given of the agencies and organisations used. If they are Council specific details are provided of their connection to the objectives of the organisation.

RAG TOLERANCE LEVEL SETTING

The process for the setting of Red, Amber and Green indicators was tested and found to be operating as designed. There is one agreed exception, where an original agreed plan has been revised with new target dates, it is reported as "on track to revised plan" this will show as amber in the higher levels, as the original target has not been met and will only change to green on completion.

Clear Guidance is provided to management on setting performance target levels within the service planning packs.

FEEDER SYSTEMS

The pyramid team with the assistance of IT and a number of services have developed a process for systems to produce reports which feed directly into Pyramid; this reduces the time taken for input and reduces the potential for human error. It was noted that there are a number of other services not currently utilising feeder systems which may be an inefficient use of resources.

MANUAL OVERRIDE OF DATA

The process for entering data onto pyramid is limited to authorised "inputters" within services. If data is entered incorrectly the data can be changed at any time, however, a previous audit agreed action due to be completed in December 2015 was to "identify an agreed mechanism for data control after period end." This is currently reported as "on course" for completion with data being locked-out for edit when greater than one year old.

The information uploaded by feeder systems is restricted through the personnel who have access to edit the fields, where the data is queried a re-run of the report and upload is undertaken to ensure accuracy.

It was evidenced that where a service requests changes to the measures that have been agreed through the Service Planning process there are appropriate authorisation controls in place.

6. CONCLUSION

This audit has provided a Substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There were 2 high and 5 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There is one low recommendations which is not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the improvement and organisational development staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Success Measure Design		**High/ Medium or Low**		
One service success measure was found to have variations in the base level calculation which resulted in inconsistent roll up of the data. The level of detail and design of the measure did not allow for transparent and clear interpretation.	Inconsistent presentation of data resulting in reduced clarity in reporting of performance information.	Medium	**Bring consistency to roll-up of data presentation within Pyramid Performance Management System.**	**Head of Improvement & HR** **31 March 2016**
2. Missing Data				**High/ Medium or Low**
It was evidenced during testing that where data is missing in sub-measures the roll up to higher level scorecards is still taking place and has the potential to provide a misleading value	Missing data leading to roll up of inaccurate calculation resulting in inaccurate reporting.	High	**Roll up of data should be disabled when data is missing from a measure that feeds up to a Scorecard.**	**Head of Improvement & HR** **31 December 2015**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
3. Success Measure Design		**High/ Medium or Low**		
It was evidenced that some measures are pulling the base data for their calculation from other areas within Pyramid. These measures have other information showing below them which is not used for their calculation, although it does relate to the measure. It is unclear as to which set of data underpins the calculation and there are no descriptions of where the data is pulled from.	Inability to recalculate values leading to lack of certainty in accuracy of data.	Medium	**Investigate extent of the exercise to update descriptions and devise a plan to take forward following agreement of Customer Services DMT.**	**Head of Improvement & HR** **31 March 2016**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
4. Target Maintenance		**High/ Medium or Low**		
There were inconsistencies in the application of the resetting of targets to zero, in instances where no activity had taken place to measure.	Incorrect targets leading to roll up of inaccurate data resulting in misreporting.	Medium	**Pyramid user guide will be updated and reminder issued to staff who input data to ensure they are fully aware of consequences to scorecard data if guidance is not followed.**	**Head of Improvement & HR** **31 December 2015**
5. Base data		**High/ Medium or Low**		
Where measures show as a percentage, the underlying data is not available in all cases and values have been directly input to the Pyramid system.	Lack of control of source data leading to the potential for errors to occur resulting in misreporting.	Medium	**Measures are designed and guidance issued to all services to ensure that base data is entered to allow the system to calculate percentage values.**	**Head of Improvement & HR** **30 June 2016**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
6. Feeder Systems		**High/ Medium or Low**		
There are opportunities to increase use of feeder systems to improve performance and create efficiencies.	Potential efficiencies are not realised resulting in wasted resources.	Medium	**Discussions with IT and services to identify and develop reports which can be used to upload into Pyramid. For example Ctax/NDR (Northgate), HR (Resourcelink), Community Services (CareFirst) etc.**	**Head of Improvement & HR** **31 March 2016**
7. Placement within Scorecard		**High/ Medium or Low**		
It was noted that one of the Governance and Law service outcomes is rolling up to the Council Scorecard, SOA Outcome – Education, skills and training maximises opportunities for all, this would appear to be more relevant to another area within the scorecard.	Potential to skew top level results resulting in misreporting.	Medium	**The measure will be reviewed with management and relocated.**	**Head of Improvement & HR** **31 December 2015**

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Argyll & Bute Council

2015-16 Annual Review of Risk Management Arrangements

Contents

1 Executive Summary

1.1 Background

Effective risk management is a key element of the Council's overall governance arrangements. The Audit Committee has a role to promote risk management and provide reasonable assurance that arrangements are effective. We therefore agreed that a review of risk management arrangements will be included as part of the annual internal audit programme of work.

The key objective for the audit is to ensure that the Council is not exposed to an unacceptable level of risk as a result of failing to adequately determine its risks and monitor changes in the Council's risk profile. To maintain independence, the review was led by Grant Thornton, the Council's internal audit strategic partners.

1.2 Audit Approach

Our review considered the way in which strategic and operational risks are managed at the Council. We considered the following risks as part of the review:

- Roles and responsibilities for risk management are not clear leading to ineffective corporate governance and resulting in confusion over lines of accountability.
- Current arrangements fail to identify new and emerging risks resulting in potential exposure to unacceptable risk.
- Arrangements to manage and mitigate risks are ineffective leading to inappropriate allocation of resources.

Our approach included interviews with key officers across the Council, including a sample of Heads of Service, review of risk management policies and guidance documents, minutes of meetings and updates to the Strategic and Operational Risk Registers. We also reviewed the risk monitoring facilities on the Council's performance monitoring system, Pyramid.

1.3 Key findings

Roles and responsibilities

The Risk Management Policy and supporting guidance provides a clear framework for risk across the Council. Responsibility for risk management is delegated to the Strategic Management Team (SMT), with responsibility for risk management led by the Head of Strategic Finance. The SMT receive updates on the Strategic Risk Register on a 6 monthly cycle, and there was evidence of discussion and challenge both on the risks and on scores. A recent proposal to improve risk management arrangements by formally documenting and monitoring risk appetite has recently been submitted to the SMT for approval.

Interviews with officers at service level confirmed a good level of understanding of risk management and their individual responsibilities. Training on risk management is included within the Argyll & Bute Manager Programme, and refresher training has been provided. In addition, support and guidance is available from the Council's Chief Internal Auditor, as the Risk Champion.

As part of our review of internal controls, we reviewed the Terms of Reference of the Council's committees. As Table 1 highlights, three committees currently have a role to play in relation to risk management.

Table 1: Committee responsibilities for Risk Management

Committee	Role
Policy and Resources Committee	"to oversee the arrangements for risk management"
Performance Review and Scrutiny Committee	"…monitoring the delivery of corporate improvement programmes and ensuring they are progressing in line with the corporate aims and objectives"
Audit Committee	"promote good internal control, financial and risk management, governance and performance in order to provide reasonable assurance of effective and efficient operation"

Source: Argyll and Bute Council Constitution

To allow them to discharge their responsibilities, the Policy and Resources Committee and Performance Review and Scrutiny Committee both receive a 6 monthly update on the Strategic Risk Register. The Audit Committee receives an annual assurance report on Risk Management. There is scope to further clarity the respective roles of each committee, particularly in relation to scrutiny of key mitigating actions to address strategic risks.

Refer to Action Plan Point 1

A risk management seminar is planned for all elected members on 7th December 2015, which will include discussion on key strategic risks, but also training on risk appetite and tolerance.

New and Emerging Risks

On a 6 monthly basis, the SMT meet with a specific focus on Strategic Risk. The Head of Governance and Law, and Chief Internal Auditor attend the meeting to formally discuss and challenge the updated Strategic Risk Register and any emerging or topical risks. Interviews with key officers, and review of minutes, provided assurance that this process is robust.

The Council's operational risk registers are updated on on-going basis and are formally reviewed on an annual basis as part of the service planning process. This provides a systematic approach to ensure that risks to key service outcomes will be identified and monitored.

The Operational Risk Register is a standing item on Departmental Management Team (DMT) Meetings. Minutes of team meetings provided evidence of the consideration and updating of emerging risks

at service level. We were also satisfied that arrangements to escalate risks are in place through DMT and SMT reporting.

Managing and Mitigating Risks

The Strategic Risk Register includes designated risk owners and details of current and planned mitigating actions, although actions are not yet framed in SMART terms.

Operational risk registers are reviewed quarterly, although there are inconsistencies in how this operates in practice. Some services maintain a detailed operational risk register on a spreadsheet, which should then be mirrored in Pyramid. Others directly amend the risk register within Pyramid.

During the review, we noted limitations with the functionality of Pyramid, specifically relating to the documentation and reporting of mitigating actions. In practice, this means that actions may be in progress, but may not be visible to elected members or other users of Pyramid.

Refer to Action Plan Point 2

1.4 Audit Opinion

Overall, we found that internal controls in place to support risk management are generally well designed and operating in practice. As a result, the level of assurance given for this report is **Substantial**. Our definitions for the levels of assurance are included in Appendix A.

1.5 Acknowledgement

Our audit involved discussions with a range of individuals across the Council, including the Chief Internal Auditor, Head of Strategic Finance and other Heads of Service. We would like to take this opportunity to thank those staff for their assistance and co-operation during the course of the audit.

2 Detailed Findings

1.	Medium	Committee Scrutiny

Finding and Implication	Proposed action	Agreed action *(Date / Ownership)*
Our review of Committee reporting arrangements highlighted strong awareness and engagement relating to risk management across the Council. However, there was limited evidence of detailed scrutiny around the effectiveness of mitigating actions taken to date and planned for the future. The Strategic Risk Register has designated risk owners, but the lack of actions framed in SMART terms means that there is limited accountability for the impact of mitigating actions. **Risk Implication**: There is a risk that Council resources may not be targeted at the most effective risk mitigation actions, and that the Council's risk profile does not reduce to an acceptable level.	We propose that the Performance Review and Scrutiny Committee should receive an annual report on the management of strategic risks which includes: ▪ Actions framed in SMART terms (including long and medium term measures). ▪ The outcomes of mitigating measures taken on the residual risk.	As part of the SRR review process consideration will be given proposed actions. An assessment of the impact or outcomes of mitigating measures will inform the review risk appetite and risk tolerance and risk scoring levels. Date Effective: August 2016 Owner: Kirsty Flanagan Head of Strategic Finance

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2.	Low	Pyramid

Finding and Implication	Proposed action	Agreed action *(Date / Ownership)*
There are inconsistencies across services in the approach taken to document operational risks, including mitigating actions. Some services continue to prepare and monitor operational risks using spreadsheets. This means that there is sometimes a delay in updating Pyramid, and that Pyramid does not reflect the wording of risks, or the mitigating actions in place to address risks. There were also inconsistencies in the approach taken to update Pyramid. For example, the Head of Planning ensures that Pyramid is updated on a quarterly basis himself. Others delegate updating to the Performance Team, who do not, therefore, have detailed understanding of the risk or potential consequences. **Risk Implication**: There is a lack of visibility of operational risks, and the actions being taken to address risks. This may also mean that elected members may not be aware of emerging risks within individual services.	We propose that operational risk registers are updated and attached to Pyramid on a quarterly basis.	Operational Risk Register update process will be reviewed to ensure a consistent and efficient approach is in place. Date Effective: 31 March 2016 Owner: Kirsty Flanagan

A Definition of internal audit ratings

Overall Level of Assurance

Every audit report is graded with an overall assurance rating. An explanation of each grading is given below:

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

Audit issue rating

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

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ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**COMMUNITY SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**Looked After Children – Equality of Education**
AUDIT DATE	**September 2015**

2015/2016

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Education – Looked After Children – Equality of Education within Community Services as part of the 2015/2016 Internal Audit programme. Looked after children and young people face many barriers to achieving success in education. The Children (Scotland) Act 1995 requires that health, housing and education services must work with social work services to look after the children and young people in their care. Status of looked after children is further considered as integral aspects of the Additional Support for Learning Act 2009. The current progress of the Education (Scotland) Bill 2015 sets out to include an objective to narrow the attainment gap between children and young people from more and less disadvantaged backgrounds. Should the Bill ascent to an Education Act it is anticipated that a duty will be placed on Education authorities to have regard to the need to narrow the attainment gap when exercising their education functions. In doing so, education authorities may be required to demonstrate that school education is delivered with the aim of reducing inequalities of outcomes which result from socio-economic disadvantage in order to improve the attainment of the lowest preforming children and young people. Within Argyll & Bute Councils' Single Outcome Agreement, 6 long term outcomes have been identified, including Outcome 3 "Education, skills and training maximises opportunities for all". Argyll & Bute have 175 (as at July 2015) Looked After Children (LAC) with foster carers, at home with parents, kinship care and residential care.

2. AUDIT SCOPE AND OBJECTIVES

The objective of the audit was to ascertain whether Argyll & Bute Council is maximising the potential of Looked After Children in respect of education attainment, including whether Argyll & Bute Council has appropriate arrangements in place to fulfil statutory duty and achieve desired outcomes. The Audit focused on young people within school years S4-S6.

3. RISKS CONSIDERED

- Failure to improve the life chances of looked after children;
- Failure to meet national priorities;
- Failure to ensure equality and fairness in the provision of education;
- Failure to ensure the effective use of resources

4. AUDIT OPINION

The level of assurance given for this report is substantial. The Education service has a Service Plan in place that includes service outcomes with improvement and performance measures to ensure the educational additional support needs of children and young people are met. A Corporate Parenting Board has been set up and a Corporate Parenting Policy and Strategy is in place. There are a number of initiatives in secondary schools aimed at improving attainment levels of Looked After Children (LAC). There are a number of guidance documents and procedures available for staff, however, it was not evidenced that there is one overarching document that provides best practice for raising attainment of Looked After Children.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

5.1 The Education service has a Service Plan that includes a service outcome: ED04 the educational additional support needs of children and young people are met. A number of improvement actions and performance measures are in place specifically relating to attainment; improve approaches to raising the educational attainment of LAC pupils through increasingly effective monitoring and tracking processes.

5.2 It was evidenced that there are a range of guidance documents available aimed at ensuring that looked after children and young people have the same educational opportunities as their peers. It was further evidenced that education services work in a child-centred way (GIRFEC – Getting it Right for Every Child), specifically promote attendance, making additional arrangements where necessary in order to support learning. There are a number of guidance documents and procedures available for staff, however, it was not evidenced that Argyll & Bute has a single co-ordinated approach in respect of attainment outcomes for Looked After Children.

5.3 In order to improve effective monitoring and tracking management have introduced Insight. Insight is a data management tool, including a benchmarking tool designed to help bring about improvements for pupils in the senior phase (S4 to S6). Insight is a professional tool for secondary schools and local authorities to identify areas of success and where improvements can be made. This will allow education professionals to interrogate and reflect on attainment results. The Insight data is not limited to SQA results but includes a wider range of SCQF (Scottish Credit and Qualification Framework) credit-rated awards and

programmes. It also has specific functionality for assessing specific groups such as looked after children. It was noted that the full functionality of Insight is not available at present but will be introduced during school session 2015-16.

5.4 In respect of governance and reporting it was evidenced that the Corporate Parenting Board receives annual reports on LAC attainment figures. The Corporate Parenting Board noted the content of the report and asked for further information relating to a break down in locality. The Board also acknowledged that figures may be skewed due to low cohort numbers.

5.5 Guidance issued by the Scottish Government suggests that there should be very clear arrangements within a local authority for informing schools when a pupil becomes looked after. It was evidenced that the Education Administration and Management Information Officer receives details of looked after children from Social Work on a regular basis. It was further evidenced that Social Work complete 'Notification of Admission Transfer or Discharge' form, this is forwarded to education advising them of any changes to young persons who are looked after. Data Protection protocols are in place to ensure that information is controlled and provided to relevant parties.

5.6 Staged intervention is used as a means of identification, assessment, planning, recording and review to meet the learning needs of children and young people. It provides a solution-focused approach to meeting needs at the earliest opportunity and with the least intrusive level of intervention. The process involves the child, parents/carers, school staff and, at some levels, other professionals, working in partnership to get it right for every child. It was evidenced that this method is used in respect to LAC within the secondary schools reviewed. A draft staged intervention framework that relates to all aspects of Additional Support, including that for looked after children is being developed.

5.7 The Children and Young People (Scotland) Act 2015 will place Corporate Parenting in statute. Councils, supported by their partner organisations have responsibilities as the 'Corporate Parent' for all children who are looked after. The role of Corporate Parent has been described as 'the formal partnership needed between all local authority departments and services and associated agencies, which are responsible for working together to meet the needs of looked after children and young people.' It is now widely recognised that the corporate parenting role is crucial in improving outcomes for looked after children (Count Us In-HMIE). It was evidenced that a multi-agency Corporate Parenting Board has been established, including representatives from the voluntary sector and councillors. It was evidenced from minutes that active engagement was taking place.

5.8 Extraordinary Lives report concluded that *"the single most important thing that will improve the futures of Scotland's looked after children is for local authorities to focus on and improve their corporate parenting skills. All local authorities should nominate an elected member who will act as a champion for looked after children".* Councillors have been appointed as 'Children's Champions' in each of the four geographical areas. The role and remit of a Children's Champion is to champion the rights of looked after and accommodated children/young people. It was evidenced that the Children's Champions are actively involved in the Corporate Parenting Board and actively involved in securing opportunities for young people. Examples include securing training for an accommodated young person.

5.9 It was evidenced that the Corporate Parenting Board has implemented a range of initiatives to assist and improve the attainment level of looked after children. Ipads or laptops had been purchased for all LAC children who are school age (Ipads for primary children and laptops for children of secondary age). These tools were provided to support their learning, IT skills and life opportunities.

5.10 A members seminars was held in 2014 focussing on raising attainment and the GIRFEC Agenda (Getting It Right For Every Child) directed at raising awareness in respect of Corporate Parenting responsibilities.

5.11 The Children and Young People (Scotland) Act 2014 requires Local Authorities to appoint a Named Person for every child. At present the Named Person function is part of a practice model and not a legislative function; it will only become the latter when the Children and Young People (Scotland) Act 2014 introduce a legislative requirement and duty in 2016. It was evidenced that schools have identified Named Persons who have the responsibility of education attainment for LAC young people and who are the main contact for the young person and their family/carers throughout their secondary education. However, it was not evidenced that there is a centrally held register of the Named Persons.

5.12 The Named Person service provider (including Local Authorities), is required to publish information about the Named Person arrangements. This will include information about what the Named Person functions are, how these are generally carried out, and how to contact a child or young person's Named Person. The Children & Young People (Scotland) Act 2014 also places a duty on local authorities to ensure continuity of the Named Person service during holiday periods or if staff are on sick leave. It also says they must advertise how the Named Person service can be accessed outside term time. It was not evidenced that arrangements had been made to ensure the continuity of access to the Named Person service during holiday periods (including how the Named Person Service can be accessed outside term time) or if staff are on sick leave. However,

management have indicated that national discussions are ongoing and this is a Local Authority wide issue which may have contractual/terms and conditions implications. This issue is currently under active discussion by the Education Management Team and a discussion paper has been presented to the central team.

5.13 It was evidenced that a Practice Guide – Getting it Right for Named Persons and Lead Professionals had been issued. This guidance was developed for all professionals working to the Getting it Right for Every Child (GIRFEC) principles which aims to improve outcomes for all children and young people in Argyll and Bute, it outlines the roles and responsibilities of being a Named Person. Getting it right for every child is founded on ten core components, one of which is: "A co-ordinated and unified approach to identifying concerns, assessing needs, and agreeing actions and outcomes, based on the Wellbeing Indicators". GIRFEC Named Person and Lead Professional Training has taken place, this event covered understanding the roles and responsibilities of the Named Person.

5.14 Improving the Education of Looked After Children – A Guide for Local Authorities and Service Providers indicate that there are clear advantages in setting up projects with the aim of encouraging achievement and higher attainment among looked after children and young people. It was evidenced within secondary schools that there are a number of individual projects in place across schools in terms of a standard or formal type of project.

5.15 It was evidenced from the secondary schools reviewed a range of initiatives are in place. Dunoon Grammar has launched the 'LAC Promise' aimed specifically at raising attainment for Looked After Children. A number of initiatives (promises) have been embedded into the LAC promise that supports young people through additional support and additional opportunities for learning. Campbeltown Grammar has developed a Support for Looked After Children. Oban High School have developed an intensive support facility which is used to offer flexible and individualised timetables for pupils with health, social, emotional or behavioural difficulties. Within Hermitage school there is a study programme. A study club runs outwith the school day and includes support with class work and advice about study techniques.

6. CONCLUSION

This audit has provided a substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There were 2 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There are 2 low recommendations which are not reported to the Audit

Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Education service staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Procedures		**High/ Medium or Low**		
There are a number of national guidance documents and best practice documents available. However, it was not evidenced that Education Services has an agreed overarching document or policy.	Lack of overarching guidance document may lead to inconsistent practice resulting in objectives not being met.	Medium	Working group to be established in Jan 2016. Working group will develop overarching policy on LAC by June 2016.	Education Manager – Inclusion and Equality June 2016
2. Named Person		**High/ Medium or Low**		
Guidance indicates that arrangements should be put in place to ensure continuity of access to the Named Person service during holiday periods effective from April 2016.	Failure to support looked after children during holiday periods, potentially, has an adverse impact on stated success measures.	Medium	Education Services to devise appropriate arrangements to allow continuity of Named Persons to be compliant with new statutory duty.	Education Manager – Inclusion and Equality August 2016

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**COMMUNITY SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**Early Years**
AUDIT DATE	**November 2015**

2015/2016

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Education – Early Years within Community Services as part of the 2015/2016 Internal Audit programme. The Children and Young People (Scotland) Act 2014 introduced new early learning and childcare entitlements to replace the funded 12.5 hours/ week during term time of pre-school education for 3 and 4 year olds. Since August 2014, the following children are eligible for 600 hours/year (the equivalent of around 16 hours/ week during term time) early learning and childcare:

- 3 and 4 year olds, starting from around the first term after their third birthday;
- 2 year olds from the point that they are looked after, under a kinship care order, or with a parent appointed guardian;
- 2 year olds, starting from the first term after their second birthday, (where their 2nd birthday falls on or after 1 March 2014) with a parent in receipt of qualifying benefits; or, the first term after their parent starts receiving qualifying benefits.

In addition from August 2015, the following children are also eligible for 600 hours/ year of early learning and childcare:

- 2 year olds, starting from the first term after their second birthday, (where their 2nd birthday falls on or after 1 March 2015) with a parent in receipt of qualifying benefits; or, the first term after their parent starts receiving qualifying benefits.

2. AUDIT SCOPE AND OBJECTIVES

The Audit will review policies and procedures in respect of arrangements for compliance with the Children's and Young People Act specifically the 600 hours element. The scope will cover:

- arrangements for identification of eligible children;
- placement commissioning an contracting arrangements;
- payment control arrangements.

3. RISKS CONSIDERED

- ED07 Failure to ensure that young children and their families are given assistance to help them achieve the best start in life;

- The council does not maintain appropriate policies and procedures resulting in a failure to provide quality services efficiently and effectively;
- Authorities, roles and responsibilities have not been identified and assigned in respect of commissioning services.

Audit Risk

- Failure to comply with legislation;
- Failure to adhere to policies and procedures.

4. AUDIT OPINION

The level of assurance given for this report is substantial.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:-

High - major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error;

Medium - observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified;

Low - minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. FINDINGS

The following findings were generated by the audit:

General

5.1 Information on the Councils' Early Years' service is available on the Council Website. Guidance includes eligibility entitlement, links to local nurseries and available childcare, a list of nurseries, childcare and early learning providers and also provides a further link to the Scottish Family Information Service where further searches can be undertaken to find a local nursery or local childcare, it also provides advice on how to register. The website also provides links to newsletters produced by Early Years' service covering news and events and other useful publications (Service Plan/Catalogue of Resources and Childminder Information on Tax and National Insurance). It was found that one link directed users to a HMRC information which was out of date.

5.2 The Children and Young People (Scotland) Act 2014 Early Learning and Childcare Statutory Guidance (The Guidance) states that authorities have a duty to consult and plan on delivery of early learning and childcare. It was evidenced that consultation has taken place and that parents had the opportunity to complete questionnaires, including group questionnaires. It was further evidenced that providers were asked to complete a questionnaire regarding the flexible model of Early Learning and Childcare provision.

Policies and procedures

5.3 It was found that the Early Years' Service have identified a number of priorities within their Draft Education Service Plan including:

- continue to develop provision for 600 hours Early Learning and Child Care for eligible 2 year olds;
- continue to recruit additional child minders of 2 year old provision;
- continue to increase flexibility of Early Leaning and Child Care provision.

5.4 Young children within Early Learning and Childcare are eligible for a free school lunch under the same criteria as school pupils, where they attend an education authority establishment in the middle of the day. This additional criteria applies to all eligible pre-school children (aged 2, 3 and 4). It was evidenced that the Early Years' service, working with colleagues from catering services has developed an implementation plan in respect of this requirement.

Duty to secure provision of early learning and childcare for eligible children - arrangements for identification of eligible children

5.5 The Children and Young People (Scotland) Act 2014 Early Learning and Childcare Statutory Guidance states that Education authorities will not be under a duty to identify those children and families eligible for Early Years and Childcare provision. Parents or carers who wish to use the entitlement for their child are required to self-refer for a place for their child. The Guidance requires that local authorities promote the entitlement at a local level. It was evidenced that the Early Years' Service has a range of self-referral and registration systems, including information on the Council website detailing a central point of contact to enable parents and child minders to obtain information. Parents can request a pack from the Early Years' Service providing details of services.

5.6 It was evidenced that Health colleagues, Social Work staff and Job Centre Plus have assisted Early Years staff to identify eligible 2 year olds and have supplied the Early Years' Service with details of families who may entitled to the 600 hours of Early Learning and Childcare. Parents who were identified were sent a pack containing a flowchart, information leaflet, the appropriate form to take to Jobcentre Plus and a list of local services who can provide a service for 2 year old children. It was evidenced that data sharing protocols are in place with Health.

Placement commissioning and contracting arrangements

5.7 A commissioning strategy is in place and is dated 2010. It was found that the Commissioning Strategy includes elements of Early Years' services which were last updated by Social Work Children and Families. Legislation has subsequently been updated and is not currently reflected in the strategy. The strategy does not make specific reference to Early Years' requirements. There are a range of documents available which provided guidance on the Early Years' service however, it was not evidenced that there was an overarching document that outlined strategy and procedures in relation to the Early Years' service.

5.8 As the 600 hour element is a statutory requirement all applications to provide an Early Years' service are required to be considered so long as the provider meets the necessary criteria. No service can be commissioned until full registration is complete with the Care Inspectorate. It was evidenced that Procurement and Commissioning service carry out a series of checks, supported by departments with specialist knowledge in the area being checked (Health & Safety). There are appropriate authorisation processes in place for acceptance of the provider, including registration with the Care Inspectorate. Once the checks are complete the Procurement and Commissioning service draw up a contract with the provider.

5.9 It was evidenced that an up to date register of all providers was kept and was available for inspection. This includes up to date details of last inspections by the Care Inspectorate and Early Years' Service, this is updated on an annual basis. Access is controlled by means of password protection.

Payment Controls

5.10 There is currently two payment processes in place. The first is in respect of Commissioned Partner Providers, who provide Early Learning and Child Care to 3 and 4 year olds who are paid on a monthly basis. Payment reports are generated from NAMS (Nursery Management System). The second payment process is where Partner Provider/Childminders submit monthly invoices.

5.11 Where payment reports are run from NAMS, there is a control in place whereby each month authorisation codes are generated for each child fully enrolled and receiving funded hours. Each provider receives an email with payment report with details containing their relevant authorisation codes. Partner Providers are required to enter their codes on to the system, confirming the pattern of provision. A counter control is in place whereby Parents of the children also confirm attendance via

signed sheet. Partner Providers are given one week to complete returns. A payment run is then generated and along with a memo which is emailed to Creditors for payment. Information is controlled and providers only receive information relevant to their establishment. However it was noted that data sent is not password protected.

5.12 In terms of the NAMS process it was found that there is weakness in respect of segregation of duties whereby payment reports generated from the system are sent to creditors for processing without separate authorisation or checking, one member of staff completes the process from start to finish and signs the memorandum on behalf of the authorised signatory.

5.13 It was evidenced that appropriate authorisation controls are in place in respect of the monthly invoicing procedures whereby each invoice is checked to confirm that the hours invoiced for against each child are correct. However, invoices are input onto Pecos retrospectively each time the invoice is received. This is an element of duplication and increases the risk of manual input error.

5.14 Budget monitoring arrangements are in place and ongoing engagement meetings are held with Early Years staff and Strategic Finance staff. Budgets are monitored against actual expenditure and from payment information taken from NAMS, any variation is recorded appropriately within Oracle Ledger system.

6. CONCLUSION

This audit has provided a substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There is one high and two medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There are 2 low recommendations which are not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Education staff and management for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Payment Controls		**High/ Medium or Low**		
A weakness was identified relating to the payment control process in respect of segregation of duties whereby payment reports are being generated and signed off by one person.	Failure to ensure segregation of duties may lead to erroneous inappropriate actions.	High	**Implement revised procedures to ensure sign off by appropriate authorised signatory.**	**Education Manager – Learning and Achievement** **December 2015**
2. Procedure Document		High/ Medium or Low		
There are a number of procedure documents and guidance documents available, however these now require to be updated.	Lack of overarching guidance document may lead to inconsistent practice resulting in objectives not being met.	Medium	**Education to update and revise procedures and guidance as appropriate.**	**Principal Officer Early Years** **June 2016**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
3. Data Security		High/ Medium or Low		
It was found that spreadsheets containing confidential information are not password protected.	Lack of internal controls leads to potential data security breaches.	Medium	**Implement revised procedure to ensure that information available to providers is password protected.**	**Principal Officer Early Years** **December 2015**

APPENDIX 2 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
4. Council Website Information		**High/ Medium or Low**		
The link to HMRC information was found to refer to an out of date page.	Information provided is not accurate.	Low	**Review website detail and update links where appropriate.**	**Principal Officer Early Years January 2016**
5. Payment Controls		**High/ Medium or Low**		
Duplication whereby invoices are retrospectively put onto Pecos.	Manual input is duplication and leads to increase risk of error.	Low	**Review process to eliminate manual input where appropriate.**	**Principal Officer Early Years March 2016**

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ARGYLL & BUTE COUNCIL **AUDIT COMMITTEE**
STRATEGIC FINANCE **04 DECEMBER 2015**

EXTERNAL & INTERNAL AUDIT REPORT FOLLOW UP 2014 – 2015.

1. EXECUTIVE SUMMARY

1.1 Internal Audit document the progress made by departmental management in implementing the recommendations made by both External Audit and Internal Audit. This report and attached appendices are the results from a review performed by Internal Audit for recommendations due to be implemented by 31 October 2015.

1.2 The process requires departmental Executive Directors assigning a 3rd tier officer to act as the sole contact for the follow up of both external and internal recommendations. The contact role involves updating both the Executive Directors and Internal Audit on progress with agreed audit recommendation implementation.

1.3 Appendix 1 is a statistical summary of all agreed recommendations arising from National, External and Internal Audit reports by department. Detailed is the number of recommendations due as at 31 October 2015, the number implemented, the number of agreed future recommendations and their status, e.g. on course etc.

1.4 Appendix 2 provides a summary as at 31 October 2015, of all outstanding recommendations from National, External and Internal Audit reports by department and service. Detailed is the report name along with the weakness identified, agreed management action, revised date, any previous implementation dates reported to the Audit Committee management comment and Pyramid status.

2 RECOMMENDATIONS

2.1 The audit committee note the content of this report.

3 CONCLUSION

3.1 Of the recommendations due for completion by 31 October 2015, 17 have been completed. Internal Audit is satisfied with the status of the remaining 6 recommendations being delayed but rescheduled. Good progress is being made on the recommendations due after 31 October 2015 with 6 completed early. Further programmed testing of post follow-up actions will be undertaken via the continuous monitoring programme.

4. IMPLICATIONS

4.1	Policy:	None
4.2	Financial:	None
4.3	Legal:	None
4.4	HR:	None
4.5	Equalities:	None
4.6	Risk:	Failure to implement agreed actions leads to financial, physical and reputational loss and adversely impacts organisational objectives.
4.7	Customer Service:	None

For further information please contact Kevin Anderson (01369 708505)

Kevin Anderson
Chief Internal Auditor
04 December 2015

APPENDIX 1

SERVICE SUMMARIES

RECOMMENDATIONS DUE 01 AUGUST 2015 – 31 OCTOBER 2015

SERVICE	Complete	Delayed but rescheduled	Total Of ACTION PLAN NUMBER
ADULT CARE	1	0	1
CHILDREN & FAMILIES	1	2	3
COMMUNITY & CULTURE	2	1	3
ECONOMIC DEVELOPMENT	4	1	5
GOVERNANCE & LAW	0	1	1
IMPROVEMENT & HR	1	0	1
PLANNING & REGULATORY SERVICES	1	0	1
ROADS & AMENITY SERVICES	6	1	7
STRATEGIC FINANCE	1	0	1
TOTAL	**17**	**6**	**23**

RECOMMENDATIONS DUE AFTER 31 OCTOBER 2015

SERVICE	Complete	On Course	Total Of ACTION PLAN NUMBER
CHILDREN & FAMILIES	0	1	1
COMMUNITY & CULTURE	0	6	6
ECONOMIC DEVELOPMENT	2	0	2
EDUCATION	0	3	3
EXECUTIVE DIRECTOR COMMUNITY SERVICES	1	0	1
EXECUTIVE DIRECTOR CUSTOMER SERVICES	0	3	3
FACILITY SERVICES	0	1	1
IMPROVEMENT & HR	3	14	17
PLANNING & REGULATORY SERVICES	0	2	2
PLANNING AND PERFORMANCE	0	1	1
ROADS & AMENITY SERVICES	0	1	1
STRATEGIC FINANCE	0	2	2
TOTAL	**6**	**34**	**40**

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Appendix 2

Recommendations Overdue 31 October 2015

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES:	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
DEPARTMENT	**COMMUNITY SERVICES**				
SERVICE	**CHILDREN & FAMILIES**				
REPORT NAME	**REVIEW OF FOSTERING & ADOPTION ARRANGEMENTS**				
3	It was noted that arrangements for record keeping are fragmented and information is held in a number of separate systems. **LOW**	The Adoption and Fostering Service operates Carefirst as its primary record keeping system and is in the process implementing further Carefirst modules to improve management information and the payment of allowances.	30 September 2015 **31 March 2016**	The Finance modules of CareFirst are being tested through November 2015 with the target date for live February 2016.	**Delayed but rescheduled** Practice Lead – Foster & Adoption
4	The handbook requires to be updated. Foster carers are provided with a hardcopy in the form a large folder. An electronic version is not currently available. MEDIUM	An update of handbook will be completed and a decision on whether to make the handbook fully electronic will be taken.	30 September 2015 **30 November 2015**	Draft handbook was presented for consultation and reviewed at the Foster Carers day on the 14th November. Feedback has been collated and the Final version of the handbook is being prepared for launching.	**Delayed but rescheduled** Practice Lead – Foster & Adoption
SERVICE	**COMMUNITY & CULTURE**				
REPORT NAME	**REVIEW OF ADULT LEARNING**				
2	It was noted that an increasing number of referrals to access Adult Learning services are coming from Job Centre Plus which has led to resourcing pressures within Community Based Learning. **MEDIUM**	Monitor and report the number of referrals coming from Job Centre Plus and any associated resource pressure. service.	30 September 2015 **31 March 2016**	Staffing resources under considerable pressure. Revised Date based upon Universal Support - Delivered Locally (USDL) trial completion and its related effects on	**Delayed but rescheduled** Community Learning Manager

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES:	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
DEPARTMENT	**CUSTOMER SERVICES**				
SERVICE	**GOVERNANCE & LAW**				
REPORT NAME	**REVIEW OF INSURANCE ARRANGEMENTS**				
2	It was noted there was a low response to the Invite to Tender due to the approach adopted .i.e. dealing directly with brokers. **MEDIUM**	Council's traditional requirements for single supplier of all insurances was the industry norm at time of tender. Procurement and legal to review sourcing strategy at time of insurance renewal.	31 December 2014 28 February 2015 31 May 2015 30 September 2015 **30 November 2015**	The relevant staff met to review the draft strategy on the 28th October. The approved draft strategy was circulated for open tender at the beginning of November and and responses are due towards the end of November, with a view for completion by 30 November 2015.	**Delayed but rescheduled** Legal Services Manager-Commercial/ Procurement Commission Manager
DEPARTMENT	**DEVELOPMENT & INFRASTRUCTURE SERVICES**				
SERVICE	**ECONOMIC DEVELOPMENT**				
REPORT NAME	**AUDIT SCOTLAND - ANNUAL REPORT ON THE 2013/14 AUDIT**				
4	Gourock to Kilcreggan Ferry Service - The council should consider obtaining a signed agreement from Clydelink, enabling SPT to pay monies due directly to the council. **N/A**	The Council will contact both Clydelink and SPT to seek to put this in place. **30 November 2015**	30 November 2014 30 September 2015	A meeting with SPT and Clydelink has been Scheduled for mid-November to agree and finalise arrangements.	**Delayed but rescheduled** Head of Economic Development and Strategic Transportation
SERVICE	**ROADS & AMENITY SERVICES**				
REPORT NAME	**REVIEW OF CREMATORIUM 2014/15**				
3	It is unclear as to whether the applicant or the undertaker is the customer of the Council. **MEDIUM**	Initial meeting has taken place. A new protocol is being developed regarding debt recovery from funerals. **30 November 2015**	31 March 2015 31 August 2015	Draft policy document is to be altered after feedback from consultation.	**Delayed but rescheduled** Streetscene Area Manager in consultation with Principal Accountant and Legal Services Accountant and Legal Services

ARGYLL & BUTE COUNCIL
STRATEGIC FINANCE

AUDIT COMMITTEE
4 DECEMBER 2015

DRAFT ANNUAL AUDIT PLAN 2016/17

1. SUMMARY

1.1 This report introduces the draft Annual Audit Plan for financial year 2016/17.

2. RECOMMENDATIONS

2.1 To note proposed content and feedback any comments to the Chief Internal Auditor.

3. DETAILS

3.1 The Committee agreed that a draft audit plan would be submitted to the December meeting of the Audit Committee to allow members to review proposals and feedback any comments to the Chief Internal Auditor prior to approving the finalised plan at the March meeting of the committee.

3.2 The Public Sector Internal Audit Standards (PSIAS) stipulate that the Council's internal audit plan must be risk based and focused on governance, risk and controls to allow the chief internal Chief Internal Auditor to provide an annual opinion on the Council's internal control framework, based on the work undertake during the year. This annual opinion informs the Annual Governance Statement.

3.3 The draft Annual Audit Plan in shown in Appendix 1. The audits detailed in the audit plan have been selected using a risk based assessment of our audit universe which is all of the auditable areas within the Council.

3.4 Factors used in the risk assessment process included the potential impact on the Council's corporate outcomes, financial materiality, links to strategic risks, key changes within the operating environment, a review of complaints register and assurance received from other sources.

3.5 Consideration was also given to the requirement to provide an annual assurance statement, volume of transactions and impact on the Council's framework for internal control.

The Audit plan is broken down into 4 main areas which are;

- Cross-cutting Reviews
- Service Department Reviews
- Verification Reviews
- Continuous Monitoring Activity

3.6 Cross Cutting reviews include auditable areas which are non-specific to an individual department or service activity and which are of a corporate or organisational wide focus

3.7 Service Department Review: Auditable Units within the Audit Universe which are specific to an individual department

3.8 Internal Audit undertake a number of Verification Reviews throughout the year. These reviews are primarily focused on testing and verifying areas such as grant claims and performance indicator submissions.

3.9 The Continuous Monitoring Programme includes a number of auditable units which were previously subject to individual annual audits. These areas are now tested on a regular recurring basis with control weaknesses reported by exception
.

3.10 An indicative outline scope is given for each of Auditable units. Full terms of reference will be discussed and agreed with relevant Head of Service.

3.11 The plan is based on an estimated available 975 Audit days with suitable contingency factored in. The plans remains fully flexible, to accommodate changes in the Council's risk profile and /or emerging risks.

4. CONCLUSION

4.1 The draft Annual Audit plan is risk based and is aligned to the Council's Long Term Outcomes, Corporate Outcomes and Strategic Risk Register. The plan now incorporates continuous monitoring and verification activity sections.

5. IMPLICATIONS

5.1	Policy:	None
5.2	Financial:	None
5.3	Personnel:	None
5.4	Legal:	None
5.5	Equal Opportunities:	None
5.6	Risk	None
5.7	Customer Service	None

For further information please contact Internal Audit (01369 708505)

Kevin Anderson
Chief Internal Auditor
04 December 2015

Appendices:
1. Draft Audit Plan 16/17

Appendix1. Audit Plan

DRAFT AUDIT PLAN 2016/17			Planned days	High Level Scope
Department / Service Area	**Sub Service**	**Topic**		
CROSS CUTTING				
Council	Major Projects	Tax Incremental Financing (Lorn Arc)	30	Governance, Risk and Reporting arrangements
	Major Projects	Hub North (Education Capital Projects)	30	Governance, Risk and Reporting arrangements
	Risk Management	Policy and Procedures	20	Review of Risk Management arrangements including Assurance Mapping
	Performance Management	Service Planning	20	Arrangements for Service Planning
Chief Executives /Departmental	Strategic Finance	Departmental Support	20	Review of Departmental Support – Accounting and Budgeting
Total Cross Cutting			**120**	
CUSTOMER SERVICES				
Customer and Support Services	Procurement	PECOS	20	Follow-up Audit.
	Procurement	Off –Contract purchasing	20	Arrangements for Identifying, reporting and reducing off contract purchasing.
Customer and Support	Revenues and Benefits	Debt Recovery and Write-off procedures	20	Debt recovery arrangements and application of policy.
Customer and Support	ICT	Security of Data	20	Review controls in place for managing and sharing sensitive data.
Facility Services	Asset Management	Property Maintenance	20	Review adequacy of framework and controls for identification of repairs, prioritisation of resources and contract management.
	Asset Management	Common Good Property	20	Arrangements in respect of Registers, Disposal and Use of Common Good property.
Governance and Law	Governance	Freedom of Information Requests Arrangements	20	Review key controls established by the Council to capture and respond to FOI requests, across all departments, within required legislative requirements.
Improvement and HR	Projects	Resource-link	20	Review key project management controls.

Appendix1. Audit Plan

Total Customer Services			**160**	
COMMUNITY SERVICES				
Adult Services	Older Peoples Services	Homecare – Contract Compliance arrangements	20	Monitoring, Testing Controls and Reporting arrangements.
Adult Services	Older People Services	Charging Scheme – Waivers policy	20	Application of policy and internal control environment
Children and Families	Criminal Justice	National Outcomes and Standards	20	Governance and Reporting Arrangements
Children and Families	Children's Units	Financial Controls including Budgeting, Allowances and procurement.	20	Administrative and financial compliance with the Council's Financial Regulations
Community and Culture	Housing	Repair and Improvements Grants	20	Review grants to ensure that there are sufficient controls in place and evidence over expenditure
Education	Additional Support Needs	Needs Analysis	20	Policies and Procedures
	School Support	Teacher Census	20	Submission arrangements
	School Support	Education Maintenance Allowances	15	Control Environment
Total Community Services			**155**	
Development and Infrastructure Services				
Fleet, Waste and Infrastructure	Waste Management	Sustainability of Waste Delivery Model	20	Review and Reporting protocols including governance arrangements.
Economic Development	Sustainable Communities	Support Third Sector orgs access external funding.	20	Review of support arrangements to Third Sector Organisations
Roads Management and Maintenance	Management Information Systems	TOTAL (Road Costing)	20	Recording & reporting arrangements and internal controls environment.
Marine and Airports	Airports	Aerodrome Operation Manual	10	Evidence Compliance with Aerodrome Operating Manual
Strategic Transportation	Projects	Project Certification	10	Arrangements for project certification including retention of documentation and record keeping.

Appendix1. Audit Plan

Total Development and Infrastructure			**100**	
Continuous Monitoring Programme	Arrangements of prevention /detection of Fraud. Anti-Fraud Strategy. Serious Organised Crime.		30	Policy review. Participation in NFI
	Budgeting	Cipfa Matrix Testing	15	Internal Control Environment
	General Ledger	Cipfa Matrix Testing	15	Internal Control Environment
	Creditors	Cipfa Matrix Testing	20	Internal Control Environment
	Debtors	Cipfa Matrix Testing	20	Internal Control Environment
	Payroll	Cipfa Matrix Testing	30	Internal Control Environment
	Treasury Management	Cipfa Matrix Testing	15	Internal Control Environment
	Council Tax and NDR	Cipfa Matrix Testing	20	Internal Control Environment
	Establishment Visits	School Funds Imprest Accounts	20	Internal Control Environment
	Follow –up	Sample Testing	20	Compliance
Total Continuous Monitoring			**205**	
Verification Activity /Short Audits	Leader & Flag	File and Claim review	15	Evidence Compliance with award Criteria
	LGBF	Accuracy of Submission	10	Accuracy of Submission
	Travel and Subsistence	Use of Pool cars	10	Policy review
Total Verification			**35**	
Health and Social Care Scheme of Integration – Governance, Development of Risk Management and Auditing Arrangements			40	Development of support arrangements as per Scheme of Integration to support Partnership in respect of Risk Management and Auditing
Internal Audit Management			120	Planning & reporting Risk Management Service Support and Advice Project Support and Advice
Contingency			40	Investigations, Adhoc requests.
Total Audit Days			**975**	

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ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **4 DECEMBER 2015**

RISK MANAGEMENT OVERVIEW

1.0 EXECUTIVE SUMMARY

1.1 This report provides an update in relation to the undernoted risk management areas of activity.

- Strategic Risk Register
- Risk Appetite
- Operational Risk Registers
- CIPFA Benchmarking
- Annual Assurance Statement review
- Annual review of Policy, Strategy and Guidance.
- Risk Management Action Plan

1.3 Overall Argyll and Bute's risk management activity is assessed as "embedded and integrated" which is defined as "A framework of risk management processes in place and used to support service delivery".

1.4 Risk Management processes and protocols continue to improve and development is on-going. Specific work for 2015/2016 is targeted at the development of a shared risk register in respect of the Health and Social Care Integration project.

1.5 Operational Risk information is evidenced as being reviewed and updated. A number of red risks are showing within individual registers, however, mitigating plans and actions are in place to address these. A review of red risk information will take place over the autumn /winter period with findings reported February 2016.

1.6 Risk Assurance Statements, Risk Profile data and CIPFA Benchmarking analysis demonstrate consistency of approach in respect of risk management activity.

1.7 Risk Appetite work is on-going and a draft General Statement of appetite has been developed together with suggested tolerance levels for each of the strategic risks.

1.8 A risk management action plan is in place for 2015/16 which outlines a number of key actions.

1.9 Audit Committee is requested to note the continued good progress in respect of integrating and embedding risk management.

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

CHIEF EXECUTIVE **4 DECEMBER 2015**

RISK MANAGEMENT OVERVIEW

2.0 INTRODUCTION

2.1 This report sets out a summary of the progress and key issues / developments in relation to risk management and key related activities.

3.0 RECOMMENDATIONS

3.1 Members are requested to note the content of the report and further note the continued good progress in respect of integrating and embedding risk management.

4.0 DETAIL

Strategic Risk Register (SRR)

4.1 The SRR is continuously monitored; however, it is subject to a formal bi-annual review in August and February in line with Service Planning and Budget Setting processes.

The process for reviewing the SRR is outlined below:

- Designated risk owner to update on an ongoing basis in consultation with appropriate chief officers, service managers and policy leads.
- SMT to review progress /update report.
- Performance Review and Scrutiny Committee to consider progress/ update reports.
- Policy and Resources Committee to consider progress/update reports

4.2 Risk owners were requested to review risk information, liaise with policy leads and provide commentary and/or detail of any amendments to the Risk officer. The Strategic Risk Register has been updated accordingly.

4.3 The Strategic Risk Register now shows indicative Appetite levels. Risk Appetite is about how much risk the organisation is willing to accept. It is not a single, fixed concept and there can be a range of appetites for different risks and these appetites may well vary over time. Risk appetite is about what the authority wants to do and how it goes about it. An authority must be flexible and keep the basic precept in mind that risk appetite can and will change over time.

A basic outline process in agreeing risk appetite levels is set below and has five key stages:

- Agreeing overall appetite level: What is acceptable?
- Agreeing individual risk tolerance levels and trigger or escalation points together with any intervention actions
- Cascading: Raising awareness within organisation of the planned direction of travel with key stakeholders
- Reporting: Ensure active monitoring protocols in place
- Review: Agreeing appropriate periodic review of appetite levels in line with reporting schedules

4.4 Indicative appetite levels are underpinned by an appetite matrix starting at Risk Averse through to Risk Hungry. This matrix details a range of actions and behaviors associated with each appetite level and is shown at appendix 1. In line with Institute of risk management thinking, appetite is generally lower than tolerance levels. Appetite levels have been discussed with the Chief Executive, Executive Directors and Head of Strategic Finance.

4.5 Stage 2 of the 5 stage approach requires tolerance levels to be agreed. Tolerance levels are simply the trigger points at which a form or intervention or escalation is deemed appropriate. Tolerance levels are generally above an organisation's appetite level. Whilst the appetite for a particular risk may be low, public sector authorities are often limited by legal or regulatory requirements meaning a higher tolerance is necessary.

4.6 It is suggested that there are 2 risks on the SRR which are scoring above indicative tolerance levels. These are Risk number 1, Population and Economic Decline and risk number 7 Health and Social Care Integration where current scoring exceeds indicative tolerance levels. These risks together with mitigating actions require active management as per the Council's agreed risk management policy and interventions include Prioritisation or redirection of resources, Prioritisation of mitigations and defined action plans. This is not saying that further intervention is required, it is reflecting current active management in respect of these risks.

Cascading, Reporting and Reviewing arrangements are supported by a detailed guidance document and an agreed review timetable.

The strategic risk register is shown in appendix 2.

Risk Appetite Statement:

4.7 A draft risk appetite statement has been prepared and an extract is shown below with the full statement detailed in appendix 3.

4.8 In terms of both Strategic and Operational Risk, the Council, like many public sector organisations has an overall Cautious (Low) appetite for risk although there are areas where a more Open (Medium) appetite can be evidenced.

The Council faces a broad range of risks which are reflective of its aims, objectives and responsibilities in the public sector. Risks identified cover subject matters such as financial stability, Demography, Economy, Environmental and Infrastructure, as well as its day-to-day operational activities.

The Council is exposed to a number of risks which are outside its direct ability to control or fully influence. It actively pursues policies which in some part contribute to mitigating the likelihood or impact thus reducing any potential threat.

Resources are aligned to priorities and arrangements are in place to monitor and mitigate risks to acceptable levels. Whilst appetite may be Cautious (Low), tolerance levels may be higher and the Council recognises that it is not possible or necessarily desirable to eliminate some of the risks inherent in its activities. In some instances acceptance of risk within the public sector is necessary due to the nature of services, constraints within operating environment and a limited ability to directly influence where risks are shared across sectors.

Operational Risks

4.9 ORRs were subject to major review during 2013-14 and a further review as part of the 14/15 service planning exercise. Risk owners are responsible for ensuring that risk information is current and as such are reviewed on a live basis with quarterly scorecard reporting and six monthly updates to SMT.

4.10 The Council has agreed a demand and supply approach to operational risk identification.

4.11 Demand risks represent the key challenges facing the Council. These are driven /imposed externally through others having demands, expectations or obligations for the Council to meet and are directly linked to service outcomes.

4.12 Supply risks are defined as the risks related to how we plan, organise and deliver our services to meet our demand risks. To ensure consistency of approach across services, supply risks are categorised into areas such as Human Resources, Finance, Assets, Information etc.

4.13 The Demand and Supply approach ensures operational risks are linked to planned activity and outcomes, however, services do have the opportunity to introduce Topical risks where required. During 14/15 services did not identify any additional topical risk areas.

4.14 Services have identified approximately 450 individual risks, 20% being demand (outcome) related, 80% being supply type risk.

4.15 Approximately 40 red risks have been identified within services with some 70% of these being identified within people focused service areas such as Education, Children and Families and Adult Services. Red risk profile ranges from 0% within lower risk services such as Governance and Law to 27% with Education services.

Table 1: Number of Red Risk as a % of number of service risks identified.

Service	No of Risks	Red No & %
Strategic Finance	21	2 (10%)
Adult Care	40	6 (15%)
Children and Families	54	9 (17%)
Community and Culture	52	1 (2%)
Education	51	14 (27%)
Customer and Support	45	0
Facility Services	40	2 (5%)
Governance & Law	59	0
Improvement & HR	51	1 (2%)
Economic Development	37	2 (5%)
Planning & Regulatory	70	0
Roads and Amenity	62	4 (6%)

4.16 The overall operational risk profile has remained constant during 14/15 with minimal change to average scoring and risk content. A review of the individual ORRs shows that although overall profile has remained constant, updates are being made; however, these do not necessarily impact on the overall risk score /profile. It was evidenced that mitigation plans and actions have been updated and remain current. Risk owners have confirmed via annual risk assurance statements that risks are relevant to their service and further confirmed that mitigation plans and actions have been identified. Risk profile averages for 14/15 and 15/16 (to date) are shown in Table 2.

Table 2.

Department	Average Demand Risk Profile 14/15	Average Demand Risk Profile 15/16	Average Supply Risk Profile 14/15	Average Supply Risk Profile 15/16
Chief Executives	Amber 8	Amber 9	Amber 8	Amber 8
Community Services	Amber 9	Amber 10	Amber 9	Amber 9
Customer Service	Amber 6	Amber 6	Amber 6	Amber 6
Development & Infrastructure	Amber 8	Amber 8	Amber 7	Amber 7

Strategic Risk Group

4.17 The work of the SRG, i.e. Risk Management, Health and Safety, Business Continuity and Civil Contingencies are now standing items on SMT business agenda with progress reports submitted on a minimal 6 monthly basis.

In respect of Risk Management Activity, SMT consider reviews of SRR and ORRs, results of CIPFA benchmarking, updates to risk management policy and guidance together with progress reports on developmental issues.

Risk Management Benchmarking

4.18 The Council is a member of the CIPFA Risk Management Benchmarking Club. The results of the 2014 exercise highlights continued improvement with an overall rating of Embedded and Integrated. Two themes have been identified for improvement, i.e. Outcomes & Delivery and Partnership and Shared Resources. Any recommended actions arising from this exercise are incorporated into the Risk Management Action plan.

Risk Management Action Plan

4.19 An improvement plan (Risk Management Action Plan) is maintained. This includes the key issues identified from the risk CIPFA benchmarking report and any areas targeted for improvement and further development. The Risk Management Action Plan is shown at Appendix 4.

Annual Risk Assurance Statements

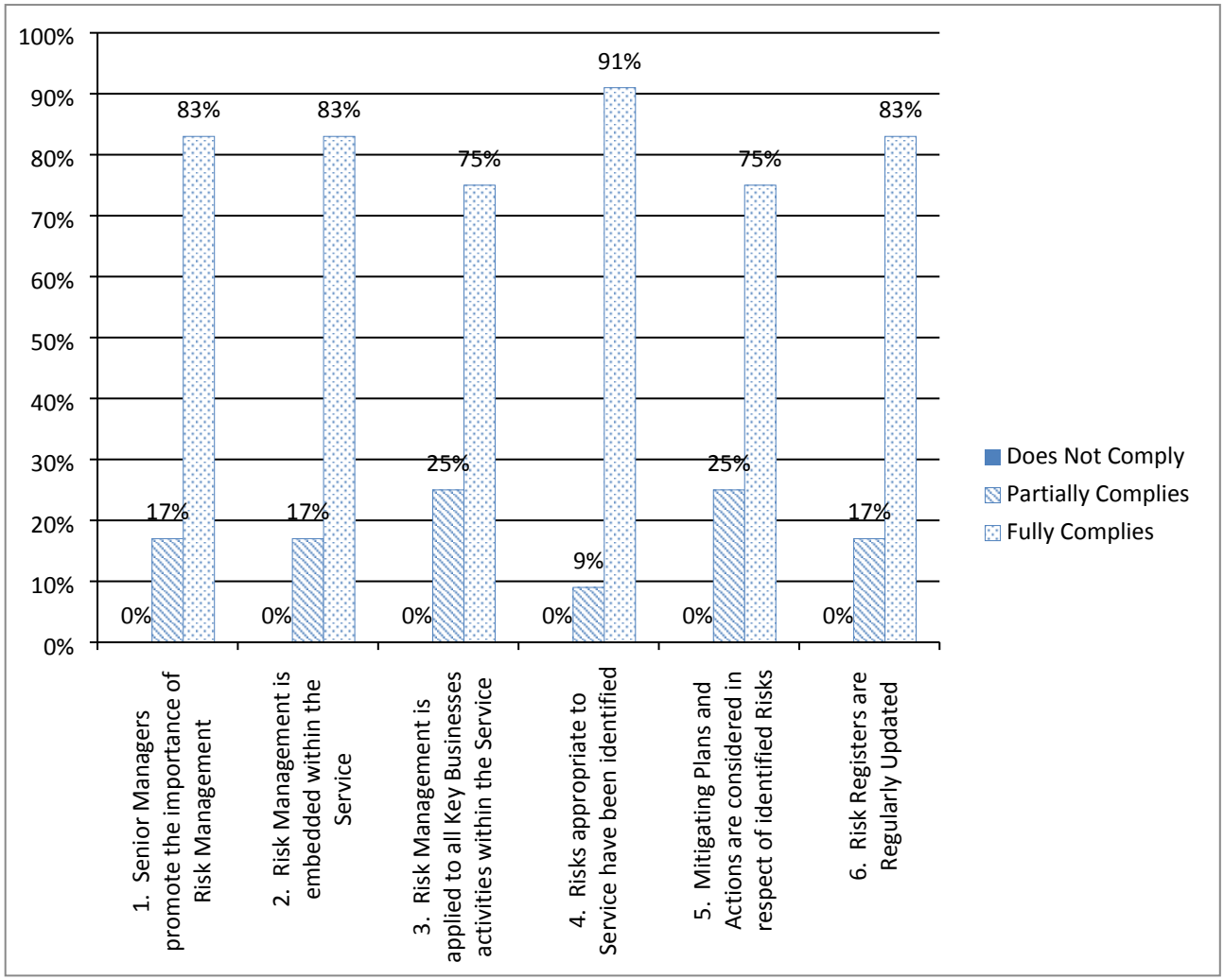
4.20 Annual Risk Assurance statements are completed as part of our Risk Management Policy.

The risk assurance statements are based on the following:

- Senior managers promote the importance of risk management.
- Risk management is embedded within the service.
- Risk management is applied to all key business activities within the service.
- Mitigating plans and actions are considered in respect of identified risks.
- Risk registers are regularly updated

Heads of Service are requested to indicate whether they fell into one of three categories, non –compliance, partial compliance or full compliance for each of the statements. Heads of Service are further requested to evidence their selection and where appropriate give further detail of actions to be taken.

An analysis of the 2014/15 returns is shown in the chart below. There are zero instances of non-compliance and it was evidenced that risk management is embedded within service activity although some improvements are required in order to ensure full compliance.



Annual Review of Policy Strategy and Guidance.

4.21 Risk Management protocols stipulate than an annual review of our Risk Management Policy, Strategy and Guidance is required.

Both Risk Management Policy and Strategy documents have been reviewed and are deemed current and fit for purpose. Risk Management Guidance has also been updated in respect of revised governance and reporting arrangements. Documentation has also been updated to include reference to Risk Appetite and Risk Tolerance.

5.0 CONCLUSION

5.1 Overall risk management activity is assessed as "embedded and integrated" which is defined as "*A framework of risk management processes in place and used to support service delivery*". Risk Management processes and protocols continue to improve and development work is on-going. A risk management action plan is in place for 2015/16.

6.0 IMPLICATIONS

6.1 Policy – Inclusion of Risk Appetite and Risk Tolerance further enhances Risk Management Activity.

6.2 Financial – None. Report is for noting

6.3 Legal – None. Report is for noting

6.4 HR – None. Report is for noting

6.5 Equalities– None. Report is for noting

6.6 Risk– None. Report is for noting

6.7 Customer Service– None. Report is for noting

KIRSTY FLANAGAN
9 NOVEMBER 2015

For further information contact: Kevin Anderson, Chief Internal Auditor 01369 708505

APPENDICES
1. Appetite Matrix
2. Strategic Risk Register
3. Risk Appetite Statement
4. Risk Management Action Plan 15/16

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APPENDIX 1 – RISK APPETITE BEHAVIOUR MATRIX

	AVERSE	**MINIMALIST**	**CAUTIOUS**	**OPEN**	**HUNGRY**
	Avoidance	Ultra-safe	**Low –** Trade of between low risk /reward.	Medium – Value for Money	Innovative – Higher rewards
Category	**Example Behaviours / Actions**				
Compliance/ Legal Regulatory	Avoid anything which could be challenged even unsuccessfully	Confident we would win any challenge	Reasonably sure would win any challenge	Challenge will be problematic but likely to win and gain outweighs adverse consequence	High chance of losing and serious consequence Win seen a great coup.
Financial/ VFM	Avoidance of financial loss Only willing to accept low cost option Resources withdrawn	Only prepared to accept possibility of very limited financial loss if essential. VFM primary concern	Some limited financial loss VFM weighted against benefits Resources generally restricted to core objectives	Prepared to Invest for reward and minimise possible of financial loss Value and benefits considered Resources allocated to maximise potential opportunities	Prepared to invest for best possible reward and accept potential financial loss Resources allocated without firm guarantee of return.
Operational /Policy Delivery	Defensive approach – maintain or protect rather than create or innovate Priority of tight management controls and oversight. General avoidance of systems technology developments	Innovations always avoided unless essential Only essential systems/ technology developments to protect current operations.	Tendency to stick to the status quo. Systems / development limited to improvement to protect current operations	Innovation supported with demonstration of commensurate improvement in management control. Systems /developments considered to enable operational delivery	Innovation pursued – desire to break the mould and challenge current practices New technologies viewed as key enabler High levels of devolved authority.
Reputation	Minimal Tolerance for any decisions /actions that could lead to adverse scrutiny	Tolerance for risk taking limited to events where there is no significant repercussion	Tolerance for risk taking limited to events where little chance of failure or repercussion	Take decisions with potential to incur additional scrutiny but with mitigations to minimise exposure	take actions that attract scrutiny or criticism but where benefits outweigh risks

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APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
1. Population and economic decline	Projected population decline and potential economic decline and failure to identify relevant factors causing the decline and the need to develop and strategies and action plans to address that decline in an effective manner.	Sustained economic decline and population loss, particularly amongst our economically active generations results in a circle of decline with reduced employment, lower earnings, failing businesses and poor perception of the area. Population decline reduces Government funding and reduces scope for efficiencies and economies of scale. Combined population and economic decline may increase the need and costs for services	5	4	20	Sustainable economic growth and population growth in Argyll and Bute with a focus on economically active generations.	Single outcome agreement targets population and economic recovery. Strategic Economic Development Action Plan (EDAP). Argyll and Bute Development Plan implementation. Some CHORD works and additional area regeneration works. Economic Sustainable Forum Action SOA delivery plans	Relevant CPP policies and strategies underpin a business friendly ethos. Implementation of local development plans Deliver area based economic development action plans Holistic approach to economic development and regeneration Maximise funding levered in from external sources to support economic development	4	4	16	12	L	Executive Director of Development and Infrastructure

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
2. Condition and suitability of overall Council infrastructure and asset base.	Infrastructure and asset base does not meet current and future requirements. Infrastructure and asset base is not being used or managed efficiently or effectively.	Infrastructure and asset base do not support overall Council objectives. Infrastructure and asset base do not support delivery of service outcomes. Infrastructure and asset base is allowed to deteriorate resulting in cost, lost opportunities and wasted resource.	4	4	16	The Council has an infrastructure and asset base that is maintained, safe, efficient and fit for purpose and which supports development of the area and achievement of objectives and service delivery	Corporate Plan and Service Plans. (actions) Capital planning and monitoring process. Asset Management planning process. Project prioritisation process Business case prepared with regard to asset sustainability, service development and strategic change.	Asset Management within the Council is currently subject to a Best Value 2 Audit by Audit Scotland, our processes and procedures will be updated to take account of any recommendations that arise.	3	4	12	12	M	Head of Facility Services.

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
3. External – built environment non-council assets and infrastructure	Our built environment is not maintained to an adequate standard and does not support investment or regeneration aspirations. Built environment deteriorates to levels where intervention is required.	We do not have a built environment which supports sustainable growth. Communities and public sector partners fail to make the best use of our natural and built environment.	3	4	12	We have an environment which supports sustainable growth. Communities and public sector partners make the best use of our natural and built environment with clear plans for development and investment	Townscape Heritage Initiative THI – Conservation Area Regeneration Scheme. CARS – Building Standards Area Teams	Physical Regeneration programmes focused on enhancing and maintaining the built environment including THI and CARS	3	4	12	12	M	Executive Director of Development and Infrastructure

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15															
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
4. Welfare reform	Implementation of welfare reform is not managed well resulting in increased poverty and deprivation or short term crisis.	Increase in demand or costs for Council services. Financial crisis and hardship for individuals. Adverse impact on local economic development. Adverse impact on communities. Potential widening of inequalities gap.	5	4	20	Well managed implementation of welfare reform in a way that minimises impact on individuals and communities but does not create a financial burden for the Council.	Separate project established to manage welfare reform with clear plans, resources and risks identified. Joint working with DWP, CPP and other Agencies to plan response to potential impact. Discussions on-going at national level re local services support framework which will lead to targeted support. USDL trial (Universal Services Delivered Locally) to work with individuals and families in need of money management support and/or digital access and training.	Mapping of the existing network of support available in all areas of Argyll and Bute across all sectors. Work closely with all stakeholders in relation to the implementation of Universal Credit in Argyll and Bute in 2015	3	4	12	12	L	Head of Customer and Support Services

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
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			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
5. Political leadership	Political instability resulting in a lack of collective strategic leadership by councillors.	Loss of Strategic direction. Deterioration in performance. Negative impact on reputation.	4	5	20	Improved Strategic focus. Performance level maintained and improved.	Administration in place with working majority. Revised political management arrangements agreed at Council on 23 January 2014. Action plan to address issues set out in Audit Scotland statutory report approved by Council 23 Jan 14. On-going Members seminar programme and support from Improvement Service secured in order to take forward aspects of elected member development	On-going Members seminar programme and support from Improvement Service secured in order to take forward aspects of elected member development. Plans are being developed to provide mentoring and support for policy leads. Priorities agreed by all members.	3	4	12	12	L	Chief Executive

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
6. Finance – Income and funding	A major reduction in income /funding as result of a reduction in grant funding. This may arise from global or local economic circumstances, government policy on public sector budgets and funding or data that determines grant funding formula.	Lack of income /funding to support Council objectives. Requirement to reduce service provision or budget allocations. Reduced income may impact on performance levels.	4	4	16	The Councils finances are managed effectively.	Effective framework for longer term financial planning that takes account of longer term funding projections. Monitoring of grant funding formula. Research opportunities for maintaining or enhancing government funding to the Council.	Actions to improve current income streams. Actions to attract new income streams. Targeted Investment in specific areas /initiatives Contributing to Local Authority Spending review	3	4	12	12	M	Head of Strategic Finance

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
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			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
7. Health and social care integration	Implementation of health and social care integration is not managed effectively.	Unable to proceed with health and social care integration on a managed basis and/or in accordance with timescales. Integration has a negative impact on health and social care service delivery.	4	5	20	Planned and managed implementation of health and social care.	A separate project has been established to focus on implementation and identifying and addressing any issues arising. Integration scheme approved by Scottish Government Clear Project Governance Preparation of 3 year Strategic Plan Creation of Integration Joint Board Agree Senior Management Structure	Delivery of Integration project plan. Review individual workstreams and monitor progress Action Outline Strategic Plan Consulation process	3	5	**15**	**12**	L	Chief Officer Integration

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
8. Reputation	The Council fails to maximise its profile at national level. Trust and Integrity of the Council is undermined leading to diminishing reputation resulting in negative external scrutiny. Council fails to maintain its general reputation with residents, the Community and the wider Local Government	Reputation declines. Negative impact on morale. Poor reputation undermines action being taken to target population and economic growth. Increased risk of audit and inspection activity.	4	4	16	The reputation of the Council is protected and enhanced.	Community Engagement Strategy. Improved Communications Strategy. Planning and performance management framework to ensure services properly planned and managed and performance targets achieved.	Action plan to improve customer services. Employee survey to develop internal communication. Update approach to reporting performance. Increase options for communication with citizens through improved communications strategy. Newsroom Website	3	4	12	12	M	Head of Improvement and HR

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
9. Demographic change	The Council fails to recognise, plan and deliver services in a way that takes account of demographic trends.	Services not configured to meet user/citizen requirements This will impact on the Council's ability to attract and retain staff and the model of care we provide for Social work services.	4	4	16	Performance of key priority services and other key areas identified by the public maintained or improved	Monitoring of population trends. Corporate and service plans. Planning and performance management framework (PPMF). Community Engagement Strategy. Workforce planning.	Continued workforce planning. Corporate and service planning.	3	4	12	12	L	Head of Improvement and HR

APPENDIX 2

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			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
10. Finance - expenditure	Expenditure is estimated to exceed available resource and the Council is facing a considerable funding gap in the medium term. Expenditure continues to rise against an increasing demand for services.	Resources need to be diverted. Reduced levels of performance. Expenditure exceeds available resource Services are unable to make required efficiencies	3	4	12	The Councils finances are managed effectively.	Revenue and capital budget monitoring and preparation including review of base budget, inflation, cost and demand pressures. Maintaining an adequate contingency within General Fund reserve. Procurement Strategy Service Choices Initiative in place. On-going forecasts being prepared and updated.	Efficiency monitoring process integrated into routine budget monitoring Exploration of shared services (shared cost) opportunities Consideration into investment for income opportunities Innovation fund.	3	4	12	12	M	Head of Strategic Finance

APPENDIX 2

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Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**T O L**	**A P P**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
11. Partnership governance	Inadequate Partnership Governance Arrangements. Risk that partnership arrangements are poorly defined and constituted leading to an inability to deliver outcomes and objectives or being democratically deficient	Lack of Accountability. Lack of democratic input to key decisions. Partnership viewed as having failed and not achieving objectives. Wasted resources and effort. Reputational damage.	4	3	12	Effective and efficient Partnership which is both accountable and democratic and focused on delivering outcomes.	Single Outcome Agreement Clear line of sight from SOA to individual partner contributions CPP governance arrangements and partnership agreement. Area community planning groups	Review Single Outcome Agreement Delivery Plans	3	3	9	9	L	Head of Community and Culture.

APPENDIX 2

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			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
12. Engagement and alignment of service delivery.	The Council fails to understand service user needs and align service delivery to meet these.	Gaps between community needs and Council services. Also impacts on reputation.	3	4	12	The Council understands local needs and aligns service deliver accordingly.	Community Engagement Strategy. Customer service board and action plans. Scorecard analysis Operation & development of: Panels & Forums - Young Peoples Panel - Youth Website - Citizens Panel etc	Planning for Our Future consultation exercise Ensure Council is best placed to meet requirements of Community Empowerment Act. Enabling necessary culture shift	2	4	8	8	L	Executive Director Customer Services. All Heads of Service

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**TOL**	**APP**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
13. Leadership and management	A lack of Strategic Leadership and Direction will have a negative impact on the ability of the Council to set out strategic objectives and then align service delivery and resources to ensure these objectives are achieved. May also impact on development of the community planning partnership. Risk that organisation is not focussed on outcomes /objectives resulting in poor decision making and inadequate governance arrangements	No clear strategic direction/set of objectives. Objectives not achieved as services and resources are not fully aligned to objectives. Opportunities missed to demonstrate community leadership. Confidence in, and reputation of, the Council harmed. Fail to adapt to changing environmental, social and economic conditions. Fail to meet service needs of citizens.	3	4	12	The Council has a clear strategic direction and service and resources are aligned to ensure Council objectives are achieved.	Corporate Plan sets out overall Council objectives. Community Plan/SOA sets out CPP objectives with clear links to Council contributions Corporate Improvement Plan. PPMF and service planning and performance monitoring to ensure service outcomes and activity is aligned with Council and Government objectives and performance is meeting targets. Community engagement and consultation to understand activity local needs. Leadership development programme	Delivery Plans for Single outcome agreement. Communication Strategy – Internal Communications	2	4	8	8	L	Chief Executive

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**TOL**	**APP**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
14. Civil contingency and business continuity	The arrangements in place for civil contingencies and business continuity are not effective.	Ineffective management of major emergencies affecting Council services and communities in Argyll and Bute in response to a major emergency. Incident and recovery phase of an emergency lead to greater inconvenience and hardship and a longer timescale for return to normal. Council unable to effectively deliver its own services as a result of an emergency.	2	4	8	Effective plans and procedures in place to respond to a major event affecting Council services and/or the general public.	On-going training programme in place and continual update of Emergency Plans and procedures. Recent review of business continuity arrangements. All critical activities identified. West of Scotland local resilience partnership EMST regular meetings Regular testing of procedures Regular training Community resilience plans.	Emergency Planning Test events. Regular Critical Activity Recovery Plan (CARP) updates. Further roll out of community resilience partnership programme7	2	3	6	6	L	Head of Governance and Law

APPENDIX 2

STRATEGIC RISK REGISTER AUG 15														
Risk Ref	**Description Of Risk**	**Example Consequences**	**Gross Risk**			**Desired Outcome**	**Current Mitigations**	**Planned Mitigations**	**Residual Risk**			**TOL**	**APP**	**Risk Owner**
			Li	**Im**	**Sc**				**Li**	**Im**	**Sc**			
15. Management of services and resources	Services and resources are not effectively managed. Services fail to achieve agreed performance levels and as a result are not contributing fully to Council objectives Resources are poorly managed with result that agreed outcomes and objectives are not fully achieved. Unable to achieve continuous improvement and improve effectiveness and efficiency.	Poor performance. Increased costs. Negative publicity. Unable to demonstrate best value.	3	3	9	Performance targets achieved. Performance improves over time and compared to others. Improved use and management of resources.	PPMF and service planning Regular performance monitoring and review. Performance scorecards and Pyramid. Corporate Improvement Plan and monitoring of progress. Effective communications team Argyll and Bute Manager Programme. HR plan and policies including maximising attendance Service Choices Initiative.	Continued roll out and development of Argyll and Bute Manager Programme Further development and continued implementation of Attendance Management Policy	2	3	6	6	L	Executive Directors

Li = Likelihood
Im = Impact
Sc = Score

TOL = Tolerance
APP = Appetite

Risk Assessment Matrix – Appendix 2			
Likelihood		Impact	
Score	Description	Score	Description
1	Remote – Very unlikely to ever happen.	1	None – minimal impact on objectives, budget, people and time
2	Unlikely – Not expected but possible.	2	Minor – 1%/10% budget, first aid, minor impact objectives, 1wk/3 months delay.
3	Moderate – May happen occasionally.	3	Moderate – 10%/30% budget, medical treatment required objectives partially achievable, 3/12 months delay.
4	Likely – Will probably occur at some time.	4	Major – 30%/70% budget, permanent harm, significant impact on service delivery, 1/2 years delay.
5	Almost certain – Will undoubtedly happen and possibly frequently	5	Catastrophic – Over 70% budget, death, unable to fulfil obligations, over 2 years delay.

A combined score of 15 or more is classed as a red risk. HIGH
A combined score of between 6 and 14 is classed as an amber risk. MEDIUM
A combined score of less than 5 or less is classed as a green risk. LOW

APPENDIX 3

Risk Appetite Statement

1. Introduction

Argyll and Bute Council, within its corporate plan, has a stated mission "to make Argyll and Bute a place people choose to live, learn, work and do business. The Council has agreed a number of key strategic priorities including:

- Making Argyll and Bute a place people choose to live
- Making Argyll and Bute a place people choose to learn
- Making Argyll and Bute a place people choose to work and do business

The Council will deliver these priorities by:

- Ensuring our culture, structure and systems make our Council a high performing and improving organisation that people choose to work for
- Managing our resources robustly and sharing resources, buildings and facilities where appropriate
- Ensuring our workforce has the skills, knowledge and behaviours that support our vision
- Growing excellent leaders in our officers and elected members
- Having systems and processes in place that support and enhance customer focussed service delivery
- Providing excellent communications, customer service, consultation and engagement
- Continually looking at how we can improve and deliver quality services

This statement considers the most significant risks to which the Council is exposed and provides an outline of the Risk Management Framework, a general statement of appetite and the approach to managing these risks.

APPENDIX 3

2. General Statement of Appetite

The Council faces a broad range of risks which are reflective of its aims and objective and responsibilities in the public sector. Risks identified cover subject matters such as financial stability, Demography, Economy, Environment and Infrastructure, as well as its day-to-day operational activities.

The Council is exposed to a number of risks which are in some-part outside its direct ability to control or fully influence although it actively pursues policies which in some part contribute to mitigating the likelihood or impact.

In terms of both Strategic and Operational Risk the Council has a Low appetite for risk. Resources are aligned to priorities and arrangements are in place to monitor and mitigate risks to acceptable levels. Whilst appetite may be low, tolerance levels may be higher and the Council recognises that it is not possible or necessarily desirable to eliminate some of the risks inherent in its activities. In some instances acceptance of risk within the public sector is necessary due to the nature of services, constraints within operating environment and a limited ability to directly influence where risks are shared across sectors.

Risk Appetite and Risk Tolerance levels have been agreed for each of the risks within the Strategic Risk Register.

3. The Risk Management Framework

The Council's risk management framework seeks to ensure that there is an effective process in place to manage risk within the organisation. Risk management is an integral part of the planning and performance management framework. Detailed guidance is available to Services to assist in identification and evaluation of their risk environment and to put in place appropriate controls and and mitigations. The risk management culture emphasises careful analysis and management of risk in all business processes.

Risks are identified, assessed and managed at both Strategic and Operational level using an in-house Demand and Supply approach which allows outcome based demand risks and their associated supply type risk to be managed.

Governance arrangements include individual risks assigned to risk owners. Overview and review arrangements include Senior Management Team input, Performance Review and Scrutiny and Policy and Resources committee oversight. The Audit Committee are also provided with assurance as to the effectiveness of risk management arrangements.

Strategic Risks

The Council has a low appetite for risks and threats to the effective and efficient delivery of services and realisation of desired outcomes. It recognises that the actual or perceived inability to deliver strategic initiatives could have a significant impact on its ability to achieve its overall objectives as well as its reputation.

APPENDIX 3

A Strategic Risk Register is in place and is reviewed on a bi-annual basis. Strategic Risks by nature tend to be longer term and the Council has recognised that there is a timeline associated with the elimination or reduction in threat. In the short and interim terms tolerance levels may be above agreed risk appetite levels, however, it is important to recognise that appetite levels are not targets and any deviation between current risk scoring and appetite may be acceptable. Risk Appetite levels are not fixed and can change over time. Protocols include the setting of trigger points, i.e. the threshold where scoring exceeds tolerance levels and escalation processes are initiated.

The Strategic Risk Register has recently been updated and now includes Appetite Level and Tolerance levels.

Operational Risks

The Councils appetite for specific operational risks is also low. The Council is generally risk adverse, although, as Services become more commercially orientated there may be a shift to a higher appetite level linked to organisational change, innovation and exploration of opportunities. Examples are shown below:

Information Technology

Processing – Prolonged outage of core systems: The Council has a very low appetite for risks to the availability of systems which support its critical business functions. Maximum recovery times have been identified and agreed with each business area and critical activity recovery plans are in place.

Security – Cyber-attack on systems or networks: The Council has a very low appetite for threats to its assets arising from external malicious attacks. To address this risk, the Council operates strong internal control processes and utilises robust technology solutions.

On-going development: The implementation of new systems and processes creates new opportunities, but may also introduce new risks. Risks are also formally assessed prior to deciding on any new IT investment. The Council has adopted ITIL service management framework and operates strict controls over Change Management reflecting it has a low appetite for IT system-related incidents which are generated by poor change management practices.

Fraud and Corruption

The Council has no appetite for any fraud or corruption perpetrated by its staff. The Council takes all allegations of suspected fraud or corruption very seriously and has a robust anti-fraud policy and public interest disclosure policy. A code of conduct is also in place for both members and staff.

Compliance

The Council is committed to a high level of compliance with relevant legislation, regulation, sector codes and standards as well as internal policies and sound corporate governance principles. Identified breaches of compliance will be remedied as soon as practicable. The Council has no appetite for deliberate or purposeful violations of legislative or regulatory requirements.

APPENDIX 3

Information Management

The Council is committed to ensuring that its information is authentic, appropriately classified, properly conserved and managed in accordance with legislative and business requirements. It has a very low appetite for the compromise of processes governing the use of information, its management and publication. The Council has no appetite for the deliberate misuse of its information.

4. Implementation of the Council's Risk Appetite

All staff, Chief Executive, Executive Directors and Heads of Service are responsible for the implementation of, and compliance with, this Statement.

Communication

The Council's Risk Appetite Statement is published on the Council's Website and HUB.

Risk Registers

Each Service maintains a Risk Register of the operational risks it faces in its day-to-day operations and the control framework which is in place to mitigate risks. These Registers take into account risks from within the Council and external sources and are reviewed regularly. Risk Registers are also updated when there are key changes in policies, structures or functions.

All risks which are judged as unacceptable, above agreed tolerance points at departmental level are reported to the Senior Management Team (Strategic Risk Group) and action plans to reduce these risks to acceptable levels are prepared.

Departments are delegated responsibility to manage their specific operational risks in a manner which is consistent with this Statement and Risk Management Guidance and appropriately escalating any risks outside appetite or agreed tolerance levels. Departmental risk appetite settings for each risk in their Risk Registers must also be consistent with this statement.

Reporting & Monitoring

Reporting systems are maintained to provide assurance that the risk appetite is effectively incorporated into risk management activity decisions.

Feedback on the implementation of the Council's Risk Appetite Statement is provided through the Senior Management Team, Performance Review & Scrutiny Committee, Policy and Resources Committee and the Audit Committee.

5. Review

This Risk Appetite Statement is reviewed annually as part of an overall annual review of risk management arrangements. This review is co-ordinated by the Internal Audit Section. Proposed changes to the Risk Appetite Statement are endorsed by Policy and Resources committee following review by Senior Management Team (SRG).

Risk Management Action Plan 15/16

Theme	Outcome	Action Required	Timescale	Responsible Officer(s)	Current Status	Comment
Policy & Strategy	Embed Risk Appetite into Risk Management Processes	Develop Risk Appetite Protocols	30 August 2015	Kirsty Flanagan	Complete	
Partnership, shared risk & resources	Agreed Health and Social Care Shared Risk Register(s)	Develop shared risk register. Liaison with NHS	31 December 2015	Kirsty Flanagan	On Track	Initial Meetings have taken place June /Aug 2015.
Assurance	Increased level of Management and Member assurance	Review and Update Assurance Map	31 December 2015	Grace Scanlin	On Track	
Outcomes and Delivery	Resource allocations address priorities and key risks	Review Budget Planning processes to ensure cognisance of identified priorities and key risk	31 March 2016	Kirsty Flanagan	On Track	
Information	Enhanced Risk Data: Further develop Operational Risk Registers (ORRs) – specifically phrasing of risk	Ensure ORR's are reviewed against guidance and risk descriptions updated	31 March 2016	Kirsty Flanagan	On Track	.

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ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**
STRATEGIC FINANCE **4 DECEMBER 2015**

STRATEGIC RISK ASSURANCE MAPPING EXERCISE

1 SUMMARY

1.1 This report sets out internal audit's assessment of the sources of assurance for the Audit Committee on the management of the Council's strategic risks.

The report describes the approach to the work and the outcomes, including recommendations for future internal audit work.

Appendix A highlights our overall assessment against each of the strategic risks. It should be noted that the assessment is based on the level of assurance that the Committee can rely on at each level. A 'low' level therefore highlights where there are gaps in evidence of active /targeted actions /activity and therefore the level of assurance that can be given, rather than an assessment on the management of that risk.

2 RECOMMENDATIONS

2.1 The Audit Committee notes the Risk Assurance Map at Appendix A.

2.2 The Audit Committee considers implications for the Internal Audit annual plans in 2016-17 and 2017-18.

3 BACKGROUND

3.1 We agreed with the Audit Committee that internal audit would prepare and update an assurance mapping exercise on an annual basis to:

- give senior management and elected/committee members comfort that there is a comprehensive risk and assurance framework with no duplicated effort or potential gaps
- ensure that internal audit plans are targeted to address the key risks facing the Council, and where assurance gaps remain
- identify any potential areas of overlap or duplication of assurance.

3.2 Appendix A provides a summary of the Council's strategic assurance map which follows the three lines of defence model.

The assurance map details where the Audit Committee can gain assurance against the monitoring and management of strategic risks.

The assurance map is based on the following three lines of defence model:

First Line	Second Line	Third Line
The first level of the defence is the control environment - the business operations that perform day to day risk management activity	Oversight functions such as the SMT (operating as the Risk Management Group) and individual committees set directions, define policy and provide assurance	Internal and external audit, and any other scrutiny or regulatory body, offer independent challenge to the levels of assurance provided by business operations and oversight functions

4 FINDINGS

4.1 The Assurance Map has identified 2 areas where independent assurance has been limited. These are:

- reputation; and
- demographic changes.

4.2 In the draft Internal Audit Annual Plan 2016-17, Internal Audit has identified an audit relating to the Arrangements for Service Planning. The scope of this audit could therefore include arrangements to monitor the impact of demographic change. The Audit Committee uses the Assurance Map to inform and consider the Internal Audit Annual Plan for 2016-17 and 2017-18.

4.3 Appendix A highlights that there has been limited movement in the residual risk scores, despite mitigating actions and reporting, as a result of the longer term nature of strategic risks and the time necessary to observe improved outcomes.

4.4 A key improvement during 2015 is the introduction of risk tolerance and appetite to the Council's risk management processes. This will allow the Council to better monitor the effectiveness and impact of mitigating actions. It is too early in the development of the revised approach to conclude on the effectiveness of arrangements, but our assessment of risk management arrangements in 2016-17 will consider the extent to which risk appetite and tolerance are understood and embedded across the Council.

5 CONCLUSION

5.1 Overall, Appendix A highlights a strong performance management framework is in place across the Council. We have used the exercise to

highlight areas for improvements to the assurance framework, to ensure that the Audit Committee and Performance Review and Scrutiny Committee understand how risks are managed and mitigated.

6 IMPLICATIONS

6.1 Legal – None.
6.2 Finance – None.
6.3 HR – None.
6.4 Policy – None.
6.5 Risk – None.
6.6 Equalities – None.
6.7 Customer Services – None.

For further information please contact

Grace Scanlin
0131 659 8526

APPENDIX A: Strategic Risk Assurance Map

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
1	Population and Economic Decline	**Red 16**	**Red 16**	• Economic Forum • PPMF/quarterly scorecards • Service Planning linked to SOA/Corporate Outcomes • Economic Development Action Plan • Exception reporting within Team Quarterly Performance Report	• Quarterly performance reports considered by Performance Review and Scrutiny Committee • Quarterly Department Updates challenged by SMT • CHORD progress updates to Policy & Resources Committee • Audit Committee review of CHORD Action Plan • D & I quarterly performance reporting to Environment, D & I Committee • D & I Annual Performance Report • SOA Delivery	Internal audit coverage: • CHORD (Limited Assurance) • Employability (Substantial Assurance) • Business Support (Substantial Assurance) • Single Outcome Agreement (Substantial Assurance) External audit coverage: • CHORD Project – focussed follow up work on the Oban Bay/Harbour project **Future:** Internal audit Sustainable Communities 2016-17 External audit will continue to monitor CHORD projects	There are a range of assurance sources across the three lines of defence.

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
					Plan reported to Council		
2	Condition and suitability of overall Council Infrastructure and asset base	Amber 12	Amber 12	• Strategic Infrastructure Plan – sets out a plan for the strategic infrastructure to support economic growth • Direct link to Corporate Objectives within the Corporate Plan • Service Planning linked to SOA/Corporate Outcomes • PPMF/quarterly scorecards • Exception reporting to DMT	• Quarterly performance reports considered by Performance Review and Scrutiny Committee • Quarterly Department Updates challenged by SMT • D & I quarterly performance reporting to Environment, D & I Committee • D & I Annual Performance Report • Corporate Asset Management Strategy reported to Policy & Resources Committee	Internal audit coverage: • Roads Maintenance Prioritisation (Limited Assurance) • Land and Asset Review (Limited Assurance) External audit coverage: • Asset Management review CIPFA • Independent health check on review of assets Local Government Benchmarking Framework 2013-14: • Corporate Services: Asset Management Suitability (4th Quartile) • Corporate Services: Asset Management Suitability (2nd Quartile) **Future:** Internal Audit Property	Independent assurance processes during 2015-16 have largely focused on asset disposals, rather than the condition and suitability of the Council's infrastructure. Good level of assurance from management reporting, and supported by benchmarking across other Councils.

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
						Maintenance	
3	External – built environment is not maintained to an adequate standard.	Amber 12	Amber 12	• Local Development Plan • Planning and Regulatory Services Service Plan and quarterly monitoring	• SMT – regeneration focus • CHORD progress updates on Townscape Heritage Initiative (THI) • Reports on Conservation Area Regeneration Scheme (CARS) funding • THI progress reports to Council	Internal audit coverage: • Enforcement/retrospective permissions • THI and CARS monitoring of outcomes	This risk relates to non-Council assets. However, the THI and CARS projects are subject to external funding and therefore monitoring of progress. Third line of defence coverage relating to Council enforcement actions and monitoring of outcomes.
4	Welfare Reform – implementation is not managed well resulting in increased poverty and deprivation or short term crisis.	Amber 12	Amber 12	• Community and Social Services Service Plan • Service Planning linked to SOA/Corporate Outcomes • PPMF/quarterly scorecards • Project Board in place with	• Welfare Reform Working Group (WRWG) report to SMT • SMT ongoing monitoring of risk Consideration or high and medium hardship cases • Oversight by the Community Services	Internal audit coverage: • Housing Welfare Payments External audit high level review of Welfare Reform arrangements - no recommendations arising	There are a range of assurance sources across the three lines of defence.

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
				partners - and monitoring of associated action plan	Committee		
5	Political Leadership – political instability means there is a lack of collective strategic leadership by councillors	Amber 12	Amber 12	• Corporate Governance Improvement Plan • Audit Scotland Action Plan and monitoring • Customer Services Service Plan and associated outcomes/monitoring	• Customer Services Quarterly Performance Reporting to Performance Review and Scrutiny Committee	**Future**: Audit Scotland Best Value follow up work anticipated in December 2015	Post-implementation review will be conducted by Governance & Law. Internal audit follow up likely to be considered in 2017.
6	Finance – income and funding	Amber 12	Amber 12	• Strategic Finance Service Plan • Medium Term Financial Strategy • Finance Outcome measures within Scorecards	• Policy & Resources Committee consider Financial Monitoring reports, including monitoring of financial risks • Service Choices – Investing for Income	External audit: • Work on Financial Management and Sustainability included review of budget and actual income streams to consider potential areas of risk.	There are a range of assurance sources across the three lines of defence.

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
					• Budget and budget working papers considered by full Council		
7	Health and Social Care Integration	Amber 12	Red 15	• Reflected within Service Plans and therefore subject to monitoring at DMT/SMT level • Action Plan developed by Project Implementation Team • Strategic Plan in place and subject to consultation	• Progress reports considered by the Community Services Committee • Standing item on community planning groups/board	Internal audit: • Health and Social Care Governance Arrangements (substantial assurance) External audit overview of arrangements	Good level of coverage across three lines of defence.
8	Reputation – the Council fails to maximise its profile at national level. Trust and integrity of the Council is undermined.	Amber 12	Amber 12	• Performance and Community Engagement reflected within Service Plans • PPMF in place	• Local Government Benchmarking Framework and annual reporting mechanisms • Customer satisfaction ratings	External audit: • Audit Scotland's assessment of Public Performance reporting	Lack of specific assurance on reputation but customer satisfaction and service planning processes are incorporated within the Council's PPMF.
9	Demographic change	Amber 12	Amber 12	• Population Summit • SOA annual profile update and planning pmrocesses	• SMT receive reports on population change • PRS Committee receive reports	**Future**: • Arrangements for Service Planning	No third line coverage providing assurance that planning is effective. Potential to therefore include demographic

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
				• Service Planning arrangements – guidance and approach	on population change		change within scope of Service Planning audit.
10	Finance - expenditure	Amber 12	Amber 12	• Service Choices framework • Strategic Finance Service Plan • Medium Term Financial Strategy • Finance Outcome measures within Scorecards	• Policy & Resources Committee consider Financial Monitoring reports, including monitoring of financial risks • Service Choices – community engagement and challenge process • Budget and budget working papers considered by full Council	External audit: • Work on Financial Sustainability and follow up of recommendation	Coverage across all three lines of defence.
11	Partnership governance	Amber 9	Amber 9	• SOA delivery plans which make clear links to individual partner contributions • DMT quarterly performance reporting	• Governance review of CPP presented to the Audit Committee	Internal audit: • Single Outcome Agreement Delivery Plan monitoring	Coverage across all three lines of defence.
12	Engagement and alignment of service	Amber 8	Amber 8	• Community Engagement Strategy	• Service Choices and Planning for Our Future	Internal audit: • Single Outcome	Coverage across all three lines of

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
	delivery			• PPMF and quarterly monitoring • Departmental scorecards include measures on customer satisfaction	community engagement overseen by the P&R Committee • SOA Delivery Plan	Agreement Delivery Plan monitoring	defence and key improvements noted via the Service Choices framework
13	Leadership and management - A lack of Strategic Leadership and Direction will have a negative impact on the ability of the Council to set out strategic objectives and then align service delivery and resources to ensure these objectives are achieved.	Amber 8	Amber 8	• Corporate Plan sets out overall Council objectives. • Community Plan/SOA sets out CPP objectives with clear links to Council contributions • PPMF and service planning and associated monitoring .	• Corporate Improvement Strategy considered by the P&R Committee • Service Choices and Planning for Our Future community engagement overseen by the P&R Committee • Audit Scotland Improvement Plan and monitoring reports	Internal audit: • Single Outcome Agreement Delivery Plan monitoring External audit: • Audit Scotland Best Value follow up	There are a range of assurance sources across the three lines of defence.
14	Civil contingency and business continuity	Amber 6	Amber 8	• Critical activities identified within review of business continuity arrangements • West of Scotland local resilience	• Critical Activity Recovery Plan (CARP) updates to DMT/SMT. • Pyramid and Performance Scorecards updated	Internal audit Review of Business Continuity in 2013-14 restricted to Educational Establishments	Scope to provide additional 3rd tier assurance on management of CARP.

Risk	Risk Title and Description	Risk Score December 2015	Risk Score December 2014	First Line of defence	Second Line of Defence	Third Line of Defence	Assessment
				partnership provides additional support • Community resilience plans	quarterly with status of CARP actions and reviewed by PRS		
15	Management of Services - Services and resources are not effectively managed. Services fail to achieve agreed performance levels.	Amber 6	Amber 6	• Service Planning process • PPMF including quarterly reporting • DMT exception reporting/monitoring	• Quarterly performance reports to the PRS Committee.	Internal audit: • Performance Management review	Coverage across all three lines of defence.

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ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **4 DECEMBER 2015**

AUDIT COMMITTEE DEVELOPMENT PLAN

1. Executive Summary

1.1 This report provides a progress update in respect of the Audit Committee Development Plan action points. The plan is a rolling document and is underpinned by effectiveness session activity.

1.2 A number of action points were completed by September deadline and as agreed by the committee these have been removed from the plan. Similarly action points with Quarter 3 deadlines and which are showing as complete will also be removed from the plan subject to member agreement.

1.3 A number of new action points were identified during the Committee's September 2015 effectiveness session and these have been added to the development and are noted below.

1. **Agenda Management:** Review Audit Committee terms of reference and ensure work-plan aligns to requirements. Ensure Internal Audit reports are given sufficient profile within the agenda and where possible feature early in the agenda**.**

2. **Report Review Forum:** To aid committee effectiveness and manage business, members agreed that an arrangement be introduced which will provide members with the opportunity to discuss issues in detail with colleagues and the Chief Internal Auditor prior to the formal meeting of the Committee. The detail will be developed over the next few months however it is proposed that these sessions will be introduced for 16/17 Audit Plan and will be on-line via micro-soft lync**.**

3. **Member Feedback / Questions**: Consideration to a protocol where members have a series of questions for officers and where these are known in advance, that these are submitted prior to the meeting to allow officers to consider responses and provide any relevant information**.**

4. **Sharepoint Overview**: Internal Audit has developed a share point site which will be accessible to Committee Members. This is an electronic repository for all Internal Audit Reports. An overview session for members will be arranged for the March Effectiveness session.

1.4 An action point in relation to developing links between Audit and Scrutiny has been rescheduled for March 2016. Work is in progress and discussions are taking place at officer level and between respective Chairs. Appendix 1 details the Audit Committee Development Plan.

2. RECOMMENDATIONS

2.1 1) Members to note report and updated of 15/16 Audit Committee development plan.

2) Members to approve removal of actions points showing as complete.

3 CONCLUSION

3.1 The Audit Committee development plan is a working document and is underpinned by effectiveness session activity. All current action points are either complete, on track or not scheduled.

4. IMPLICATIONS

4.1 Policy –.None

4.2 Financial – None directly however potential resource implication of additional internal audit work which may be offset by reduced external audit fee.

4.3 Personnel – None

4.4 Equal Opportunities – None

4.5 Legal – None.

4.6 Risk – None

4.7 Customer Service – None.

SHEILA HILL
VICE CHAIR AUDIT COMMITTEE

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Appendix 1- Audit Committee Development Plan

Appendix 1 – Audit Committee Development Plan 15-16

No.	Issue arising	Proposed action	Lead responsibility	By (date):	Comment
Role of Audit Committee					
1.	Lack of clarity about sources of assurance and the respective roles of the Audit Committee and Performance Review and Scrutiny Committee	• Development of protocols for forwarding /co-ordinating Audit reports to PRS for Outcome scrutiny work	Chair of Audit Committee Chair of Performance Review and Scrutiny Committee	Revised to 31 March 2016	Off -Track
2.	Managing Business: Agenda Management	• Review Audit Committee terms of reference and ensure work-plan aligns to requirements. Ensure Internal Audit reports are given sufficient profile within the agenda and where possible feature early in the days business	Chair of Audit Committee	31 March 2016	On Track
Audit Committee Effectiveness					
3.	Using CIPFA practical guidance for audit committees	• Hold Regular Effectiveness sessions during 15/16	Chair of the AC, but facilitated by Vice Chair /Grant Thornton	31 March 2016	On Track
4.	Increasing the impact of the audit committee, and the understanding of the role the committee plays in the internal control framework	• Chair to present Annual Report to the Council November 2015	Chair of the AC	30 November 2015	Complete
5.	To aid committee effectiveness and manage business members agreed that a review forum be introduced.	• Develop protocol and timetable. Ensure all committee members have access to Microsoft Lync and an appropriate overview of the functionality is provided. To be introduced for the 16/17 Audit Plan	Chief Internal Auditor	31 March 2016	On Track

No.	Issue arising	Proposed action	Lead responsibility	By (date):	Comment
6.	Effectiveness: Advance question protocol.	• Consideration to a protocol where members have a series of questions for officers and where these are known in advance, that these are submitted prior to the meeting to allow officers to consider responses and provide any relevant information	Governance and Law Manager	31 March 2016	On Track
Delivering impact					
7.	Sharepoint Overview	• Deliver Sharepoint overview session for members	Chief Internal Auditor	31 March 2016	On Track
8.	Ensuring that the Audit Committee can comment on the scope and coverage of internal audit to meet their assurance requirements	• IA to prepare indicative 2016-17 annual audit plan for December audit committee meeting, to ensure that Audit Committee members have the opportunity to comment on the plan.	Chief Internal Auditor	December 2015	Complete

Audit Committee Work Plan 2015 - 2016

December 2015: This is an outline plan to facilitate forward planning of reports to the Audit Committee.

Date	Report Designation	Lead Service	Regularity of occurrence/ consideration	Date of Reports to Committee Services	Additional Comment
Friday 4 December 2015					
	External Audit Progress Report	Verbal report by Audit Scotland, External Auditors	By exception	25 November 2015	
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	25 November 2015	
	Internal Audit Reports to Audit Committee 2015 - 2016	Chief Internal Auditor	Quarterly	25 November 2015	
	External & Internal Audit Report Follow – Up 2014 – 2015	Chief Internal Auditor	Quarterly	25 November 2015	
	Draft Annual Audit Plan 2016/17	Chief Internal Auditor	Annual	25 November 2015	
	Risk Management Overview	Head of Strategic Finance	Annual	25 November 2015	
	Strategic Risk Assurance Mapping Exercise	Grant Thornton Audit Partners	Annual	25 November 2015	
	Audit Committee Development Plan	Vice-Chair Audit Committee	Quarterly	25 November 2015	
Friday 11 March 2016					
	Vat Risk Review	Head of Strategic Finance	By Exception	2 March 2016	
	Tax Risk Review	Head of Strategic Finance	By Exception	2 March 2016	

Audit Committee Work Plan 2015 - 2016

	Financial Statements 2015 – 16 Timetable	Head of Strategic Finance	Annual	2 March 2016	
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	2 March 2016	
	Internal Audit Reports to Audit Committee 2015 - 16	Chief Internal Auditor	Quarterly	2 March 2016	
	External & Internal Audit Report Follow Up 2015 – 2016	Chief Internal Auditor	Quarterly	2 March 2016	
	Annual Audit Plan 2016/17	Chief Internal Auditor	Annual	2 March 2016	
	External Audit Plan 2015 - 16	External Auditors	Annual	2 March 2016	
	Audit Committee Development: Action Plan	Vice-Chair Audit Committee	Quarterly	2 March 2016	
Friday 17 June 2016					
	Unaudited Financial Accounts	Head of Strategic Finance	Annual	8 June 2016	
	Review of Code of Corporate Governance	Head of Strategic Finance and Executive Director – Customer Services	Annual	8 June 2016	
	Best Value Audit 2016	Head of Strategic Finance	Annual	8 June 2016	
	Risk Management and Audit	Chief Executive	Annual	8 June 2016	
	Audit Committee Development Plan 16 - 17	Vice-Chair Audit Committee	Quarterly	8 June 2016	
	Audit Committee Annual Report 2015/16	Chair Audit Committee	Annual	8 June 2016	

Audit Committee Work Plan 2015 - 2016

	Internal Audit - Annual Report 2016-17	Chief Internal Auditor	Annual	8 June 2016	
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	8 June 2016	
	Internal Audit Reports to Audit Committee 2016 - 2017	Chief Internal Auditor	Quarterly	8 June 2016	
	External & Internal Audit Report Follow up 2015 -2016	Chief Internal Auditor	Quarterly	8 June 2016	
	External Audit Reports	External Auditors	Quarterly	8 June 2016	
	National Fraud Initiative in Scotland	External Auditors	Bi-Annual	8 June 2016	
Friday 23 September 2016					
	Performance Management Reporting Update	Head of Improvement and HR	Annual	14 September 2016	
	Review of Community Planning Partnership Governance	Area Governance Manager & Community Planning Manager	Annual	14 September 2016	
	Treasury Management Annual Assurance Report	Head of Strategic Finance	Annual	14 September 2016	
	Audited Financial Accounts	Head of Strategic Finance	Annual	14 September 2016	
	External Audit Annual Report	External Auditors	Annual	14 September 2016	
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	14 September 2016	
	Internal Audit Reports to Audit Committee 2016 - 2017	Chief Internal Auditor	Quarterly	14 September 2016	

Audit Committee Work Plan 2015 - 2016

	External & Internal Audit Follow up 2015 – 2016	Chief Internal Auditor	Quarterly	14 September 2016	
	Audit Committee Development Plan	Vice-Chair Audit Committee	Quarterly	14 September 2016	
Friday 2 December 2016					
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	23 November 2016	
	Internal Audit Reports to Audit Committee 2016 - 2017	Chief Internal Auditor	Quarterly	23 November 2016	
	External & Internal Audit Report Follow – Up 2015 – 2016	Chief Internal Auditor	Quarterly	23 November 2016	
	Draft Annual Audit Plan 2017/18	Chief Internal Auditor	Annual	23 November 2016	
	Risk Management Overview	Head of Strategic Finance	Annual	23 November 2016	
	Risk Assurance Mapping	Grant Thornton Audit Partners	Annual	23 November 2016	
	Audit Committee Development Plan	Vice-Chair Audit Committee	Quarterly	23 November 2016	
Friday 24 March 2017					
	Vat Risk Review	Head of Strategic Finance	By Exception	15 March 2017	
	Tax Risk Review	Head of Strategic Finance	By Exception	15 March 2017	
	Financial Statements 2016 – 17	Head of Strategic Finance	Annual	15 March 2017	
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	15 March 2017	

Audit Committee Work Plan 2015 - 2016

	Internal Audit Reports to Audit Committee 2016 - 17	Chief Internal Auditor	Quarterly	15 March 2017	
	External & Internal Audit Report Follow Up 2016 – 2017	Chief Internal Auditor	Quarterly	15 March 2017	
	Annual Audit Plan 2015/16	Chief Internal Auditor	Annual	15 March 2017	
	External Audit Plan 2017 – 18	External Auditors	Annual	15 March 2017	
	Audit Committee Development: Action Plan	Vice-Chair Audit Committee	Quarterly	15 March 2017	
Future Reports – dates to be determined					
	Combined report Chairs of Audit Committee & PRS Committee on report forwarding/co-ordinating Audit reports to PRS	Chair of Audit Committee & Chair of Performance Review and Scrutiny Committee			Audit Committee meetings 19 June 2015 & 25 September 2015

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