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Argyll and Bute Council
Comhairle Earra-Ghàidheal Agus Bhòid

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12 September 2017

NOTICE OF MEETING

A meeting of the **AUDIT AND SCRUTINY COMMITTEE** will be held in the **COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD** on **TUESDAY, 19 SEPTEMBER 2017** 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 3 - 8)
   Minutes of the Audit and Scrutiny Committee as held on Tuesday 27 June 2017.

4. **INTERNAL AUDIT SUMMARY OF ACTIVITIES** (Pages 9 - 18)
   Report by Head of Strategic Finance

5. **INTERNAL AUDIT REPORTS TO AUDIT AND SCRUTINY COMMITTEE 2017/18** (Pages 19 - 102)
   Report by Head of Strategic Finance

6. **EXTERNAL & INTERNAL AUDIT FOLLOW-UP 2017/18** (Pages 103 - 110)
   Report by Head of Strategic Finance

7. **TREASURY MANAGEMENT ANNUAL ASSURANCE REPORT** (Pages 111 - 116)
   Report by Head of Strategic Finance

8. **AUDITED FINANCIAL ACCOUNTS**
   Report by Head of Strategic Finance (to follow)

9. EXTERNAL AUDIT ANNUAL REPORT

Report by External Audit (to follow)

10. AUDIT & SCRUTINY COMMITTEE DEVELOPMENT PLAN (Pages 117 - 120)

Report by Executive Director – Customer Services

REPORTS FOR NOTING

11. AUDIT SCOTLAND'S ANNUAL UPDATE ON HOUSING BENEFIT PERFORMANCE 2016/17 (Pages 121 - 140)

Report by Executive Director – Customer Services

12. AUDIT & SCRUTINY COMMITTEE WORKPLAN (Pages 141 - 142)

Audit and Scrutiny Committee

Martin Caldwell (Chair)
Councillor George Freeman
Councillor Sir Jamie McGrigor
Councillor Alan Reid
Councillor Andrew Vennard
Councillor Jim Findlay
Sheila Hill (Vice-Chair)
Councillor Julie McKenzie
Councillor Sandy Taylor

Contact: Adele Price-Williams 01546 604480

MINUTES of MEETING of AUDIT AND SCRUTINY COMMITTEE held in the COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD on TUESDAY, 27 JUNE 2017

Present: Martin Caldwell (Chair)

Sheila Hill
Councillor Alan Reid
Councillor Sandy Taylor
Councillor Andrew Vennard

Attending: Kirsty Flanagan, Head of Strategic Finance
Iain Jackson, Governance and Risk Manager
Peter Cupples, Finance Manager
Kevin Anderson, Chief Internal Auditor
Graeme Forrester, Area Committee Manager
David Meechan, Senior Auditor - Audit Scotland
Ursula Lodge, Senior Manager - Audit Scotland

Welcoming Members to the first meeting of the Audit and Scrutiny Committee, the Chair made comment on the importance of attendance in order to engage as a team, and thereafter introductions were made.

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of Councillor Jim Findlay, Councillor Julie McKenzie, Councillor Sir Jamie McGrigor and Councillor George Freeman.

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The minutes of the Audit Committee held on 24 March 2017 were approved as a correct record.

4. AUDIT AND SCRUTINY COMMITTEE - TERMS OF REFERENCE

The Committee considered a report which detailed that on 18 May 2017 Council agreed to introduce an Audit and Scrutiny Committee to take forward the functions of the previous Performance Review and Scrutiny Committee and the Audit Committee. Members were advised that the formation of the new committee requires an amendment to the Council's Constitution to the set terms of reference for the committee and requires Members and Officers to consider practice to ensure the functions of the new Audit and Scrutiny Committee are appropriately fulfilled. Members were invited to give feedback to the Area Committee Manager over the next few months in preparation of a draft Terms of Reference.

Decision

The Committee noted the current circumstances and considered the indicative timescales for development of terms of reference and practice for the Audit and Scrutiny Committee.

(Reference: Report by Executive Director, Customer Services dated 27 June 2017, submitted)

5. REVIEW OF CODE OF CORPORATE GOVERNANCE

The Committee considered a report advising that the Council's Governance Group has reviewed the content of the local Code of Corporate Governance to reflect the governance position within the Council for 2016/17. The review allowed the Council to include a Statement of Governance and Internal Control in the Annual Accounts for 2016/17. Members further considered the action plan for 2017/18 prepared by the Governance Group.

Decision

The Committee:

i) approved the content of the revised Code of Corporate Governance for 2016/17;

ii) approved the content of the Action Plan for 2017/18; and

iii) approved the draft Statement of Governance and Internal Control for 2016/17.

(Reference: Report by Executive Director, Customer Services dated 27 June 2017, submitted)

6. INTERNAL AUDIT ANNUAL REPORT 2016/17

A report providing the opinion that, subject to the matters listed in the Statement of Governance and Internal Control being actioned, substantial assurance can be taken that the systems of governance and internal control are operating effectively was considered by Members.

Decision

The Committee noted the contents of the report.

(Reference: Report by Chief Internal Auditor dated 27 June 2017, submitted)

7. INTERNAL AUDIT SUMMARY OF ACTIVITIES

The Committee considered a report which provided an update on Internal Audit activity during Quarter 1 against a number of areas which included;

- 2017/18 Audit Plan progress;
- Individual Audits undertaken;
- Continuous Monitoring Programme Testing;
- Internal Audit Development Plan; and
- Performance Indicators

Decision

The Committee reviewed and endorsed the report.

(Reference: Report by Chief Internal Auditor dated 27 June 2017, submitted)

8. INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE 2017/18

The Committee considered a report which provided detail in respect of the following 6 audits:

- Crematorium;
- Additional Support Needs Analysis;
- Education Management Circulars;
- Civil Aviation Authority Compliance – Oban Airport;
- Health and Social Care Partnership Charging Orders; and
- Fees and Charges

The Committee noted that actions 2 and 3 in the Fees and Charges audit have implementation dates of November 2017.

Decision

The Committee reviewed and endorsed the summary report and detail within each individual report.

(Reference: Report by Chief Internal Auditor dated 27 June 2017, submitted)

9. EXTERNAL & INTERNAL AUDIT REPORT FOLLOW-UP 2017/18

The Committee considered a report and accompanying appendices which documented the results from a review performed by Internal Audit into the progress made by departmental management in implementing recommendations made by both External and Internal Audit, which were due to be implemented by 30 April 2017.

Of the overdue actions the Committee noted the 3 delayed but rescheduled dates were as a result of staff absence which has now been resolved and that there are 5 superseded dates, in relation to the review of the all-weather pitches. Responsibility for these will transfer to the Leisure Charitable Trust and Internal Audit will then undertake additional follow-up work to ensure any outstanding issues are being addressed in any new arrangements.

Decision

The Committee reviewed and endorsed the report.

(Reference: Report by Chief Internal Auditor dated 27 June 2017, submitted)

10. INTERNAL AUDIT ANNUAL AUDIT PLAN 2017/18

Consideration was given by the Committee to a report which presented the Internal Audit Risk Assessment and Annual Audit Plan for Argyll and Bute Council for the 2017/18 financial year.

Decision

The Committee noted the contents of the report.

(Reference: Report by Chief Internal Auditor dated June 2017, submitted)

11. INTERNAL AUDIT CHARTER

The Committee considered a report outlining the proposed changes to the Internal Audit Charter as a result of the recent revision of the Public Sector Internal Audit Standards.

Decision

The Committee approved the updated Internal Audit Charter.

(Reference: Report by Chief Internal Auditor dated 27 June 2017, submitted)

12. AUDIT COMMITTEE ANNUAL REPORT 2016/17

The Committee gave consideration to a report which provided an overview of the Audit Committee's activity during the financial year 2016/17 and provided detail on developing the scrutiny element of the new Audit and Scrutiny Committee.

Decision

The Committee noted the report.

(Reference: Report by Chair of Audit and Scrutiny Committee dated June 2017, submitted)

13. UNAUDITED FINANCIAL ACCOUNTS

Members considered a report which gave an overview of the Unaudited Annual Accounts for 2016/17 and a summary of the significant movements from 2015/16.The report also provided information on the revenue outturn for 2016/17.

Decision

The Committee reviewed and endorsed the Unaudited Annual Accounts for the year ending 31 Match 2017.

(Reference: Report by Head of Strategic Finance dated 27 June 2017, submitted)

14. EXTERNAL AUDIT REPORTS

Consideration was given by the Committee to a report containing a summary of key issues identified during the interim audit work carried out at Argyll and Bute Council by Audit Scotland, which resulted from testing key controls within the financial systems in order to gain assurance over the processes and systems used in preparing the financial statements.

Decision

The Committee noted the report.

(Reference: Report by Audit Scotland dated June 2017, submitted)

15. LOCAL SCRUTINY PLAN 2017/18 - AUDIT SCOTLAND

The Committee considered a report which introduced the Local Scrutiny Plan for 2017/18 which set out the planned scrutiny activity at Argyll and Bute Council during financial year 2017/18 and was based on a shared risk assessment undertaken by a Local Area Network comprising of representatives of all scrutiny bodies who engage with the Council.

Decision

The Committee noted the content of the Local Scrutiny Plan 2017/18.

(Reference: Report by Head of Strategic Finance dated 27 June 2017, submitted)

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ARGYLL AND BUTE COUNCIL **AUDIT & SCRUTINY COMMITTEE**

STRATEGIC FINANCE **19 SEPTEMBER 2017**

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 2.

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

- **17/18 Audit Plan progress**: The Audit plan is currently on track.
- **Individual Audits undertaken**: 7 audits have been completed during the period. Of these Audits, 4 are rated as Substantial and 3 are rated as Reasonable. There is a further audit currently in progress.
- **Continuous Monitoring Programme Testing**: A number of auditable units are subject to continuous testing. Management have responded to previous quarter notifications and there are no outstanding issues.
- **Performance indicators**: Current status is green / on track.

ARGYLL AND BUTE COUNCIL **AUDIT & SCRUTINY COMMITTEE**

STRATEGIC FINANCE **19 SEPTEMBER 2017**

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 2 against a number of areas;

- 17/18 Audit Plan progress
- Individual Audits undertaken
- Continuous Monitoring Programme Testing
- Internal Audit Development Plan
- Performance indicators

3. RECOMMENDATIONS

3.1 Members are requested to review and endorse this report.

4. DETAIL

4.1 Audits completed to August are detailed in Table 1. At the time of writing there is one Quarter 2 Audit in progress and which will be reported to the December meeting of the Committee.

Table 1: Summary of Audits performed in Quarter 2 2017/18

Audit Name	Level of Assurance	No. of Actions	High Actions
Strategic Housing Fund	Substantial	2	0
LEADER	Substantial	2	0
Travel & Subsistence	Substantial	5	1
Gifts & Hospitality	Substantial	2	1
Review of Client Accounts	Reasonable	3	0
Piers & Harbours	Reasonable	5	1
VAT	Reasonable	5	1
Performance Management	In Progress	-	-

4.2 Indicative Audits planned for the Quarter 3 17/18 are shown in table 2 below

Table 2: Audits scheduled for Quarter 3 2017/18

Quarter 3
Records Management Plan
Recruitment & Selection
SEEMIS
ICT – SLA's & User Testing Protocols
Trading Standards
Earmarked Reserves
Procurement - Catering
Risk Management

4.3 Our Continuous monitoring programme is generally focused on transactional type activity. Standard audit tests are applied relevant to each auditable unit. Control design tests look at whether the control in place adequately addresses the potential risk event. Control effectiveness tests the application and or /compliance.

There are 4 assessment levels, these being Effective, Satisfactory, Improvement Needed and Weak.

Control Effectiveness Scales	
Effective	Indicates minimum uncontrolled risk due to strong controls in place and operating effectively. Tested, monitored and fully compliant
Satisfactory	Control mitigations in place however refinement opportunity exists to further reduce risk and /or enhance compliance.
Improvement Needed	Residual risk exists which place some of system objectives at risk. Indicates a need for improvement in either control design and /or compliance
Weak	Significant residual risk exists with weaknesses identified in control design /and or compliance

4.4 A follow up process is in place whereby management are advised of continuous monitoring findings and where appropriate, requested to take remedial actions. There are currently no outstanding follow-up points arising from previous quarters testing. Table 3 below summarises activity to date outlining issues arising and provides an overall level of control effectiveness with follow up detail.

Table 3: Continuous monitoring programme results:

Test Area	Controls Tested	Control Design	Control Effectiveness	Findings	Management Commentary
Monthly Payroll Testing	Monthly Payrun reports	Effective	Effective	1 issue r.e duplicate bank details.	Satisfactory explanation received.
Dunoon Grammar School	School Fund Check	Satisfactory	Satisfactory	There is neither a formal committee nor payments sub-committee in place.	Action plan in place to address weaknesses. Meeting scheduled to in September.
Dunoon Grammar School	Imprest Check	Effective	Effective	Receipts/ vouchers are not submitted to Creditors along with claim for re-imbursement	Appropriate adjustments have been made to ensure compliance with requirements.
NDR	Arrears follow up procedures	Effective	Effective	N/A	N/A
Council Tax	Billing and collection procedure	Effective	Effective	N/A	N/A
Council Tax	Properties accurately recorded	Effective	Effective	N/A	N/A
Debtors	Bad Debt Process	Effective	Effective	N/A	N/A
Debtors	File Back Up	Effective	Effective	N/A	N/A
General Ledger Testing	Financial procedures & System Access	Effective	Effective	N/A	N/A
General Ledger Testing	Changes to the Chart of accounts	Effective	Effective	N/A	N/A
General Ledger Testing	Journal authorisation	Effective	Effective	N/A	N/A
General Ledger Testing	Journal segregation of duties	Satisfactory	Satisfactory	Consolidated journal uploaded by Senior Accounting Assistant. This upload included journal request by same member of staff.	Management accepts inherent risk associated with this. Deemed Low level.

Test Area	Controls Tested	Control Design	Control Effectiveness	Findings	Management Commentary
Creditors Testing	Batch Invoice testing	Satisfactory	Improvement Needed	From a sample of 20 batch invoices there were 4 instances of individuals authorising invoices from cost centres which were not noted on the signatory list. 3 batches were authorised electronically via email. Electronic authorisation did not come directly from the authorisers own inbox. Authorisation was forwarded by a secondary member of staff.	Remedial Action in place to mitigate against re-occurrence. Electronic authorisation will no longer be accepted when forwarded by third parties.
Creditors Testing	Duplicate Invoice testing	Effective	Effective	N/A	N/A

4.5 The Committee previously requested that completed audit actions are periodically reviewed for ongoing compliance. A sample of 20 actions was reviewed in quarter 2; of which, 18 were all found to be compliant. At the time of reporting, 2 responses were outstanding and or/ evidence required.

4.6 The Audit Plan includes a time allocation for reviewing and verifying Local Government Benchmarking Framework indicators. Benchmarking is an improvement process that helps organisations understand how they perform in comparison to other relevant organisations. Benchmarking uses specific 'indicators' to measure how organisations are performing, for example, how much a service costs per user. These provide a simple metric which can then be compared across organisations and year-on-year. Part of the control process in place requires Internal Audit to verify Local authority submissions. A sample of indicators were selected for review and the result are shown in table 4.

Table 4: Local Government Benchmarking Framework verification results:

Test Area	Controls Tested	Control Design	Control Effectiveness	Findings	Management Commentary
LGBF Verification	Equal Opportunities	Effective	Effective	N/A	N/A
LGBF Verification	Council Tax	Effective	Effective	N/A	N/A

Test Area	Controls Tested	Control Design	Control Effectiveness	Findings	Management Commentary
LGBF Verification	Payment of Invoices	Effective	Effective	N/A	N/A
LGBF Verification	Museum Visitors	Satisfactory	Satisfactory	Supporting documentation should be clearly labelled and indicate the contents, to make it easier in the future to ensure robust testing of figures.	Management will clearly label documentation going forward.
LGBF Verification	Library Visitors	Satisfactory	Satisfactory	Supporting documentation should be clearly labelled and indicate the contents, to make it easier in the future to ensure robust testing of figures.	Management will clearly label documentation going forward.

4.7 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. The Council is currently on track with NFI upload timetable and where matches have been released these are being reviewed. A reminder process is now in place to ensure that matches are addressed on a timely basis. Recommended matches are the priority matches and where resources are allocated in the first instance.

Table 5: National Fraud Initiative Progress:

Operational Area	Total Matches	Recommended Matches	Matches Complete (August 2017)
Council Tax to Electoral Register	2111	2111	1936
Council Tax rising 18s	244	244	227
Council Tax to other Datasets	1080	1080	0
Housing Benefits	500	29	164
Payroll	740	146	6

Operational Area	Total Matches	Recommended Matches	Matches Complete (August 2017)
Blue Badges	194	156	194
Private Residential Care Homes	50	23	50
Housing Waiting list	433	416	236*
Personal Budgets	19	1	19
Council Tax	729	13	303
Creditors	4831	240	80
Procurement	176	68	0

*Source working offline from downloads; NFI Application still to be updated therefore further work may have taken place.

4.8 The table below detail progress against the actions points in our 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 self-assessment activity.

Table 6: 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:	On-going
Audit Plan Preparation	2018/19 Draft Plan submitted to December Audit & Scrutiny Committee	On track	December 2017
PSIAS – Internal Self-Assessment	Agree development actions arising from Peer to Peer review scheduled Quarter 4.	On Track	March 2018

4.9 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 2017– 18 – FQ2 17/18			
TEAM RESOURCES			
PRDs IA Team G ➡	TARGET	Percentage of PRDs complete	
	90%	100%	
	Number of eligible employees FTE	Number of PRDs complete FTE	
	4	4	
Financial			
Revenue Finance	BUDGET	ACTUAL	G
YTD Position Year End Outturn	£90,667 £240,265	£75,502 £240,265	➡
BO28 Our processes and business procedures are efficient, cost effective and compliant (SF)			
Risk management policy, strategy and guidance manual reviewed.	Status	On Track	G ➡
	Target	On Track	
Risks Management Overview report approved	Status	On Track	G ➡
	Target	On Track	
Review of Strategic Risk register	Status	On Track	G ➡
	Target	On Track	
Annual Audit Plan	Status	On Track	G ➡
	Target	On Track	
Planned number of days continuous monitoring programme complete	Status	On Track	G ➡
	Target	On Track	
Annual audit plan approved by 31 March	Status	On Track	G ➡
	Target	On Track	
Effective participation in NFI – Data completion	Status	On Track	G ➡
	Target	On Track	
% of audit recommendations accepted	Actual	100%	G ➡
	Target	100%	
% Recommendations followed up	Actual	100%	G ➡
	Target	100%	
Percentage qualified staff	Actual	60%	G ⬆
	Target	60%	
% satisfaction rates from post audit surveys	Actual	100%	G ⬆
	Target	80%	
% customer satisfaction with audit reports	Actual	100%	G ⬆
	Target	80%	
Internal Audit Training days	Actual	29 days	G ⬆
	Target	24 days	

5. CONCLUSION

5.1 The 17/18 Audit Plan is on track. Continuous monitoring testing undertaken during the period has provided an overall effective level of assurance in respect of control design and effectiveness.

6. IMPLICATIONS

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

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

Kirsty Flanagan,
Head of Strategic Finance
19 September 2017

For further information contact:
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ARGYLL AND BUTE COUNCIL **AUDIT & SCRUTINY COMMITTEE**

STRATEGIC FINANCE **19 SEPTEMBER 2017**

INTERNAL AUDIT REPORTS TO AUDIT & SCRUTINY COMMITTEE 2017 - 2018

1. EXECUTIVE SUMMARY

1.1 There are 7 audits being reported to the Audit & Scrutiny Committee.

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 identified, which are either being accepted or dealt with. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources to the issues.

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

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

- **Client Accounts:** This audit has provided a Reasonable level of assurance as internal control, governance and the management of risk are broadly reliable. Records and supporting documentation were found to be complete and accurate and held securely, with access limited to authorised personnel. Although there is a recognised process in place this was not documented in a formal procedure note and monthly reconciliations had not been independently reviewed.

- **Strategic Housing Fund**: This audit has provided a Substantial level of assurance. The audit focused on the controls in place in regard to awarding of grants from the Strategic Housing Fund. Records and supporting documentation were found to be available and complied with policy and procedures minor concerns were raised in relation to accessibility of documentation and improvement is required with respect to risk analysis.

- **VAT:** This audit has provided a Reasonable level of assurance as internal control, governance and the management of risk are broadly reliable. VAT returns sampled were comprehensive and accurate. Returns were found to be completed on a timely basis and were appropriately authorised prior to submission. Weaknesses were identified in respect of a lack of guidance documentation, training for service system users, timely completion of agreed remedial actions and incorrect transactional classification.

- **Piers and Harbours:** This audit has provided a Reasonable level of assurance. The audit focused on compliance with the Port Marine Safety Code. Roles and responsibilities are well defined and clear terms of reference are in place in respect of the Harbour Board Committee. Relevant documentation is available at Ports and on the Council website. Issues were raised in regard to Harbour Board representation, integrated reporting arrangements and completion of the Safety Management System appendices which were in draft format.

- **LEADER**: This audit has provided a Substantial level of assurance. Procedures and systems of work are designed to ensure compliance with funder requirements. Appropriate controls are in place. Low level weaknesses were found which do not impact on objectives in any significant way but which if addressed will aid efficiency and effectiveness.

- **Travel and Subsistence:** This audit has provided a Substantial level of assurance as internal control, governance and management of risk is generally sound. Claims sampled were submitted on a timely basis, authorised appropriately and back up documentation was available to support expenses paid (where relevant). Weaknesses were identified in respect of outdated guidance notes and the VAT element of system mileage claims.

- **Gifts and Hospitality**: This audit has provided a Substantial level of assurance as Internal Control, governance and management of risk is generally sound. Codes of Conduct inform both Councillors and Officers of their responsibilities regarding declarations of offers of gifts and hospitality. Registers were fully completed and authorised where relevant. Weaknesses were identified in respect of reference to a policy that is no longer in use and the access to declaration forms for completion.

- **Performance Management:** In progress

2. RECOMMENDATIONS

2.1 Audit & Scrutiny Committee to review and endorse 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.

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

Kirsty Flanagan
Head of Strategic Finance
19 September 2017

For further information contact:
Kirsty Flanagan, Head of Strategic Finance, 01546 604268


Governance
Assurance
Risk
Control

ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**REVIEW OF CLIENT ACCOUNTS 2017/18**
AUDIT DATE	**JUNE 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

Individuals/organisations can apply for the right to deal with the benefits of someone who can't manage their own affairs because they're mentally incapable or severely disabled. Only 1 appointee can act on behalf of someone who is entitled to benefits (the claimant) from the Department for Work and Pensions (DWP).

An appointee can be:

- an individual, eg a friend or relative
- an organisation or representative of an organisation, eg a solicitor or local council.

The Council will complete a referral form to request a DWP assessment of a client whom they think may be incapable of managing their own benefits, DWP will then arrange a visit to the client to assess whether an appointee is required and appointeeship will be arranged where appropriate.

Currently, there is one client account operated by the Council and is situated in the Helensburgh social work department. The Local Authority currently acts as DWP appointee for 8 clients who are receiving benefits only and who have no savings. These clients do not have capacity to manage their own affairs and there is no other person (e.g. friend or relative) suitable or willing to take on this role. It has been noted that there are currently no other client accounts operating across the Council.

2. AUDIT SCOPE AND OBJECTIVES

The main objective of the audit was to assess the adequacy of the control environment with regards to the operation of Mental Health client accounts.

Internal audit reviewed the process and procedures in place and a site visit was undertaken to Helensburgh Social Work office, where the client account is operated. Testing was undertaken to assess compliance with the documented process and check that controls are in place and operating effectively in practice.

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	There is no formal documented procedure in place which details the roles and responsibilities in relation to the client account process.
Occurrence - Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation	A local process is in place and is followed by administrative staff; however there is no agreed overarching policy in place. Records and supporting documentation were available on request.
Completeness - Policies and procedures are aligned to relevant legislation and /or good practice and all required documentation is accurately and fully maintained	A local process is in place and is followed by administrative staff; however there is no agreed overarching policy in place.
Measurement - Policies and procedures are in line with requirements of relevant legislation	A local process is in place and is followed by administrative staff; however there is no agreed overarching policy in place.
Timeliness – Documentation is regularly reviewed and updated where necessary.	Monthly reviews and reconciliations are carried out; however these have not been independently reviewed by a second member of staff.
Regularity – Documentation and records are complete, accurate and not excessive and compliant with the data retention policy. It is stored securely and made available only to appropriate members of staff.	Current records and supporting documentation reviewed were complete and accurate. Records and funds were held securely and appropriate access and authorisation controls were in place.

3. RISKS CONSIDERED

ORR - AC02: Failure to safeguard vulnerable adults

SRR - Risk08: Reputation

Audit Risk: Failure to ensure people have positive service-user experiences

Audit Risk: Failure to ensure controls are in place in respect of cash handling

4. AUDIT OPINION

The level of assurance given for this report is Reasonable.

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Current Process

- A recognised process is in place, which, subject to the control issues identified is deemed adequate; however, there is no approved policy/procedure in place which covers the entire client account process.

Control Environment

- Current records and supporting documentation reviewed were found to be complete and accurate. Records and funds were held securely and appropriate access and authorisation controls were in place.
- The movement of monies was detailed on a daily sign in/out sheet. The transactions on these sheets were signed by the relevant administrative team member, the client's case worker & the client.
- Monthly reconciliations are carried out between the bank account and each individual client's daily sign in/out sheet. These reconciliations have not been signed as being independently reviewed.

- Imprest funds are also held in the client bank account and there were 2 instances where money was borrowed from the imprest in order to pay clients. This was paid back from clients' fund following the next trip to the bank.
- Client funds are held securely in the office, and access is limited to appropriate personnel; however, it was noted that the office safe holds a significant level of funds which is in excess of the agreed insurance threshold. The current insurance arrangements require that safes regularly holding in excess of the threshold must be detailed separately on the insurance documents.

Observations

We have also highlighted to management the following observations which have been identified during the review. Although not included in the scope the matters were brought to auditor's attention during the audit and either indicate a potential risk exposure and /or could be considered as a matter of good practice and therefore noted for information and completeness:

- There is currently one bank account used to hold funds for 8 clients. Record keeping was well maintained and transactions were easily identified for individual clients. Management should consider the adequacy of maintaining one account if the level of clients increases in future.
- 2 members of staff are required to attend the bank (in Dumbarton) to withdraw funds for paying clients and there are occasions when this can be difficult due to staff availability.

6. CONCLUSION

This audit has provided a Reasonable level of assurance as Internal Control, Governance and Management of risk is broadly reliable, however, although not displaying a general trend there are a number of areas of concern which have been identified. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There are 3 actions which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to 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. Availability of procedure note		**High/ Medium**		
The client account process is not documented in a formal procedure note.	Failure to ensure appropriate guidance is readily available to staff may lead to inefficient and ineffective operations.	Medium	**A formal procedure document detailing the full client account process will be created.**	**Admin officer Helensburgh/Team Leader, Mental Health** **31 October 2017**
2. Imprest funds				
Imprest funds are held in the client bank account and there were 2 instances where money was borrowed from imprest in order to pay clients.	Failure to ensure council and client funds are recorded separately may result in misappropriation of clients' and council assets.	Medium	**Management to arrange for a separate bank account for imprest funds and issue instruction to staff to ensure funds are not borrowed from imprest in the future.**	**Admin Officer Helensburgh** **30 September 2017**
3. Insurance arrangements				
The level of funds held within the safe is in excess of the agreed insurance threshold.	Failure to ensure appropriate insurance arrangements are in place may lead to financial loss.	Medium	**Management to liaise with the insurance team to ensure safe is detailed appropriately on the council's insurance documents.**	**Admin Officer Helensburgh** **31 July 2017**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**COMMUNITY SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**STRATEGIC HOUSING FUND**
AUDIT DATE	**JULY 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

In November 2006 Argyll and Bute's Council housing stock was transferred to Argyll Community Housing Association (ACHA).

The Strategic Housing Fund (SHF) was then established in 2007 and is the Councils primary source of funding to deliver the priorities set out within the Strategic Housing Investment Plan (SHIP).

The SHIP is the Councils framework for the prioritisation of housing projects The SHIP has been developed in consultation with key stakeholders and it is the Councils primary document for identifying strategic housing projects in Argyll and Bute to assist with the achievement of the Scottish Government's national target for 50,000 affordable new build homes over the period from 2017/18 to 2021/22. The SHIP:

- Sets out investment priorities for affordable housing;
- Identifies the resources required to deliver these priorities;
- Demonstrates how these will be delivered; and
- Enables the involvement of key partners.

There are 3 primary funding sources for the affordable housing programme namely:

- Scottish Government Grant;
- Council grant namely the Strategic Housing Fund (SHF); and
- Registered Social Landlord (RSL) Private Finance

Since the 2007 approximately £17m has been allocated from the SHF to priority housing projects. As at 31st March 2017 a further 3.6m had been committed to projects already underway.

The audit will focus on the controls in place in regard to awarding of grants from the SHF.

2. AUDIT SCOPE AND OBJECTIVES

The objective of the audit is to assess adequacy of controls in place by reviewing

- Governance and policy & procedures
- Carry out walkthrough testing on a sample of grant payments from the fund to determine adequacy of controls and compliance with policy.
- Reporting arrangements

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	Strong arrangements are in place with roles and responsibilities clearly defined and documented within the procedural document. There are deemed to be operating well in practice.
Occurrence - Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation	Whilst documentation was found to be available and complied with policy and procedures, minor concerns were raised in relation to accessibility of documentation.
Completeness - Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained	
Measurement - Policies and procedures are in line with requirements of relevant legislation	Awards are made in line with policy and procedures. Improvement is required in respect of risk analysis.
Timeliness - Policies and procedures are regularly reviewed and updated as necessary	Adequate controls are in place.
Regularity – Documentation is stored securely and made available only to appropriate members of staff.	Documentation is stored securely however was not readily accessible. An improvement action in respect of introducing Microsoft project is underway.

3. RISKS CONSIDERED

- Policy not agreed
- Procedures not documented
- Failure to have adequate controls
- Failure to have sufficient documentation to support grant applications
- Reputational damage to Council

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.

Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Review Governance and policy & procedures

- Governance arrangements sit within Community services with approval of applications to the Strategic Housing Fund being delegated to the Executive Director of Community Services as agreed by Council in 2013. Prior to this, approval for each project grant award was given at a meeting of the full Council. It was evidenced that all applications reviewed were authorised in line with the agreed approval process.

- Council policy for the SHF is outlined within the "Strategic Housing Fund report "which is presented to full Council annually. The report outlines the following:

    - Payments into the Fund (principally from Council tax on second homes)

    - Expenditure charged to the fund
        - Expenditure in relation to assets formally held in the HRA account
        - Expenditure in relation to acquisition of land for the landbank
        - Expenditure in relation to the purchase of homes under the empty homes initiative
        - Payments to enhance infrastructure where this is restricting development of affordable housing
        - Payments to registered social landlords (RSL's) to partially fund proposed projects to deliver houses in accordance with the local housing strategy

  The latest report was presented to a meeting of the full Council in June 2017 and a review found that the policy detailed within the report is consistent with Scottish Government guidelines and legislation. The minutes of the meeting showed that the report had been noted by Council.

- Community Services have in place an overarching procedural document that sets out the following:

    - Administrative arrangements
    - Grant Application Process
    - Assessment and Approval Process
    - Claim Process

A review of the procedural documents found them to be adequate with roles and responsibilities of Council personnel clearly defined, documentation required in support of each grant was clearly specified and they complied with Scottish Government guidance .However the following points were noted:

- The procedural document refers to an assessment being carried out on the risks associated with each project. Section 4 of the SHIP clearly sets out the risk criteria that should be evaluated when assessing the risk associated with each project. It was noted from a review of project documentation that whilst risk had been considered there was no documentary evidence detailing how each of these risks was assessed e.g. risk scoring or how it would be mitigated.

- There are no indicative timeframes set out within the procedures in regard to Council processes involved in project delivery e.g. from when the grant application is received to formal final offer being issued.

- No evidence of a checklist control that summarises the required documentation and that they have been received and reviewed.

<u>Filing and Record Keeping/Documentation</u>

- Documentation supporting grant awards was not always readily available and in many instances is kept in hard copy files. Management have advised that there is a project underway to introduce Microsoft Project which should enhance document tracking and verification.

Carry out walkthrough testing on a sample of grant payments from the fund to determine adequacy of controls and compliance with policy

- A sample of 18 housing grant awards from the SHF. The following controls were checked:
    - Grant application has been completed
    - Grant application has been signed by applicant
    - Project has been awarded a grant by the Scottish Government prior to approval
    - Project assessment and been carried out prior to award and fully completed.
    - Offer authorised by Legal Services
    - Award letter has been properly authorised
    - Grant payment has been made as per award letter and properly authorised.
    - Grant awarded per unit is within target agreed by Council at grant award period

Check carried out	No. of Projects checked	Error rate volume	Comments
Grant Application has been completed.	18	0	-
Grant Application has been signed by applicant	18	2	Unable to obtain signed application documentation for 2 of the projects.
Project has been awarded a grant by Scottish government prior to approval	18	0	-
Project assessment has been carried out prior to award and fully completed	18	4	Project assessment documentation was available for all awards post 2013.

Offer authorised by legal services.	18	1	Signature of witnessed not evidenced.
Award Letter has been properly authorised	18	0	Approved either by Council or Community services Director as per procedures
Grant payments have been made as per award letter and properly authorised.	18	0	-
Grant awarded per unit is within target agreed by Council at grant award period	18	0	-

- Overall there are adequate controls in place to administer the award of grants from the Strategic Housing Fund as prescribed by procedures. Minor errors were found in relation to evidence of authorisation and availability of supporting documentation however these primarily related to awards pre 2013. Revised controls are in place post 2013 and are deemed strong.

Review reporting arrangements

- An annual report is prepared by Strategic Finance and submitted to Council. The report, amongst other things, should include:

    - Summary of SHF policy over life of the SHF fund
    - Movement in Fund over year i.e. opening balance, income and expenditure, closing balance
    - Detailed table by project on funds allocated
    - Detail by project of funds committed but not yet paid

  A review of the June 2017 reports showed that the report adequately covered the above points and that it had been submitted to Council within the agreed time frame. Minutes of Council meetings showed that the report had been noted.

- Argyll and Bute Council publish on an annual basis “The Local Housing Strategy Report” This report summarises those housing projects which were completed for the year in question and were supported with grants from the SHF.

- A performance measure re number of housing completions which have received a grant is reported via pyramid quarterly.

6. CONCLUSION

This audit has provided a Substantial level of assurance, 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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There were 2 actions which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Strategic Housing Fund 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. Risk Analysis		**High/ Medium**		
There was no documentary evidence of risk analysis having taken place.	Failure to fully assess project risk may lead to housing outcomes not being achieved.	Medium	**Process to be agreed as part of the SHIP Procedure Review.**	**Team Leader – East, Community Services** **30th November 2017**
2. Timeframe				
There was no indicative timeframe set out within the procedures in regard to Council processes involved in project delivery	Failure to ensure or monitor timely completion of application or process may adversely impact on efficiency and effectiveness	Medium	**Process to be agreed as part of the SHIP Procedure Review.**	**Team Leader – East, Community Services** **30th November 2017**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CHIEF EXECUTIVE'S UNIT**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**REVIEW OF VALUE ADDED TAX 2017/18**
AUDIT DATE	**JULY 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

A taxable person must charge VAT on any taxable supply of goods or services made in the UK in the course or furtherance of any business carried on by them

- Taxable person = someone that is registered or required to register for UK VAT, this can include individuals, companies, partnerships, Local Authorities and charities
- Taxable supply = a supply of goods or services made in the UK for which a consideration is received in return, unless it is exempt

The Council, as a 'taxable person' must ensure that VAT is correctly charged on the supply of goods & services; if supplies are treated incorrectly then penalties could be applicable.

S33 of VATA 1994 sets out special VAT rules for 'public bodies', including Local Authorities, in relation to the recovery of VAT incurred on expenditure relating to 'non-business' activities and on exempt business activities.

All parties involved in the payment/cash receipting process have a general responsibility for ensuring the effectiveness of the VAT system. The Corporate Support Team is responsible for preparing and submitting the monthly return to HMRC and is the key point of contact for VAT queries for officers within the Council.

The table below shows the annual VAT figures for the previous 3 years:

	2014/15	**2015/16**	**2016/17**
Value of Output Tax	887	901	640
Value of Input Tax	17,519	15,644	14,750
Net VAT Reclaimed	16,632	14,743	14,110

*Figures shown are rounded to the nearest £000

2. AUDIT SCOPE AND OBJECTIVES

The main objective of the audit was to assess the adequacy of the arrangements for compliance with HMRC VAT rules. Internal audit reviewed processes and procedures in place to test that controls, in relation to the VAT system and the classification and treatment of VAT, were in place and were operating effectively in practice.

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	Reasonable: There is no documented VAT guidance document or procedure note available although there was a recent training seminar provided by KPMG to key finance staff. Key staff are aware of role and responsibilities.
Occurrence - Sufficient documentation / audit trail exists which supports compliance with policies, procedures and relevant legislation and support VAT claims	Substantial: Supporting working papers were available for each VAT return sampled; these were comprehensive and accurate. Returns were found to be completed on a timely basis and were appropriately authorised prior to submission.
Completeness - Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained in line with HMRC requirements	Limited: There is no documented VAT guidance document or procedure note available. There was a recent training seminar provided by KPMG to key finance staff.
Measurement - Systems and Processes are designed to capture relevant VAT data	Limited: VAT is a mandatory field within the systems sampled and the VAT amount is automatically calculated depending on the VAT category chosen by the user. No VAT training has been provided to staff that input into these systems.
Timeliness - Controls are in place which allow timely	Substantial: VAT returns sampled were submitted on a

capture of source data and ensure timely completion of statutory returns	timely basis. No penalties for late submission have been incurred within the period sampled.
Regularity - Documentation / System data is complete, accurate and not excessive and is compliant with the HMRC and data retention policy. It is held securely and adequate access controls are evident	Substantial: Generally, supporting VAT invoices were available for the transactions in the samples tested. The invoices available on file for one supplier did not meet HMRC VAT invoice requirements.

3. RISKS CONSIDERED

SRR - Risk 08: Reputation

SRR – Risk 10: Finance – Expenditure

ORR - SF01: Failure to plan, report and manage Finance, Risk and Treasury transactions.

ORR - SF02: Failure to ensure Financial and Management controls are operating effectively

Audit Risk: Failure to accurately report VAT liability to HMRC

4. AUDIT OPINION

The level of assurance given for this report is Reasonable.

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of

	residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Policies & Procedures

There is currently no documented VAT guidance document or procedure note available for staff. The Council's VAT consultant's KPMG recently delivered a VAT training seminar to key Finance Staff however training has not yet been provided to other Council staff.

VAT Returns

VAT returns covering the period 2015 - 2017 were reviewed and it was found that returns were appropriately authorised prior to submission and supporting working papers were available for review. The returns sampled were submitted on a timely basis and no penalties for have been incurred for late submission within the period sampled. HMRC carry out a periodic compliance check on VAT returns where samples of working papers are reviewed for accuracy; there have been no penalties in relation to this to date.

Systems – Creditors

When invoices are passed to the Creditors system, VAT details should be provided by the requester on the standard invoice stamp or should be clearly displayed on the invoice. Invoice details, including VAT treatment, are input to the system manually by creditor's staff as per the details provided by the requester. The VAT category is a mandatory field and the VAT amount is calculated automatically depending on the VAT category selected.

The Creditors supervisor attended the training seminar provided by KPMG however; other creditor team members have not received VAT training.

- A sample of 30 creditors transactions were sampled, 2 of the transactions had the incorrect VAT treatment

System – Debtors

Debtor's transactions are input to the system by various staff across the Council. The debtors system has been set up with a number of charge codes, which automatically populate coding details and VAT treatment. When inputting to the system users can select a pre-existing charge code or, where a relevant charge code is not available can manually select the relevant VAT category from a drop down list.

It was noted that requests for new charge codes do not require authorisation or a secondary check for correctness before input to the system. VAT training has not been provided to staff that input into the Debtors system.

- A sample of 20 charge codes was selected and reviewed for appropriateness, there were 3 errors identified.
- A sample of 31 debtors' transactions was tested, there were 2 transactions identified that potentially have the incorrect VAT treatment.

System – Cash Receipting

The cash receipting system is set up with pre-determined charging codes set up with the relevant default VAT treatments. The VAT amount is calculated automatically depending on the relevant VAT category.

Requests for alterations, deletions and additions of charge codes must be submitted to the cash receipting systems administrator on a standard request form signed by the requester's Line Manager and the relevant Principal Accountant. A record of all charge code changes is maintained by the systems administrator.

- A sample of 15 cash receipting codes was selected and reviewed for appropriateness, there were 4 errors identified.

KPMG identified 14 cash receipting codes that were set up with incorrect VAT liabilities during their last VAT review (2016). At the time of audit these had not been updated on the system.

Tax Point

- The recorded tax point of a sample of 30 debtors' transactions was tested and reviewed for appropriateness; no issues were noted within the sample selected.

It was noted that there is a control mechanism in place, whereby the Business Support Officer, Treasury and Taxation, undertakes a monthly sample check of tax points and selected VAT liability prior to preparing VAT return. Any issues identified will be queried by management and/or KPMG where necessary.

Valid VAT Invoices

- The debtors system generates a standard template for invoices. These templates contain the information as per HMRC's VAT invoicing requirements.
- Supplier Invoices were retrieved for a sample of 30 transactions. The invoices available on file for 26 transactions were in compliance with HMRC's VAT invoicing requirements.
- The remaining 4 transactions all related to the one supplier. The invoices available on the system for this supplier do not meet HMRC VAT invoice requirements.

Coding

There are dedicated accounts codes set up for the different VAT categories. Transactions that are categorised as zero rated, exempt and out with scope are all coded to the same account code.

- It was noted that payments made to non-VAT registered suppliers are currently coded to one of the '0' categories (zero rated, exempt or out with scope). Application of this was not consistent.
- KPMG has advised that a separate account code should be set up where possible for non-VAT registered suppliers, if this is not possible then these transactions should be categorised as 'out with scope'.

Correction Process

There is no process in place, following identification of an error/incorrect VAT treatment, which ensures that each of the financial systems are updated with the correct information.

Observations

We have also highlighted to management the following observation(s) which have been identified during the review. Although not included in the scope the matter was brought to auditor attention during the audit and either indicates a potential risk exposure and /or could be considered as a matter of good practice and therefore noted for information and completeness:

- VAT returns are generally completed by the one individual. At the moment, there is a secondary member of staff who can cover when necessary. Management should give consideration to ensuring continuity of cover for this process in the future.
- There are 5 VAT codes available for selection within the Debtors system, one of which is 'Non-Business'; this category relates to transactions that are 'out with the scope' of VAT. This terminology is inconsistent with the VAT categories in the other systems.

6. CONCLUSION

This audit has provided a Reasonable level of assurance as Internal Control, Governance and Management of risk are broadly reliable, however although not displaying a general trend there a number of areas of concern which have been identified. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There were 5 actions which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Corporate Support 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. Guidance/Procedure Note		**High/ Medium**		
There is no documented VAT guidance/procedure note available for staff.	Failure to provide formal guidance and procedures may lead to incorrect VAT treatment/ reporting resulting in penalties and fines from HMRC.	High	**VAT Documentation will be prepared and issued.**	**Finance Manager, Corporate Support** **31 December 2017**
2. VAT Training				
VAT training has not been delivered to all staff involved in determining VAT treatment.	Failure to promote VAT awareness and provide training to staff may lead to incorrect VAT treatment/reporting resulting in penalties and fines from HMRC.	Medium	**VAT training in the format of an e-learning module will be prepared to allow Argyll and Bute specific training to be delivered.**	**Finance Manager, Corporate Support** **31 March 2018**
3. System – Cash receipting				
Cash receipting codes identified by KPMG as having incorrect VAT treatment had not been updated at the time of	Failure to ensure errors are corrected on a timely basis may result in ongoing incorrect VAT treatment/reporting	Medium	**The corrections will be implemented.**	**Finance Manager, Corporate Support** **31 October 2017**

audit.	resulting in penalties and fines from HMRC.			
4. Systems				
From samples tested, there were a number of errors in relation to incorrect and inconsistent VAT treatment identified across the different systems.	Inconsistent / incorrect practice may lead to incorrect VAT treatment/reporting resulting in penalties and fines from HMRC.	Medium	**Sample testing will continue and any inconsistencies will be addressed.** **The correct treatment will be emphasised in the VAT training being prepared**	**Finance Manager, Corporate Support** **30 September 2017**
5. Valid VAT invoices				
Invoices held on file for one supplier do not comply with HMRC's VAT invoice requirements.	Failure to retain appropriate evidence to support VAT recovery may lead to failure to reclaim VAT from HMRC resulting in financial loss for the council.	Medium	**The issue of the invoices in respect of this supplier has been addressed.** **The HMRC requirements for an invoice will be included in the VAT training.**	**Finance Manager, Corporate Support** **31 March 2018**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**DEVELOPMENT AND INFRASTRUCTURE SERVICES**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**PIERS AND HARBOURS**
AUDIT DATE	**JULY 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

The Council operates 39 Piers and Harbours throughout Argyll and Bute together with 4 lifeline ferry services to island communities. The Piers and Harbours are operated on both a commercial and leisure basis and generate budgeted fees in the region of £5.4m per annum. There are charges for several activities such as the shipping of goods, vehicles and passengers, storage and harbour vessel fees.

As a consequence of the "Sea Empress" disaster in Milford Haven in 1996 the Port Marine Safety Code (the Code) was introduced in the UK in October 2000. The Council as a statutory harbour authority is subject to national legislation most notably the Harbours Act 1964 and as such is required to comply with the Code. The Code establishes a UK national standard for every aspect of port marine safety and aims to enhance safety for those who use or work in ports, their ships, passengers and the environment. The Code applies to all harbours within the UK which has statutory powers and provides the standard against which the policies, procedures and the performance of harbour authorities can be measured. The Code covers a range of areas including the following;

- Accountability of Duty Holder and Designated person
- Consultation and Communication
- Safety Management system
- Risk Assessments
- Emergency preparedness and Response
- Conservancy
- Pilotage Service Review
- Towage
- Professional Qualification and Competencies
- Accident Investigation and Enforcement

Governance responsibilities for Piers and Harbours had previously been delegated to Area Committees; in August 2015 the Council introduced a single Harbour Authority Management Board to oversee the governance of all Ports and Harbours within Argyll and Bute.

2. AUDIT SCOPE AND OBJECTIVES

The audit scope will be limited to controls in place and will include:

- Governance arrangements
- Documentation and records management in relation to the Code
- Performance reporting

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	Roles and responsibilities are well defined and clear terms of reference are in place in respect of the Harbour Board Committee. Appropriate compliance in regard to Designated person and Duty holder is in place with responsibilities being clearly defined within the Safety Management System (SMS).
Occurrence - Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation	Relevant documentation is available at Ports and on the Council website however the Safety Management System document specific to the 4 main ports is still in draft form.
Completeness - Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained	Compliance with the Port Marine Safety Code has been attained for Rothesay; compliance with regards to the remaining Ports is ongoing.
Measurement - Policies and procedures are in line with requirements of relevant legislation	
Timeliness - Policies and procedures are regularly reviewed and updated as necessary	It was evidenced that policy and procedures are subject to review and updated as necessary. There

	are outstanding issues in regard to the main ports Safety Management System being in draft format
Regularity - Documentation is complete, accurate and not excessive and is compliant with the data retention policy. It is stored securely and made available only to appropriate members of staff.	Documentation was found to be complete, accurate and not excessive. There are no issues as regards access; information is available only to appropriate members of staff.

3. RISKS CONSIDERED

- Non-compliance with legislation requirements
- Non-compliance with operational policy
- Reputational damage to the Council

4. AUDIT OPINION

The level of assurance given for this report is Reasonable

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.

Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Scope 1: Governance Arrangements

Previous Governance arrangements

- The Council agreed to implement the requirements of the Port Marine Safety Code (PMSC) in August 2001 at a meeting of the Strategic Policy Committee. It was decided that each of the 4 Area Committees be designated as the appropriate Harbour Board to oversee the management of Harbour facilities within their area.

Current Arrangements

- A Policy and Resources Committee paper dated December 2014 acknowledged that the previous Area Committee arrangements did not provide “the most efficient or consistent model for compliance with the Code“. The paper recommended that a single Harbour Board be established which met for the first time in August 2015.

- The Council is the statutory Harbour Authority for all Piers and Harbours under its ownership and has delegated that function to the Harbour Board. Terms of reference are available and stipulate that the Harbour Board is to provide “policy direction to the officers/others involved in the operational management and use of facilities and for scrutinising the implementation of these.” The Harbour Board is responsible for the ongoing monitoring and implementation arrangements of the PMSC.

- The Council agreed at its meeting in May 2017 to a recommendation from the Short Life Working Group that the Harbour Board should meet twice a year (previously 4 times)and that the Harbour Board be reduced to 8 elected members (previously 10).

- A review of papers submitted at the last 4 Harbour Board meetings indicate agenda items are consistent with the terms of reference and included areas such as formulation of policy and operational management of the Councils Piers and Harbours and also issues in respect of implementation of the PMSC.

- The PMSC stipulates that 2 of the principal positions required are that of Duty Holder and Designated Person. The Duty Holder would be responsible for management of all Harbour operations. The executive director of Development and Infrastructure has been appointed as the Duty Holder and it was evidenced that the roles and responsibilities of this position have been included within the Safety Management System (SMS).The Code recommends that the Designated Person should

have specialist marine knowledge and that they should provide independent assurance. It was evidenced that an independent consultant with specialist knowledge of marine activities was appointed to the role of Designated Person in November 2014 with the remit on a 3 year basis.

- Port marine safety requirements state that the Designated Person should report direct to the duty holder. It was evidenced that this is taking place.

- The Harbour Board Committee paper of 13th August 2015 specified that specialist training would be provided to Harbour Board Committee members in order for them to fulfil their role. It was evidenced that a development day to provide training took place in September 2015. The agenda included the following:

    - The role of the Board
    - What is the Board seeking to achieve?
    - How do you assess effectiveness?
    - Working with other Committees

  It was noted that since the elections of May 2017 the composition of the Harbour Board Committee has changed significantly. It was evidenced that training by the Designated Person will be given to members of the Harbour Board at the next meeting in September 2017.

- There is currently no representation from external stakeholders within the present Committee. This is contrary to the British Ports Authority guidance dated December 2014 where it states;

    - The Harbour Board committee should have “approximately 50% local elected members”.
    - The Harbour Board committee should include external appointees who are stakeholder representatives or individuals with valuable skills and experiences.

Scope 2: Review documentation in relation to the Port Marine Safety Code

A review of the documentation available noted the following findings:

Consultation and Communication

- It is a requirement of the PMSC that Harbour Authorities should undertake regular stakeholder meetings in regard to the safe operation of the Harbour. It was evidenced that stakeholder meetings have taken place at Rothesay, Oban North Pier, Campbeltown, Carradale and Dunoon and that safety issues were discussed. Although these meeting have taken place there is no evidence of an ongoing schedule of meeting which outlines frequency, agenda, etc.

- It is a requirement of the PMSC that navigational information is available for both professional and recreational mariners in regard to navigational data. It was noted that the website has been recently updated and that Harbour Masters are consulted in regards to accuracy of information and that this subject to ongoing and regular review.

Safety Management Systems

- It is a requirement of the Code that harbour authorities should maintain a formal Safety Management System document (SMS) which incorporates safety policies and procedures covering the following areas:
    - Policies
    - Control of Ship Movements
    - Protection of the General Public and Employees
    - Roles and responsibilities of Key personnel including Duty Holder and Designated person
    - Procedures regarding ships arrivals and departures
    - Measuring performance against targets
    - Incident recording and investigation
    - Reference to Emergency plans
    - Objectives for next 3 years

- It was evidenced that a generic Safety Management System document is available on the Council website and that a review of the documentation found it to be comprehensive covering all headings as detailed above. The SMS has been approved by the Harbour Board Committee at its March 2017 meeting.

- It was noted that an external audit report dated January 2015 prepared by the Designated Person recommended that a separate appendix should be attached to the generic SMS referencing areas specific to individual Ports. A review of documentation available showed this action is currently outstanding as the appendices are still in draft form.

Risk Assessments

- It is a requirement of the Code that risk assessments should be carried out.

- It was evidenced that specialist Marine software (MARinis) has been introduced at the 4 main Ports and that Port and Navigational risk assessments are included within the MARinis system.

- It was evidenced that shore side Safety Risk Assessments are in place for the 4 main Harbours. Examples of risks covered are:
    - Rope handling
    - Car marshalling
    - Cleaning duties
    - General
    - Freight handling
    - Linkspan maintenance
    - Power failure
    - Vessel movements

A review of all the assessments showed that risks were assessed to be either low or medium and that each risk assessment had been completed.

- It was evidenced that the Council has appointed specialist contractor to prepare Strategic Navigational Risk assessments and that they have been prepared for the 4 main ports. It was noted that they were discussed at a workshop attended by Marine Management and Harbour personnel.

Emergency preparedness and response

- It is a requirement of the Code that emergency plans should be prepared for each Harbour facility covering Port Emergencies, Oil Pollution and Explosives.

- It was evidenced that Port Emergency plans has been completed for all 4 major ports.

- It is a requirement of the Code that oil spill contingency plans should be prepared. It was evidenced an overarching contingency plan exists for Argyll and Bute area and has been prepared by an external specialist.

- The Council does not have a license for bringing explosives into any of the Ports within Argyll and Bute thus negating the requirement for an emergency explosives plan

Conservancy

- It is a requirement of the Code that Harbour Boards conserve their harbours so that they are fit for use as harbours and to take reasonable care to see that the Harbours and Marine facilities in its ownership are in a fit condition for vessels to use them safely. This requirement covers hydrographic surveys, navigational aids and wreck removal.

- It was evidenced that the Safety Management System contains information covering hydrographic surveys and that a 6 year framework is now in place.

- It was evidenced that Rothesay, Oban and Dunoon have undertaken a hydrographic survey of the seabed for their area of operation. It was noted that Campbeltown have made use of the Ministry of Defence hydrographic survey covering their area of operation.

Maintenance of navigational aids

- It was noted that the Councils Street lighting department are responsible for the maintenance of the navigational aids however no reference to this is in the Safety Management System. Control weaknesses were identified as regards authority as there was no evidence of a document detailing roles and responsibilities of Street Lighting in relation to the maintenance of navigational aids.

- An audit of navigational aids was carried out by the Northern Lighthouse Board in 2016 with the following conclusion: "Having received all requested documentation as noted within the enclosed report, the Northern Lighthouse Board are content that Argyll and Bute Council meet the requirements of the Port Marine Safety Code with regard to the provision and maintenance of marine Aids to Navigation and now consider the audit to have been closed out."

Pilotage

- The Code stipulates where applicable harbour authorities are responsible for providing a pilotage service and should provide pilotage directions, recruitment, examination and training of pilots. It was noted that the only port providing pilot services within Argyll and Bute is Campbeltown. It was evidenced that documentary are in place covering:

    - Training scheme and evaluation
    - Risk assessment in regard to pilotage
    - Pilotage exemption certificates in place
    - Competent Harbour Authority

Towage

- It was noted that there are no tugs operated by any of the Council Harbour Authorities.

Professional Qualifications and Competencies for Port Marine Personnel

- It is a requirement of the Code that Harbour Authorities must assess the fitness and competencies appointed to the positions with responsibility for safe navigation.

- It was evidenced that a marine staff training database exists for staff with responsibility for safe navigation detailing the training carried out and completed. It was noted from a review of the database that only one of the Harbour Masters had been recorded as having completed their Harbour Masters certificate. It was confirmed that all 4 Harbour Masters have an up to date Harbour Masters certificate and that the database therefore requires to be updated.

Accident Investigation and Reporting

- It is a requirement of the Code that Harbour Authorities have a duty of care to facilitate the safe use of the Harbour against loss caused by negligence. To facilitate this requirement Harbour Authorities should have procedures in place that record and analyse all incidents and that resultant information should feedback into the risk assessments and Safety Management Systems.

- It was evidenced that each port has an accident incident control form in place and that there is a feedback mechanism included within the MARinis system that ties into the risk assessment and Safety Management System.

Scope 3: Performance Reporting

- Responsibility for Marine Services transferred to Roads and Amenity Services from Economic Development during quarter 3 of 2015. It was evidenced that the Marine Services Manager has produced a quarterly report for the Head of Roads and Amenity Service. The quarterly report includes the following :

    - Exception Reporting for targets not met
    - Operational Risk Register

- External Assessments and Audits
- Team Successes
- Team Challenges

- Each of the 4 Harbourmasters produce a generic monthly performance report detailing the following:

  - Port Activity
  - Incidents/Accidents
  - Health and Safety Issues
  - Weather
  - Staffing Issues
  - Port Infrastructure Issues
  - Risk Assessment status
  - Meetings attended

- It was evidenced that Marine Services prepare an annual performance report to the Northern Light Board highlighting navigational aids in regard to availability statistics.

- A review of the Safety Management System showed that performance measures will be assessed against the health and safety requirements as set out in national standards. It was also noted that the SMS contains a list detailing the Health and Safety performance indicators that will be used for future reporting.

<u>External Audits</u>

- An independent contractor appointed by the Council to provide the Designated Person services has undertaken audits of the 4 main ports in relation to whether these ports are compliant with the Code. The audits took place during 2015 and 2016. It was noted that the Rothesay audit report stated that the harbour complied with the Code subject to a number of recommendations being carried out in a reasonable time. As regards the other 3 ports namely Oban, Campbeltown and Dunoon the reports

stated that these Harbours did not comply with the Code as a number of recommendations would have to be carried out in a reasonable time before compliance could be agreed. A comparison of these reports with the Rothesay report showed a number of similar recommendations including preparation of a generic Safety Marine Plan with appropriate appendices for each of the ports.

- It was evidenced that a compliance letter was sent by the Duty Holder to the Maritime and Coastguard Agency dated 30th March 2015, which stated that Rothesay Harbour was compliant with the Code. This is consistent with the audit opinion formed by Marico Marine.

- The Service is currently developing a status report for all ports. It is intended that report will be presented to the Harbour Board and, amongst other things, will include detail in regard to implementation of the code as undernoted:

    - List of all those ports which are subject to the requirements of the Code
    - Requirements or actions to be taken to ensure compliance with the Code
    - Progress with individual requirements and current Status position
    - Date by which requirement will be met, if not completed

Observations

We have also highlighted to management the following observations which have been identified during the review. Although not included in the scope the matters were brought to auditor attention during the audit and either indicate a potential risk exposure and /or could be considered as a matter of good practice and therefore noted for information and completeness:

- The Council website under Piers and Harbours states that the “Council owns and manages a number of Piers and Harbours and as a statutory Authority comply with the Port Marine Safety Code”. This statement could be viewed as misleading as it could be interpreted as all ports are confirmed as being compliant with the PMSC.

- Safety management system information requires to be reviewed to ensure cross referencing is accurate and complete.

6. CONCLUSION

This audit has provided a Reasonable level of assurance, Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There were 4 actions which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Piers and Harbour 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. Appendices to Safety Management System		**High/ Medium**		
A separate appendix to the generic SMS for each of the main ports as recommended by the Designated Person is still in draft form.	Failure to have an approved separate appendix to the SMS in place may result in compliance issues with respect to PMSC	High	**Complete all appendices.**	**Marine Operations Manager** **31 May 2018**
2. Reporting				
Review Reporting mechanisms to improve integration and timely information flow.	Failure to have adequate reporting arrangements leads to ineffective decision making which may result in poor practice and/or reputational damage.	Medium	**Review of reporting mechanisms to be carried out.**	**Marine Operations Manager** **31 December 2017**
3. Maintenance of Navigational Aids				
There was no evidence of a document detailing roles and responsibilities in relation to maintenance of navigational aids.	Failure to clearly define roles and responsibilities may lead to ineffective performance resulting in noncompliance.	Medium	**Set up a formal contract with colleagues in Roads Operations - lighting section.**	**Marine Operations Manager** **28 February 2018**

4. Harbour Board				
There is no external representation on the Harbour Board contrary to British Ports authority guidance.	Failure to have external representation may result in lack of knowledge and expertise base resulting in missed opportunities and/or ineffective decision making.	Medium	**A review of the current Harbour Board framework will be carried out. Thereafter, should any changes be required to the current regime, a report will be taken to a future Harbour Board meeting.**	**Marine Operations Manager** **28 February 2018**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**DEVELOPMENT AND INFRASTRUCTURE SERVICES**
AUDIT DESCRIPTION	**VERIFICATION AUDIT**
AUDIT TITLE	**INTERNAL AUDIT REVIEW OF LEADER SERVICE LEVEL AGREEMENT 2016-17**
AUDIT DATE	**AUGUST 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

A review of Argyll and the Islands LEADER (Liaison Entre Actions de Developpement de l'Economie Rurale) 2014 - 2020 within Development and Infrastructure Services has been undertaken as part of the 2017 - 18 Internal Audit programme. This area has provided a substantial level of assurance and the Audit is included in the plan as part of Leader programme compliance arrangements at the request of the Economic Development Service.

The overall aim of the Argyll and the Islands LEADER Local Development Strategy is to "Support community-led economic growth and sustainable rural development within the Argyll and the Islands Local Action Group (LAG) area."

LEADER has a strong history in Argyll and the Islands and has contributed significantly in the past to enabling rural communities to find their own solutions to development issues. Innovation has been a central component of this success, with LEADER providing the opportunity for piloting new approaches to rural development.

This LEADER Programme seeks, through close and positive partnership working, to support rural communities throughout the area to respond to some of the many development challenges that are still facing them.

To be eligible for support from the LEADER programme, a project must meet one or more of the themes and objectives as described in the Argyll & the Islands Local Development Strategy.

Argyll and the Islands LEADER has partner representatives from a wide range of public, private and community sector organisations. LAG members meet quarterly and have responsibility for assessing applications and awarding funding to successful applicants.

2. AUDIT SCOPE AND OBJECTIVES

The objective of the audit was to review compliance with the requirements of the Argyll and the Islands LEADER 2014 – 2020 Service Level Agreement (SLA).

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	High - All applications, awards and assessment are appropriately authorised. Roles and responsibilities are clearly defined and appropriate segregation of duties is in place.
Occurrence - Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation	Substantial – In general, documentation was referenced, complete and available for review. Original forms/documentation held in accordance with requirements. Minor weaknesses were identified and management notified accordingly.
Completeness - Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained	Substantial – Applications, forms and checklists were fully completed and all records available for review.
Measurement - Policies and procedures are in line with requirements of relevant legislation	High - Policies and procedures are consistent with regulatory requirements and were appropriately followed.
Timeliness - Policies and procedures are regularly reviewed and updated as necessary	Reasonable – Documentation is submitted and reviewed in a timely manner. A weakness was identified and management notified accordingly.
Regularity - Documentation is complete, accurate and not excessive and is compliant with the data retention policy. It is stored securely and made available only to appropriate members of staff.	High – Documentation is maintained to a high standard and is compliant with the requirements of the Data Protection Act 1998.

3. RISKS CONSIDERED

SRR – Partnership Governance
Audit Risk – Non-compliance with Argyll and the Islands LEADER 2014 – 2020 Service Level Agreement (SLA)

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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

Parties to the SLA are Scottish Ministers acting as the Paying Agency and Management Authority and Argyll and Bute Council as the Accountable Body for Argyll and the Islands Local Action Group (LAG).

The LEADER team have received 62 applications to date on the Leader Actions in Rural Communities system (LARCs) for the 2014-20 LEADER Programme. Funding has been approved by the LAG for 16 of these projects from which a sample of 3 was selected for review.

The following findings were generated by the audit:

<u>Roles and Responsibilities</u>

It was evidenced that services are provided as defined in the SLA:

- Applications are processed in accordance with guidelines, checklists, regulations and the Local Development Strategy
- Claims for LEADER grants are paid in accordance with instructions and checklists with systems providing adequate separation of duties and internal supervisory checking
- Checklists are completed by Assessor and approved by either Supervisor, Programme Manager, Chair or Vice Chair
- Claims, accounting, transactional and statistical data are submitted to Scottish Government through upload to LARCs
- From sample reviewed, only one project had received payments, there is no evidence of overpayment
- Financial and statistical data is monitored by Strategic Finance contacts through a robust budget monitoring process
- There is no evidence of a potential shortfall in delivery of services
- Internal Audit carry out an annual verification audit on LEADER programme
- Meetings are held with Scottish Government and/or representatives
- Ad hoc communications with Scottish Government enable effective co-ordination and discharge of responsibilities under SLA

Performance Measures

- All applications follow consistent process through use of form templates, guidance and use of LARCs
- Scoring sheets and spreadsheets are used and uploaded to LARCs, signed scoresheets are saved on the shared drive
- There was evidence of financial scrutiny in all files reviewed – each contained evidence of tendering for quotes and evaluation of at least 3 from which to award contract
- Minutes of LAG meetings and decisions are recorded including any declarations of interest for each project. Minutes are available on the shared drive
- There is evidence of administrative checks and inspections undertaken in compliance with regulatory requirements.

Counter Fraud and Compliance Activities

- Processes were found to complement EU regulatory requirements
- There have been no suspected breaches of contractual obligations by the Accountable Body or Paying Agency and no investigations undertaken in the current programme.
- Internal Audit operates in compliance with the Public Sector Internal Audit Standards
- An annual assessment of compliance with the requirements of the SLA is provided it the form of a report.

Prosecution and Litigation Arrangements

- Argyll and Bute Council as the Accountable Body records all information regarding projects on the shared drive area and on LARCs, this is available should it be required to support any criminal investigation.

Monitoring of Delegated Functions

- Accountable body provide staff to support visits from Paying Agency/Management Authority and Internal audit and co-operate with any request in relation to compliance with SLA.

Retention of Documentation

- Records are maintained on shared drive and on LARCs; access to these records are limited to appropriate officers via system users controls.
- Records relating to the current programme are required to be kept for 3 years following closure, 6 years from end of financial year during which final payment is made and 10 years where funding contributed to purchase of heritable property. The shared drive and LARCS have sufficient capacity to support this requirement.
- LARCs contained documentation for all projects reviewed.
- Scanned copies of signed legal documents were viewed on shared drive and on LARCs.
- Documentation was made available for review on shared drive and on LARCs system.

Provision of a Confirmation Certificate and Annual Report

- Accountable Body provides an annual confirmation certificate stating SLA obligations fulfilled by 31 October each year.
- Findings of work undertaken by Internal Audit will support this statement.

Conflicts of Interest

- The register of interests for LAG members held on the shared drive is comprehensive, however, requires updating.
- Minutes of LAG meetings record interests in applications by LAG members. Where there is an interest, the member will leave the meeting room during discussion of the project and return following completion and move onto the next project.

Gifts and Hospitality

- There is no register of offers. It was intimated that to date there has been no offers in relation to gifts or hospitality.

Confidentiality and Data Sharing

- Scottish Government's IT Security policy outlines requirements for use of LARCs. Agreement is in place to allow Accountable Body access to LARCs
- Accountable Body has Acceptable Use Policy, IT Security and Data Protection (DP) policies in place
- Accountable Body has Freedom of Information (Scotland) Act and DP subject access request processes in place

Financial Arrangements

- Claims for project expenditure are promptly recorded on LARCs following receipt of evidence of payment by applicant
- Administration cost claims have yet to be submitted in respect of the current year
- Internal controls are reviewed by Internal audit and report submitted annually
- No disallowance/ expenditure incurred do date
- No claims refused or reduced to date

Accountability

- Evidence available on file to support Rural Payments and Inspection Division and Scottish Government should it be required

6. CONCLUSION

This audit has provided a Substantial level of assurance *as* Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk*".* There were 3 findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There was one action which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to the Economic 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. LEADER Administration Claim				
Claims are required to be submitted quarterly.	Failure to submit claim for costs in a timely manner may result in disallowance leading to loss of income.	Medium	**First claim to be submitted by mid-October and up to date by end of December 2017** **(This is dependent on the turn around on the LARCS system)**	**European Support Officer** **31 December 2017**

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ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CROSS CUTTING**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**REVIEW OF TRAVEL & SUBSISTENCE 2017/18**
AUDIT DATE	**AUGUST 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

The Council will reimburse travel and subsistence claims where employees and Councillors incur reasonable expenditure in the course of official Council business. Staff claims can be submitted via the Council's electronic system My View; My View is an online portal where claims can be submitted and then authorised electronically before being passed to Creditors for payment. For employees who do not have access to the MyView system, claims can be submitted manually using standard claim forms which are available on the Council's intranet site (HUB). Both system and manual claims are passed to Improvement & HR for payment via the Resourcelink System.

Councillors are required to complete a standard form for reimbursement of travel, subsistence and expense costs. The forms are available on the HUB or are available from Members Services.

For financial year 2016/17 there were approximately 40,000 individual travel claims and 18,000 travel related expense claims processed. Travel related expense claims include expenditure on subsistence and other travel related expenditure such as ferry fares and accommodation not purchased via the purchasing team.

2. AUDIT SCOPE AND OBJECTIVES

The objective of the audit was to assess the adequacy of the arrangements in place for the processing and payment of travel and subsistence claims. Internal audit reviewed processes and procedures in place and selected samples of staff and member manual/paper claims to test that the authorisation and controls in relation to both system and manual claims are operating effectively in practice.

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	Substantial: Officers are aware of roles and responsibilities and these are operating well in practice. Documented procedure notes are available

	on the Council's intranet site, however it was noted that some of the information contained within these notes is outdated.
Occurrence - Sufficient supporting information/data exists to evidence compliance with policies & procedures and to support claims where necessary	Substantial: From the samples selected, supporting documentation was available to support expenses paid (where relevant).
Completeness - Claims submitted are complete as per council policy and appropriate supporting documentation is available	Substantial: Claim forms were available for each manual claim in the sample selected and were signed by both the claimant and appropriately authorised. It was noted that paper forms were not always completed in full and were being authorised without the 'total claim' value being completed.
Measurement - Payments are made in line with approved rates and/or receipted expenditure	Limited: VAT is automatically calculated on mileage claims paid, however the submission of VAT receipts with mileage claims is not currently mandatory. From a sample of 49 paper staff/member claims only 7 had provided fuel VAT receipts as back up.
Timeliness - Submissions are made on a timely basis and policies and procedures are regularly reviewed and updated as necessary	Substantial: Generally, claims were submitted and authorised on a timely basis in line with stipulated deadlines. All claims in the sample selected were paid in the pay run following the submission of claim.
Regularity - Information/data is stored in line with the data retention policy and access is secure and limited to appropriate personnel	Substantial: Current records and supporting documentation reviewed were complete and accurate. Records were held securely and appropriate access and authorisation controls were in place.

3. RISKS CONSIDERED

SRR – RISK 08: Reputation

SRR – RISK 10: Finance – Expenditure

ORR - SF02: Failure to ensure Financial and Management controls are operating effectively

Audit Risk: Appropriate internal and/or system controls are not in place, resulting in misappropriation, error or loss

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.

No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Policies & Procedures

- Documented guidance notes are available for members, staff and managers on the Council's intranet site. It was noted that these guidance notes included outdated information.

Authorisation

- Generally, claims sampled were submitted and authorised on a timely basis in line with stipulated deadlines. All claims in the sample selected were paid in the pay run following the submission of claim.
- Each of the claims in the sample reviewed was appropriately authorised. It was noted that paper forms were not always completed in full and were being authorised without the 'total claim' amount being completed. This resulted in creditors having to calculate total claim amount and complete form following authorisation.
- A control is in place and referred to within the Financial Regulations whereby claims older than 6 months old should have the express approval of the Executive Director prior to payment. There is a process in place for paper claims by which a member of the creditors' team checks claims for appropriate Executive Director approval and claim will not be paid until approved appropriately. A control weakness was identified in respect of the system process where arrangements do not reflect financial regulation requirements.

Supporting documentation

Expense Claims

- From the samples selected, supporting documentation was available to support expenses paid (where relevant). It was noted that the current process allows for payment of system claims prior to receipts being forwarded to creditors and on occasion the receipt is not received by Creditors following payment.
- It was noted that the new MyView module will require a receipt to be attached (for expense claims) prior to passing to authoriser. This should reduce the risk of un-receipted expenditure.

Mileage Claims

- The submission of fuel receipts with mileage claims is not currently mandatory. From a sample of 49 paper staff/member claims only 7 had provided fuel VAT receipts as back up.
- For system claims, claimants are required to tick the VAT receipt box to ensure the correct rate of VAT is charged. A member of the Creditors team is required to manually go into the system and select the VAT box where this has not been selected by the claimant. This is not always actioned prior to payment meaning that the incorrect rate of VAT is calculated. From a sample of 22 system mileage claims only 8 had selected the VAT receipt box.

Observations

We have also highlighted to management the following observation(s) which have been identified during the review. Although not included in the scope the matter was brought to auditor attention during the audit and either indicates a potential risk exposure and /or could be considered as a matter of good practice and therefore noted for information and completeness:

- It was noted that paper claims are being submitted by employees who have access to submit claims via the MyView system. Going forward, management should consider promoting the use of MyView where possible in order to reduce the manual intervention associated with manual claim forms.

6. CONCLUSION

This audit has provided a Substantial level of assurance as internal control, governance and the management of risk is sound; however there are minor areas of weakness which put some system objectives at risk. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There were 2 actions which will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to 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. VAT on mileage claims		**High/ Medium**		
The system is miscalculating VAT on mileage claims where claimants do not select VAT receipt box.	Failure to ensure VAT is calculated correctly may lead to incorrect VAT reporting resulting in penalties and fines from HMRC.	High	The Development Officer to investigate the possibility to make the VAT fuel receipt field mandatory in the system.	**Development Officer, Customer Services** **30 November 2017**
2. Completion of Manual claim forms				
Paper claim forms were not always completed in full and were authorised without the 'total claim' amount being completed.	Failure to ensure claim forms are completed in full prior to signing may lead to authorised amount being unclear resulting in loss or error.	Medium	Claimants and authorisers will be reminded to complete claim forms in full prior to passing to Creditors for processing.	**Creditors Supervisor** **30 September 2017**

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ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CROSS CUTTING**
AUDIT DESCRIPTION	**RISK BASED AUDIT**
AUDIT TITLE	**INTERNAL AUDIT REVIEW OF GIFTS AND HOSPITALITY**
AUDIT DATE	**SEPTEMBER 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of 2017/18 risk based Internal Audit Annual Plan and has been conducted in accordance with relevant auditing standards. The report is based on discussions with key personnel and information available at the time of the Audit.

The Council Constitution and code of conduct for Councillors and employees provide information regarding the acceptance and recording of gifts and hospitality.

The Code of Conduct for Councillors states that: "You must record with the appropriate officer the details of any gifts or hospitality received. This record will be available for public inspection."

The instructions include the following:

- Do not accept; offers that could give rise to personal gain or show favour or disadvantage to any individual or organisation.
- Never ask for gifts or hospitality.
- Trivial gifts less than £50 in value; normal hospitality and civic gifts received on behalf of the Council may be accepted and do not require to be recorded.

The Employee Code of Conduct states that: "Generally no employee should accept the offer of gifts, hospitality or services from any service user, supplier/ contractor or member of the public other than where it is a token item"

The instructions include the following:

- Do not accept gifts or hospitality that may place you under obligation.
- Do not accept repeated hospitality or frequent personal gifts from the same person or organisation.
- Follow the Council's policy on declaring offers of gifts or hospitality and follow the current procedures for having any offers authorised.
- Consult with manager if value of offer is more than a token.
- All offers with a value of more than £25 should be registered whether accepted or not.

2. AUDIT SCOPE AND OBJECTIVES

The objective of the audit was to review recording and reporting arrangements to evaluate compliance with policy and the internal control environment.

The following control areas were reviewed as part of the audit process:

Control Objective	Control Objective Assessment
Authority - Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice	Substantial – forms and register are appropriately completed and authorised. Responsibilities are outlined in the Councillor and Employee Codes of Conduct and Council Constitution. Policy could not be located.
Occurrence - Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation	Substantial – original documentation was complete and available for review, and all Councillors and employees are made aware of and have access to the respective codes of conduct.
Completeness - Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained	Reasonable – original documentation was fully and accurately completed and is maintained and stored appropriately. The employee code of conduct references a policy that should be adhered to by staff; however, this could not be located at the time of the audit.
Measurement - Policies and procedures are in line with requirements of relevant legislation	
Timeliness - Policies and procedures are regularly reviewed and updated as necessary	
Regularity - Documentation is complete, accurate and not excessive and is compliant with the data retention policy. It is stored securely and made available only to appropriate members of staff.	

3. RISKS CONSIDERED

SRR – Risk 08: Reputation

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. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal Control, Governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal Control, Governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal Control, Governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources 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:

Councillor's and Officer's Codes of Conduct

It was evidenced that:

- The Council's intranet website (HUB) provides ready access to both Councillor's and Officer's codes of conduct within the Council Constitution.
- The Codes clearly informs Councillors and Officers of the behaviours and conduct standards expected of them.
- Councillors and Officers are instructed to record details of all offers of gifts or hospitality, whether accepted or not, with the exception of those for Councillors that fall within section 3.9 of the code or where the value of the offer is below £25 for officers.
- The Code of Conduct for Officers contains a reference to a policy document that is no longer in place.

Registers of Gifts and Hospitality

It was evidenced from the review that:

- A process is in place but is not currently recorded within a policy document.
- Forms had been completed by 4 officers and one Councillor in the current year.
- Forms had been appropriately completed and authorised where required.
- Forms are not available from a central repository, they are currently provided by the Directorate Support Officer upon request.
- Councillors are provided with a form within their induction pack.
- An additional record is maintained on behalf of the Chief Executive detailing all offers of gifts and hospitality, including those below the reporting threshold.

Observations

We have also highlighted to management the following observation which has been identified during the review. Although not included in the scope the matter was brought to auditor attention during the audit and either indicates a potential risk exposure and /or could be considered as a matter of good practice and therefore noted for information and completeness:

- There is currently no annual declaration by Officers to confirm awareness/compliance with all requirements of the Employee Code of Conduct.

6. CONCLUSION

This audit has provided a Substantial level of assurance *"as* Internal Control, Governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk*"*. There were a number of findings identified as part of the audit and these, together with agreed management actions, are set out in the attached action plan. There were 2 actions of which one will be reported to the Audit Committee. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to 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. Policy		**High/ Medium**		
The Code of Conduct for Officers contains a reference to a policy document that is no longer in place.	Failure to document a formal policy may lead to non-compliance with code of conduct resulting in reputational damage	High	**The code of conduct sets out the context for gifts so we will update this text to make it clear that the code text is in fact the policy.**	**Head of Governance and Law** **30 April 2018**

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ARGYLL & BUTE COUNCIL **AUDIT & SCRUTINY COMMITTEE**
STRATEGIC FINANCE **19 SEPTEMBER 2017**

EXTERNAL & INTERNAL AUDIT REPORT FOLLOW UP 2017-18.

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 July 2017.

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 July 2017, 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 July 2017, 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 & Scrutiny Committee management comment and Pyramid status

1.5 Appendix 3 provides a summary of External and Internal Audit reports by department and service that are due after 31 July 2017 and not on track to achieve the agreed implementation dates. Detailed is the report name along with the weakness identified, agreed management action, revised date, any previous implementation dates reported to the Audit & Scrutiny, management comment and Pyramid status.

2 RECOMMENDATIONS

2.1 The Audit & Scrutiny to review and endorse the content of this report.

3 CONCLUSION

3.1 Of the recommendations due for completion by 31 July 2017, 10 have been completed. Internal Audit is satisfied with the status of the remaining 2 recommendations being delayed but rescheduled. Good progress is

being made on the recommendations due after 31 July 2017 with 7 being completed early and the timely identification of 1 requiring to be rescheduled. 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

Kirsty Flanagan
Head of Strategic Finance
19 September 2017

For further information please contact:
Kirsty Flanagan, Head of Strategic Finance, 01546 604268

APPENDIX 1

SERVICE SUMMARIES

RECOMMENDATIONS DUE 01 MAY 2017 – 31 JULY 2017

SERVICE	Complete	Delayed but rescheduled	Total
ADULT CARE	3	0	3
ECONOMIC DEVELOPMENT	0	1	1
EDUCATION	1	0	1
ROADS & AMENITY SERVICES	3	1	4
STRATEGIC FINANCE	3	0	3
TOTAL	**10**	**2**	**12**

RECOMMENDATIONS DUE AFTER 31 JULY 2017

SERVICE	Complete	On Course	Delayed but rescheduled	Total
ADULT CARE	2	1	1	4
COMMUNITY & CULTURE	0	4	0	4
ECONOMIC DEVELOPMENT	1	0	0	1
EDUCATION	1	2	0	3
FACILITY SERVICES	3	0	0	3
ROADS & AMENITY SERVICES	0	1	0	1
STRATEGIC FINANCE	0	5	0	5
TOTAL	**7**	**13**	**1**	**21**

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Recommendations Overdue 31 July 2017

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES:	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
DEPARTMENT	**DEVELOPMENT & INFRASTRUCTURE SERVICES**				
SERVICE	**ECONOMIC DEVELOPMENT**				
REPORT NAME	**OBAN AIRPORT - 2017/18**				
1	There were a number of overdue defects **MEDIUM**	Station Manager awaiting response to an enquiry sent to the Civil Aviation Authority on 3/5/17 in a bid to remove the Buoy system from use. Other defects will be looked into however none of the others are operationally critical.	30 June 2017 **30 September 2017**	Station manager is currently awaiting a decision from CAA. CAA are due to visit the station manager week beginning 18th September.	**Delayed but rescheduled** Station Manager
REPORT NAME	**TOTAL (ROADS COSTING) - 2016/17**				
1	Roles and responsibilities have not been documented in terms of D&I responsibilities. **LOW**	Define and document tasks, roles and responsibilities in relation to TOTAL.	31 May 2017 **31 October 2017**	Project Manager Transitions appointed to complete this work.	**Delayed but rescheduled** Project Manager – Roads and Amenity Services

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Recommendations Due After 31 July 2017

ACTION PLAN NO:	WEAKNESSES/GOOD GRADE:	AGREED ACTION:	DATES:	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE
DEPARTMENT	**IJB SERVICE UNITS**				
SERVICE	**ADULT CARE**				
REPORT NAME	**REVIEW OF CLIENT ACCOUNTS – 2017/18**				
1	The client account process is not documented in a formal procedure note. **MEDIUM**	A formal procedure document detailing the full client account process will be created.	31 October 2017 **31 January 2018**	Delayed to allow suitable resource and time to be allocated to action.	**Delayed but rescheduled** Admin officer Helensburgh

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ARGYLL AND BUTE COUNCIL **AUDIT AND SCRUTINY COMMITTEE**

STRATEGIC FINANCE **19 SEPTEMBER 2017**

TREASURY MANAGEMENT ANNUAL ASSURANCE REPORT

1. EXECUTIVE SUMMARY

1.1 This annual report sets out information around the arrangements in place relating to management controls and risk for treasury management. Its purpose is to provide assurance to the Audit and Scrutiny Committee that appropriate arrangements are in place.

1.2 There are a number of management arrangements in place in relation to regulatory issues, segregation of duties, treasury reporting, Member involvement and training. The service is subject to both internal and external audit scrutiny.

1.3 The Council is supported by Capita Asset Services as its treasury advisors. The contract is currently on a two year extension with retendering in progress.

1.4 Key risks identified are transactions risks, strategic risks, interest rate risks, borrowing risks and investment risks and these are all actively management by the treasury team on a regular, in some cases, daily basis.

1.5 The recommendation is for the committee to review and endorse this report.

ARGYLL AND BUTE COUNCIL **AUDIT AND SCRUTINY COMMITTEE**

STRATEGIC FINANCE **19 SEPTEMBER 2017**

TREASURY MANAGEMENT ANNUAL ASSURANCE REPORT

2. INTRODUCTION

2.1 This annual report sets out information around the arrangements in place relating to management controls and risk for treasury management. Its purpose is to provide assurance to the Audit and Scrutiny Committee that appropriate arrangements are in place.

3. RECOMMENDATIONS

3.1 The recommendation is for the committee to review and endorse the Treasury Management Annual Assurance report.

4. DETAIL

4.1 Treasury Management is a complex area of the Council's activities with the potential for significant financial consequences and as a result there are key risk and management control issues. Recognising this and the Audit and Scrutiny Committee's overall interest in management controls and risk this report has been prepared to give assurance to the Committee that there are appropriate arrangements in place for managing the Council's treasury activities.

4.2 Treasury management is defined as:

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

4.3 The Chartered Institute of Public Finance and Accountancy's (CIPFA) Code of Practice on Treasury Management (revised November 2009) was adopted by this Council on 24 June 2010. The primary requirements of the Code tailored to show how they are met in Argyll and Bute are as follows:

a) The Council will create and maintain, as the cornerstones for effective treasury management:
   - A treasury management policy statement, stating the policies, objectives and approach to risk management of its treasury management activities
   - Suitable treasury management practices (TMPs), setting out the manner in which the organisation will seek to achieve those policies and objectives, and prescribing how it will manage and control those activities.

b) The Council will receive reports on its treasury management policies, practices and activities, including, as a minimum, an annual strategy and plan in advance of the year, a mid-year review and an annual report after the end of the financial year, in the form prescribed in its TMPs.

c) The Council has responsibility for the implementation and regular monitoring of its treasury management policies and practices and delegates responsibility for the execution and administration of treasury management decisions to the Head of Strategic Finance, who will act in accordance with the organisation's policy statement and TMPs and, CIPFA's Standard of Professional Practice on Treasury Management.

d) During 2016-17 the Council nominated the Performance Review and Scrutiny Committee to be responsible for ensuring effective scrutiny of the treasury management strategy and policies. It is assumed that this role will be fulfilled by the Audit and Scrutiny Committee going forward.

e) During 2016-17 the Council nominated the Policy Lead for Strategic Finance as the member responsible for ensuring effective scrutiny of the treasury management strategy and policies. This will now be the Policy Lead for Strategic Finance and Capital Regeneration Projects.

Management Arrangements

4.4 The Audit and Scrutiny Committee should be able to take assurance that the Council has appropriate management arrangements in place for its treasury activities based on the following:

4.5 Regulatory: The Council has adopted and complied with the Code of Practice and a review is carried out each year to ensure we continue to meet the requirements of the Code. The following TMPs are in place and reviewed annually: The TMPs can be revised with the agreement of the Head of Strategic Finance.

TMP 1 Treasury risk management
TMP 2 Best value and performance measurement
TMP 3 Decision–making and analysis
TMP 4 Approved instruments, methods and techniques
TMP 5 Organisation, clarity and segregation of responsibilities, and dealing arrangements
TMP 6 Reporting requirements and management information arrangements
TMP 7 Budgeting, accounting and audit arrangements
TMP 8 Cash and cash flow management
TMP 9 Money laundering
TMP 10 Staff training and qualifications
TMP 11 Use of external service providers
TMP 12 Corporate governance

4.6 Management: TMP 5 sets lines of responsibility, accountability and delegation in relation to treasury activities.

4.7 Reporting: The Council meets and exceeds the requirement for reporting on

treasury management by

- Preparing an annual treasury and investment strategy (submitted to Council 23 February 2017)
- Submitting an annual report on treasury and investment activities (submitted to Council on 29 June 2017)
- Submitting update reports on treasury activities 2 monthly to Policy and Resource Committee and quarterly to PRS Committee.

4.8 Member Involvement: During 2016-17 the Council Leader and Policy Lead for Strategic Finance was the nominated lead member for treasury management and received copies of all reports on treasury management for scrutiny. This will continue with the Policy Lead for Strategic Finance and Capital Regeneration Projects.

4.9 Training: Training requirements for officers are reviewed at quarterly review meetings with the treasury advisors. Officers also attend external training seminars arranged by the treasury advisors.

4.10 Internal Audit: Treasury activities are subject to regular review by internal and external audit. Internal Audit as part of their continuous monitoring programme sample test various treasury management internal controls on an on-going basis. An overall Substantial level of assurance has been provided. Management have addressed any identified weaknesses as required.

4.11 External Audit: the External Auditors as part of their audit of the 2016-17 Financial Statements found that reconciliations of the treasury ledger accounts where being carried out quarterly rather than monthly due to a lack of resources, this was a policy decision taken in full knowledge of the risks attached to the reduction in frequency of the reconciliations. Monthly reconciliations have since been reinstated.

4.12 Advisory Support: The Council is supported by Capita Asset Services as its Treasury Advisors. Capita Asset Services are part of the Capita group of companies. It is the largest provider of treasury advice to Councils in the UK. The Council reappointed Capita Asset Services in March 2012 for a period of 3 years following a tendering exercise. The contract has been extended for a year and will be retendered during 2017-18.

Key Risks

4.13 The section below outlines in summary terms how some of the key risks are managed:

4.14 Transactional Risks: Segregation of duties and in particular separation of initiator and approver roles and setting limits for individuals in terms of their delegated authority are key controls to transaction risks. There is regular reconciliation and cross checking of treasury records to act as a management/supervisory control.

4.15 Strategic Risks: There are quarterly reviews with the treasury advisors and review of economic and market data in between to assess the ongoing relevance of the agreed strategy.

4.16 Interest Rate Risk: Interest rate and market data is monitored daily and assessed in terms of any action the Council needs to consider or take. Triggers are set to prompt formal consideration of when to drawdown borrowing or reschedule debt etc.

4.17 Borrowing Risks: The borrowing portfolio is reviewed to avoid over exposure to too many loans maturing in any one period. There are also limits to balance the mix between fixed and variable rate loans. All borrowings are in sterling so there is no exchange rate exposure.

4.18 Investment Risks: The risk of counter parties is reviewed with the treasury advisors and investments are made only within agreed policy. This sets down approved counter parties and agreed limits on amount and duration of investment. All investments are in sterling so there is no exchange rate exposure. The Council complies with the Scottish Government investment regulations. Changes and potential changes in counter parties credit status is monitored in order that action can be taken where required.

5. CONCLUSION

5.1 Satisfactory assurance can be taken that adequate arrangements and controls are in place in respect of managing and delivering the Council Treasury functions. The service is subject to both Internal and External Audit Scrutiny and Management have addressed any weaknesses identified.

6. IMPLICATIONS

6.1	Policy –	None.
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.

Kirsty Flanagan, Head of Strategic Finance
Policy Lead for Strategic Finance and Capital Regeneration Projects - Councillor Gary Mulvaney

For further information please contact Peter Cupples, Finance Manager – Corporate Support 01546-604183.

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ARGYLL AND BUTE COUNCIL **AUDIT AND SCRUTINY COMMITTEE**

Customer Services **19th September 2017**

Audit and Scrutiny Committee Development Plan

1.0 EXECUTIVE SUMMARY

1.1 Council determined at its meeting on 18th May 2017 to form an Audit and Scrutiny Committee to take forward the functions of the previous Audit Committee and the scrutiny functions of the previous Performance Review and Scrutiny Committee. A report came to the 27th June 2017 meeting of the Audit and Scrutiny Committee informing members of the expected framework for the development of terms of reference and practice for the new Audit and Scrutiny Committee. This report provides a further update on arrangements being made for Committee development and for development of terms of reference for the Audit and Scrutiny Committee.

ARGYLL AND BUTE COUNCIL **AUDIT AND SCRUTINY COMMITTEE**

Customer Services **19th September 2017**

Audit and Scrutiny Committee Development Plan

2.0 INTRODUCTION

2.1 Council agreed at its meeting on 18th May 2017 to introduce an Audit and Scrutiny Committee to take forward the functions of the previous Audit Committee and the scrutiny functions of the previous Performance Review and Scrutiny Committee. The Committee was advised at its meeting on 27th June 2017 that members and officers would require to consider practice to ensure the functions of the new Committee are appropriately fulfilled. This report provides members with a further update on preparations for the holding of a development day and provides a framework for items for discussion.

3.0 RECOMMENDATIONS

3.1 It is recommended that members note the current circumstances and consider the framework of items for discussion at a development session to be arranged.

4.0 DETAIL

4.1 Council determined at its meeting on 18th May 2017 to introduce an Audit and Scrutiny Committee. This Committee replaces previous Audit Committee, and assumes responsibility for the scrutiny functions previously within the remit of the Performance Review and Scrutiny Committee.

4.2 The Audit and Scrutiny Committee was advised at its meeting on 27th June 2017 that terms of reference for the Committee would require to be set and that members and officers should consider practice to ensure that the functions of the Committee are appropriately fulfilled.

4.3 Area Committees and strategic committees – Environment, Development and Infrastructure, and Community Services committees – will take responsibility for the performance review business of the previous Performance Review and Scrutiny Committee.

4.4 The creation of the new Audit and Scrutiny Committee requires amendment of the Council's Constitution to include clear terms of reference for the new Committee to include its audit functions and its scrutiny functions. Development of practice within the Committee to apply the terms of reference will be the subject of development days or an away-day to ensure member involvement in development and that Committee members are enabled to access appropriate development opportunities. It is expected that development sessions or an

away day will take subsequent to this meeting and in advance of the scheduled December meeting of the Committee, with continuation of the previous Audit Committee's use of regular scheduled development sessions to ensure practice develops as required and members continually develop. Specific planning for the development day will be dependent upon Member and facilitator availability.

4.5 Subsequent to the Audit and Scrutiny Committee meeting in June, the Chair of the Committee has met with officers supporting the Committee, including the Chief Internal Auditor, for initial discussions on development of terms of reference for the Committee and on a framework for Member development to ensure appropriate provision of development opportunities relating to both Audit and Scrutiny.

4.6 Development of practice within the new Audit and Scrutiny Committee should bear in mind the introduction by Council of a 'reports for noting' protocol designed to promote efficient agenda management and committee effectiveness while assuring of the opportunity for members to determine to debate or discuss fully.

5.0 CONCLUSION

5.1 This report updates members on the development of terms of reference for the Audit and Scrutiny Committee and on planning for development sessions for members of the Committee.

6.0 IMPLICATIONS

6.1 Policy - none

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

Executive Director of Customer Services
Policy Lead Cllr Rory Colville
25th August 2017

For further information contact: Graeme B. Forrester, Area Committee Manager, Tel: 01546 604197

APPENDICES
None

ARGYLL AND BUTE COUNCIL **AUDIT & SCRUTINY COMMITTEE**

CUSTOMER SERVICES **19 SEPTEMBER 2017**

AUDIT SCOTLAND'S ANNUAL UPDATE 2016/17 ON HOUSING BENEFIT PERFORMANCE

1.0 INTRODUCTION

1.1 Audit Scotland recently published their annual update on Housing Benefit performance audit work in 2016/17. Eight reports were issued to councils identifying 18 risks to continuous improvement. A number of key messages have been identified which are relevant to all councils. The report also highlights key findings from a thematic review of housing benefit fraud investigation liaison arrangements in Scotland published in January. It notes that Universal Credit roll out is proceeding, and that the newly devolved social security powers to the Scottish Parliament will see discretionary housing payments and the Scottish Welfare Fund continuing to be delivered by local authorities.

2.0 RECOMMENDATIONS

2.1 The key messages from the performance audits in 2016/17 detailed below are noted along with the findings from the review of housing benefit fraud investigation liaison arrangements, early experiences of Universal Credit Full Service, and plans for future devolved benefits.

3.0 DETAIL

3.1 Local Authorities in Great Britain have a duty to administer Housing Benefit to their citizens under statute on behalf of the Department of Works and Pensions (DWP). In Scotland, Audit Scotland is responsible for carrying out performance audits on the administration of housing benefit by local authorities. This is in addition to their annual audits of Housing Benefit subsidy claims made by Councils for reimbursement of Housing benefit payments made to claimants. This council was last subject to a performance audit in July 2014.

3.2 It is important to analyse key messages from the annual reports published by Audit Scotland to ensure that the Council is well placed for future audits. The full report is attached at Appendix 1. The key messages are summarised below.

Performance audits

3.3 The main risks identified by Audit Scotland during 2016/17 were management accuracy checking, business planning and performance reporting, and interventions activity as follows:

- Management accuracy checking was an issue for 5 Councils. The level of analysis carried out on the outcomes was insufficient to inform a risk-based approach to checking and training programmes;

- In 3 Councils they found that targets were not set for all aspects of the benefit service. Therefore holistic performance was not being reported to senior management and elected members.

- Interventions were an issue in 4 Councils. Outcomes were not recorded and analysed in sufficient detail to allow the service to determine the effectiveness of their approach.

3.4 Our Benefits Service launched a new Management Checking Protocol in April 2016 that provides assurance on the integrity and security of benefit payments, compliance with legislative requirements and council policy and the quality of the business processes. The checking helps to identify opportunities for continuous improvement and weaknesses in staff performance that might inform individual training and development needs. Detailed analysis is undertaken by our quality assurance (QA) officer.

3.5 We have targets set for all aspects of Benefits performance along with appropriate benchmarks to show how we are doing. This is reported via the Pyramid system and key aspects are reported to Members via our Policy Lead reports and via review of performance, historically through the Performance, Review and Scrutiny Committee, and in future through Policy & Resources Committee. Performance is also regularly reviewed at departmental and service management team meetings.

3.6 All of our interventions are run as projects and each is backed up by statistical analysis of the impact to allow the service to determine the effectiveness of the approach. The QA officer carries out this work and it is then reported at the Benefit Management Team.

3.7 The Service therefore believes that it is reasonably well positioned in relation to the 3 types of risk identified.

Other work carried out by Audit Scotland

3.8 The report also refers to the report published by Accounts Commission on 19 January 2017 on housing benefit fraud investigation liaison arrangements in Scotland. The report identified that, despite some significant issues, DWP and local authorities were committed to delivering process improvements and to implementing a structured and regular approach to local liaison. The responsibility for housing benefit counter fraud work transferred to DWP's Fraud and Error Service (FES) and two out of our three fraud staff TUPE'd across on 1 October 2015. The Council created a small corporate counter fraud to pick up residual responsibilities for counter fraud and this team of 2 people also act as the single point of contact (SPOC) for FES. The funding from DWP for this is £1,800 for 2017/18, reduced from £2,566 in 2016/17.

3.9 The council has referred 15 cases to DWP through the SPOC since 1 October 2015. Fewer cases are referred than we used to handle in house. DWP's minimum case value is £2,000 compared to our previous in-house threshold of £750. There is very little incentive to make referrals. When referrals are made, each one is individually very time consuming – lots of forms have to be completed. With little funding for this work, there is only limited resource to do this. The SLA targets are not monitored, and no management information is exchanged. Recently a new West of Scotland area review group has been set up involving FES and 9 Local authorities to discuss the processes and propose changes and amendments. The first meeting was in November in Helensburgh, hosted by us. This group can escalate issues to the higher level national forum referred to in the report.

Universal Credit roll out

3.10 Audit Scotland notes that the roll out of Universal Credit (UC) is continuing and all councils now have some local residents claiming UC. The Housing Benefit caseload is falling as a direct consequence. UC Full Digital Service is in place in just a few councils and full rollout is expected to complete by September 2018. Those councils where is is already in place report a detrimental effect on the collection of housing rental income and that it becomes more difficult to recover any outstanding overpayments of housing benefit as such deductions rank lower. Full Service is due to be implemented for Argyll and Bute in May 2018. DWP has agreed to commence detailed planning later this summer.

Scottish Social security

3.11 The Scotland Act 2016 devolves a number of areas of social security to Scotland. Most will be delivered directly by the Scottish Government's new social security agency with Discretionary Housing Benefits and Scottish Welfare Fund continuing to be delivered by local authorities.

4.0 CONCLUSION

4.1 The committee is asked to note the key messages from the Audit Scotland report and the commentary provided in terms of the Council's position in relation to these.

5.0 IMPLICATIONS

5.1	Policy:	No change.
5.2	Financial:	None
5.3	Legal:	None.
5.4	HR:	None.
5.5	Equalities:	None.
5.6	Risk:	No change.

5.7 Customer Service: No change.

Douglas Hendry
Executive Director – Customer Services

8 September 2017

For further information contact:
Name of officer Fergus Walker, Revenue and Benefit Manager
Contact details Telephone 01586 555237, e-mail Fergus.walker@argyll-bute.gov.uk

Appendix

1 Audit Scotland Report: Housing Benefit Performance Audit 2016/2017

Councillor Rory Colville
Policy Lead

Housing Benefit Performance audit

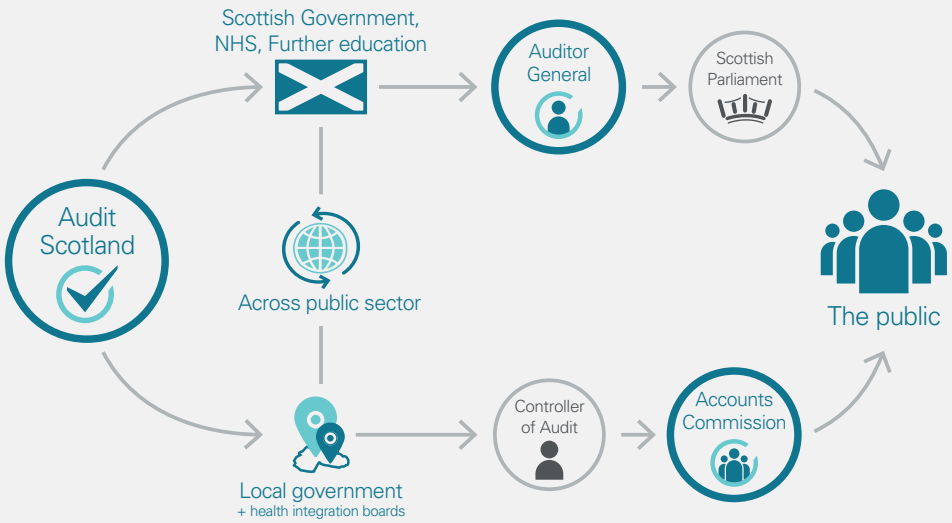
Annual update 2016/17

AUDIT SCOTLAND

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- **Audit Scotland** is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.
- The **Auditor General** is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The **Accounts Commission** is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

Contents

Purpose

1. This report provides a summary of the performance audit work carried out by Audit Scotland on Scottish council's housing benefit (HB) services during 2016/17.

Key messages

2. During 2016/17, we issued eight reports to councils which identified 18 risks to continuous improvement that were accepted. We found that 80% of risks identified during our risk assessments in previous years had been either fully or partially addressed (85% in 2015/16). Council feedback on the performance audit process remains positive.

3. Benefit services that are well managed can deliver value for money and high quality services for customers. In two of the eight councils we found no risks to continuous improvement, and in two councils, only one risk was identified. This is extremely positive and helps to demonstrate the impact of our work. However, we identified that:

- management checking was an issue in five of the eight councils. We found that the level of analysis carried out on the outcomes was insufficient to inform a risk-based approach to checking or training programmes
- in three councils, we found business planning and performance reporting risks where targets were not set for all aspects of the benefit service and therefore holistic performance was not being reported to senior management and elected members. As budgets are reducing we identified that the level of resources may not be sufficient to deliver continuous improvement, or maintain current performance levels in one council
- interventions were an issue in four councils. We found interventions outcomes were not recorded and analysed in sufficient detail to allow the service to determine the effectiveness of their approach.

4. Universal Credit (UC) continues to be rolled out across Scotland with all councils now having some local residents claiming UC. During 2016/17, the full digital UC service for all claimant types began to roll out nationally. The Department for Work and Pensions (DWP) expect a full roll-out across the UK to be completed by September 2018, with the migration of the remaining working age existing HB claimants to the full UC service to start thereafter and be completed by 2022.

5. The Scottish Parliament's newly devolved social security powers will result in some aspects of the devolved benefits being delivered by local authorities. Ten of the eleven devolved benefits will be delivered directly by the Scottish Government's new social security agency with discretionary housing payments (DHP) continuing to be delivered by local authorities. Further details are expected to be announced by the end of June 2017 in the Scottish Social Security Bill.

Background

6. During 2016/17, approximately 18 per cent of Scottish households received financial support to help pay for their rent in the form of means tested HB. Scottish councils paid out £1.74 billion in HB awards in 2016/17 (£1.77 billion in 2015/16), a reduction in spend of 1.7 per cent.

7. In 2016/17, Scottish councils received £25.2 million (£27.8 million in 2015/16) in funding from the DWP to deliver HB services. This 9 per cent reduction in funding in 2016/17 is due to DWP assumed efficiency savings and the move of the cost of fraud investigations from local authorities to DWP.

8. The main objective of the benefit performance audit is to help councils improve their benefit services but it also holds councils to account for any failing services. The audit has two phases:

- a risk assessment phase that identifies risks to continuous improvement
- a focused audit phase that examines the service, or parts of it in more detail, if a council is unable or unwilling to address key risks identified in phase one.

9. Risk assessment reports are provided to council chief executives who are invited to prepare an improvement plan detailing the actions, with associated timescales, that they will take to address the identified risks. These reports are also copied to the DWP and the council's external auditors to provide assurances over how councils are performing.

10. When a focused audit is required, the Controller of Audit prepares a report to the Accounts Commission. Focused audit reports are provided to council chief executives and are also copied to the DWP, external auditors, and published on the Audit Scotland website.

11. We also carry out reviews of, and report on, particular themes relevant to providing housing benefit services.

Work carried out during 2016/17

12. We reviewed our risk-based approach to our performance audit programme to ensure that the councils that we considered the highest risk were visited during the year. Appendix 1 (page 14) contains the details of the eight risk assessment reports that were issued to council Chief Executives during 2016/17 (11 in 2015/16). No focused audits were carried out. The reduction in the number of risk assessments was due to the retirement of one of the two performance auditors in December 2016 who has not yet been replaced.

13. Following receipt and review of council improvement plans to address the risks identified in our risk assessment reports, further progress reports were requested from four councils. These are detailed in Appendix 2 (page 15).

14. We have received progress reports from all four councils. Action taken to address risks in North Ayrshire Council, Clackmannanshire Council and Aberdeenshire Council was considered satisfactory and therefore no further updates were required. East Dunbartonshire Council was requested to provide further updates on new claims processing performance. These further updates have been received and action taken to address the risks was considered satisfactory.

15. In line with Audit Scotland's objective of identifying and sharing good practice, one thematic study was undertaken during 2016/17. More information is provided in the following paragraphs.

A review of housing benefit fraud investigation liaison arrangements in Scotland

16. Following the completion of the transfer of responsibility for the investigation of HB fraud from councils to the DWPs Fraud and Error Service (FES) in April 2016, Audit Scotland carried out a review of effectiveness of the new fraud investigation liaison arrangements.

17. The key objective of the review was to determine the extent to which benefit services are meeting their obligations to achieve continuous improvement in respect of HB counter fraud activities. Information for the review was gathered from officers in Scottish councils and the DWP.

18. The review identified that the current process did not provide sufficient assurance that public funds administered by local authorities are being protected. The report concludes that despite the significant issues identified, DWP and local authorities in Scotland are committed to delivering process improvements and to implementing a structured and regular approach to local liaison. The report was published in January 2017 and is available on the Audit Scotland website.

Outcomes of the 2016/17 risk assessments

19. Audit Scotland identified 18 risks to continuous improvement (45 in 2015/16) in the eight risk assessments completed in 2016/17. We are pleased to report that no risks to continuous improvement were identified in Inverclyde and South Lanarkshire councils and only one risk was identified in Aberdeenshire Council and East Ayrshire Council.

20. Our work identified that 80 per cent (55 out of 69) of previously agreed actions had been fully or partially implemented (85 per cent in 2015/16).

21. Improvement plans have been received from all councils visited. Analysis of the risks identified shows that:

- 100 per cent (100 per cent in 2015/16) of the identified risks were fully accepted by councils
- 20 per cent (14/69) of agreed risks from previous risk assessments were carried forward (17 per cent in 2015/16).

22. The outstanding risks relate to:

- limited reporting of performance to senior management and members in five councils
- limited analysis of intervention outcomes in three councils
- overpayment recovery performance, or limited analysis of performance to determine the effectiveness of recovery methods in three councils
- the accuracy checking approach in one council, and accuracy performance in one council
- speed of processing performance in one council.

23. Councils have cited resourcing issues and budget cuts as a reason why not all agreed actions have been fully implemented.

24. We have found that where benefit services are well managed they can deliver value for money and high-quality services for claimants.

25. During 2016/17, Audit Scotland has identified weaknesses in the following key areas:

- Accuracy - we found that quality checking was not always risk based and results were not being routinely collated and analysed in detail to inform a risk-based approach to checking or its training programme
- Business planning and performance reporting - we found that councils were not setting targets for all aspects of the benefit service and therefore holistic performance was not being reported to senior management and elected members. As budgets are reducing we identified that the level of resources

were not sufficient to deliver continuous improvement, or maintain current performance levels in one council.

- Interventions - we found interventions outcomes were not recorded and analysed in sufficient detail to allow the council to determine the effectiveness of their approach, particularly in monetary terms.

Stakeholder feedback

26. In order to ascertain the effectiveness of the audit process from the council's perspective, and to help identify areas which could be improved, a feedback questionnaire is issued to the council after each risk assessment. During 2016/17, responses received were very positive and provided Audit Scotland with assurance that the audit methodology is fit for purpose and proportionate. The following comments were received:

- "The risk assessment process acknowledged the challenges and improvements made by the council's benefit service together with opportunities to enhance specific risks to deliver further continuous improvement."
- "The auditor's experience, knowledge, and manner was refreshing, and meant that the new team were very comfortable with the process."
- "The planning and set-up of the audit was professional and offered sufficient flexibility to enable the council to meet the deadlines."
- "The audit provided a focussed external challenge to our benefit service which was beneficial."

27. From the feedback received there were no comments on what Audit Scotland could have done better. However, we continually review our work with a view to minimising the impact of the risk assessment on the council, and discussions continue with benefit managers in respect of their particular requirements and needs prior to the submission of the self-assessment. We also try to take account of the challenges faced by council's when considering our work programme.

28. HB risk assessment reports continue to be shared with the DWP. Throughout 2016/17, we have continued to monitor our approach in conjunction with the DWP through quarterly meetings between the Manager - Benefits (Technical) and senior officers in the DWP's Housing Delivery Division.

Welfare reform

29. Councils continue to work with partners to help deliver the UK Government's welfare reform agenda.

Universal credit (UC)

30. UC rollout has continued across Scotland during 2016/17. All Scottish councils have some local residents claiming UC.

Universal Credit Full Digital Service

31. The latest UC digital service allows users to make a claim, notify changes of circumstance and search for a job through a single account, making digital the primary channel for most working-age people to interact with the DWP.

32. On 23 March 2016, Musselburgh Job Centre, which serves East Lothian Council, was the first Job Centre in Scotland to provide the full UC digital service. Further rollouts of the full digital service have now taken place in jobcentres, which serve Highland, East Dunbartonshire, Inverclyde, and Midlothian councils. The DWP expects a full rollout across the UK to be completed by September 2018, with the migration of the remaining working age existing HB claimants to the full UC digital service to be completed by 2022.

33. Councils have been reporting that the roll out of UC has had a detrimental effect on the collection of housing rental income. For example, East Lothian Council reported a 12 per cent increase in rent arrears from 1 April to 30 September 2016. This is an increase of £156,000 of which the council could identify £79,000 relating directly to debt associated with UC. The council recognise that the remaining £78,000 may also be in part an indirect impact of UC, eg officers spending time with UC claimants and increased volumes of DHP applications which detracts from the time available to spend dealing with other tenant arrears.

34. Once HB claimants move onto UC it may be more difficult for councils to recover any outstanding overpayments of HB from claimants. This is because one of the most popular methods for recovering overpaid HB is through regular deductions from on-going HB. Following the migration to UC, councils will no longer have this option. Councils can apply to have previous HB debt recovered from UC, but HB debt would be ranked along with other potential debts the claimant may have.

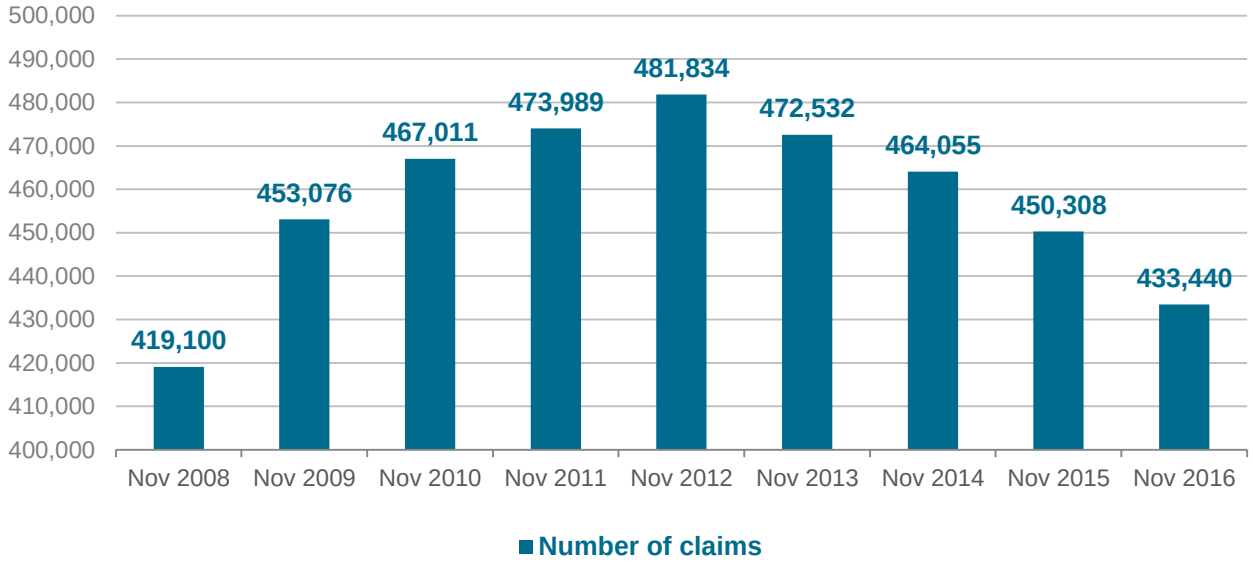
35. The Scottish Government has consulted on its newly devolved powers which will allow the rent element of UC to be paid directly to landlords. This new power may help keep rent arrears down.

36. The continued rollout of UC during 2017/18 will result in reduced HB caseloads in councils as fewer new HB claims are received. Working age claimants will start to move to UC with councils typically retaining pension aged claimants, some complex cases and contribution based Jobseekers and Employment and Support Allowance claimants.

37. The HB caseload has been falling in recent years from a high of 481,834 during 2012/13 to 433,440 during 2016/17 as shown in Exhibit 1 (page 11). This represents a ten per cent decrease in the number of claims between November 2012 and November 2016.

Exhibit 1

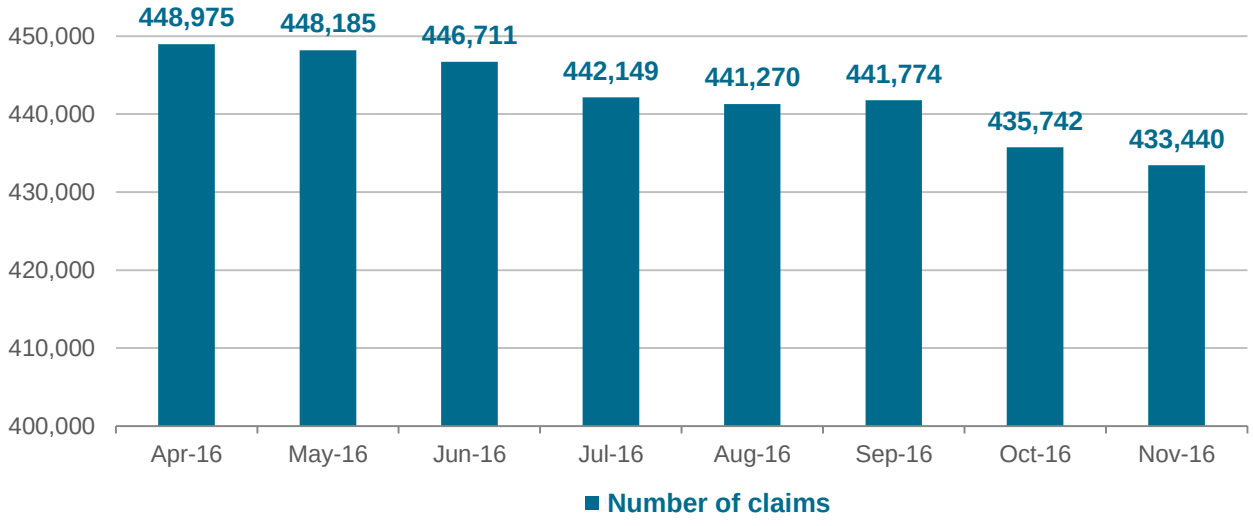
HB Caseload 2008-16 (Scotland)



38. Exhibit 2 shows that claim numbers continued to fall during 2016/17 by a further 3.5 per cent between April 2016 and November 2016.

Exhibit 2

Monthly caseload (Scotland)



Scottish Social Security

39. The Scotland Act 2016 devolves a number of areas of social security to Scotland. These cover 11 benefits totalling £2.8 billion of spending in Scotland (15 per cent of the current total social security spend in Scotland). The Scottish Government is committed to delivering these 11 social security benefits by the end of the current parliamentary session in 2021.

40. The Scottish Government's social security programme is in its early stages and in 2016, the Scottish Government carried out a consultation to gather public opinion on the devolved benefits and how they should be delivered.

41. The Scottish Parliament's new devolved social security powers will result in some aspects of the devolved benefits being delivered by local authorities. Ten of the eleven newly devolved benefits will be delivered directly by the Scottish Government's new social security agency, with DHP's and the already devolved, Scottish Welfare Fund, continuing to be delivered by local authorities.

42. Further details are expected to be announced by the end of June 2017 in the Scottish Social Security Bill.

Our reports

1. *A review of housing benefit fraud investigation liaison arrangements in Scotland*, Audit Scotland, January 2017
2. *Housing Benefit Good Practice Guide: Initiatives which deliver best value*, Audit Scotland, April 2016
3. *Benefit performance audit: Annual update 2015/16*, Audit Scotland, June 2016
4. *Housing benefit subsidy certification 2014/15*, Audit Scotland, January 2016
5. *Review of activity to reduce fraud and error in housing benefit*, Audit Scotland, September 2015
6. *Benefits performance audit: Annual Update 2014/15*, Audit Scotland, June 2015
7. *Review of auditors' housing benefit subsidy claim reported errors 2013/14*, Audit Scotland, February 2015

Appendix 1

The 2016/17 risk assessment programme

Date on site	Council	Date reported
March 2106	South Ayrshire	May 2016
March 2016	Inverclyde	May 2016
June 2016	East Renfrewshire	July 2016
June 2016	East Ayrshire	August 2016
August 2016	Aberdeenshire	October 2016
September 2016	Dundee City	November 2016
November 2016	South Lanarkshire	December 2016
January 2017	Fife	March 2017

Appendix 2

Progress reports requested during 2016/17

Council	Date progress report received/expected	Conclusion on action taken to address risks
North Ayrshire	April 2016	Update received and satisfactory progress made to date.
East Dunbartonshire	April 2016	Update received and further update requested on action regarding risks identified in respect of new claims performance.
East Dunbartonshire	July 2016	Update received and further update requested on new claims performance.
Clackmannanshire	November 2015, February 2016 & July 2016, January 2017	Update received and satisfactory progress made to date.
East Dunbartonshire	January 2017	Update received and satisfactory progress made to date.
Aberdeenshire	April 2017	Update received and satisfactory progress made to date.

Housing Benefit Performance audit

Annual update 2016/17

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

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Audit & Scrutiny Committee Work Plan 2017 - 2018

This is an outline plan to facilitate forward planning of reports to the Audit & Scrutiny Committee

Date	Report Designation	Lead Service	Regularity of occurrence/ consideration	Date of Reports to Committee Services	Additional Comment
19 September 2017					
	Audit Scotland's Annual Update on Housing Benefit Performance 2016/17	Executive Director - Customer Services	Annual	25 August 2017	
	Internal Audit Summary of Activities	Head of Strategic Finance	Quarterly	25 August 2017	
	Internal Audit Reports to Audit Committee 2017/18	Head of Strategic Finance	Quarterly	25 August 2017	
	External & Internal Audit Report Follow Up 2017/18	Head of Strategic Finance	Quarterly	25 August 2017	
	Treasury Management Annual Assurance Report	Head of Strategic Finance	Annual	25 August 2017	
	Audited Financial Accounts	Head of Strategic Finance	Annual	25 August 2017	
	External Audit Annual Report	External Auditors	Annual	25 August 2017	
	Audit & Scrutiny Committee Development Plan	Executive Director - Customer Services	Annual	25 August 2017	
1 December 2017					
	Internal Audit Summary of Activities	Chief Internal Auditor	Quarterly	8 November 2017	
	Internal Audit Reports to Audit Committee 2017/18	Chief Internal Auditor	Quarterly	8 November 2017	
	External & Internal Audit	Chief Internal Auditor	Quarterly	8 November 2017	

Audit & Scrutiny Committee Work Plan 2017 - 2018

Date	Report Designation	Lead Service	Regularity of occurrence/ consideration	Date of Reports to Committee Services	Additional Comment
	Report Follow – Up 2017/18				
	Draft Annual Audit Plan 2018/19	Chief Internal Auditor	Annual	8 November 2017	
	Risk Management Overview	Head of Strategic Finance	Annual	8 November 2017	
	VAT Update Report	Head of Strategic Finance	Annual	8 November 2017	
20 March 2018					
				23 February 2018	
19 June 2018					
				25 May 2018	
Future Reports – dates to be determined					
	Risk Management	Grant Thornton Audit Partners	Annual		