Pecyn Dogfen Gyhoeddus

Swyddog Cyswllt:
Sharon Thomas 01352 702324
sharon.b.thomas@flintshire.gov.uk

At:

Y Cynghorwyr: Geoff Collett, Chris Dolphin, Andy Dunbobbin, Patrick Heesom, Andrew Holgate, Paul Johnson ac Arnold Woolley

Aelod Cyfetholedig:
Sally Ellis

29 Mai 2019

Annwyl Gynghorydd

Fe'ch gwahoddir i fynychu cyfarfod Pwyllgor Archwilio a fydd yn cael ei gynnal am 10.00 am Dydd Mercher, 5ed Mehefin, 2019 yn Ystafell Bwyllgor Clwyd, Neuadd y Sir, Yr Wyddgrug CH7 6NA i ystyried yr eitemau canlynol.

Bydd y sesiwn hyfforddiant ar gyfer aelodau'r Pwyllgor Archwilio yn cael ei chynnal o 9.30am tan 10am

R H A G L E N

1	**PENODI CADEIRYDD**	
	Pwrpas:	Penodi Cadeirydd ar gyfer y Pwyllgor.
2	**PENODI IS-GADEIRYDD**	
	Pwrpas:	Penodi Is-Gadeirydd ar gyfer y Pwyllgor.
3	**YMDDIHEURIADAU**	
	Pwrpas:	I dderbyn unrhyw ymddiheuriadau.
4	**DATGAN CYSYLLTIAD (GAN GYNNWYS DATGANIADAU CHWIPIO)**	
	Pwrpas:	I dderbyn unrhyw ddatganiad o gysylltiad a chynghori'r Aelodau yn unol a hynny.
5	**COFNODION** (Tudalennau 3 - 10)	
	Pwrpas:	I gadarnhau, fel cofnod cywir gofnodion y cyfarfod ar 27 Mawrth 2019.

6 **DATGANIAD LLYWODRAETHU BLYNYDDOL 2018/19** (Tudalennau 11 - 48)

Adroddiad Prif Weithredwr

Pwrpas: Cael adolygiad blynyddol o'r Datganiad Llywodraethu Blynyddol i'w ardystio.

7 **ADRODDIAD BLYNYDDOL ARCHWILIO MEWNOL** (Tudalennau 49 - 72)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Rhoi gwybod i'r aelodau am ganlyniad yr holl waith archwilio a gynhaliwyd yn ystod 2018/19 a rhoi'r farn Archwilio Mewnol flynyddol ar safon rheolaeth fewnol, rheoli risg a llywodraethu yn y Cyngor.

8 **SIARTER ARCHWILIO MEWNOL** (Tudalennau 73 - 108)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Amlinellu'r Siarter Archwilio Mewnol (sydd wedi ei ddiweddaru) i'r Aelodau.

9 **ADRODDIAD CYNNYDD ARCHWILIO MEWNOL** (Tudalennau 109 - 188)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Cyflwyno diweddariad i'r Pwyllgor ar gynnydd yr Adran Archwilio Mewnol.

10 **OLRHAIN GWEITHREDU** (Tudalennau 189 - 194)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Rhoi gwybod i'r Pwyllgor am y camau gweithredu sy'n codi o'r pwyntiau a godwyd mewn cyfarfodydd Pwyllgor Archwilio blaenorol.

11 **RHAGLEN GWAITH I'R DYFODOL** (Tudalennau 195 - 202)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Ystyried Rhaglen Gwaith i'r Dyfodol yr Adran Archwilio Mewnol.

Yn gywir

Robert Robins
Rheolwr Gwasanaethau Democrataidd

AUDIT COMMITTEE
27 MARCH 2019

Minutes of the meeting of the Audit Committee of Flintshire County Council held in the Clwyd Committee Room, County Hall, Mold on Wednesday, 27 March 2019

PRESENT: Councillor Helen Brown (Chair)
Councillors: Janet Axworthy, Geoff Collett, Chris Dolphin, Andy Dunbobbin, Paul Johnson and Arnold Woolley
Co-opted member: Sally Ellis

ALSO PRESENT: Councillors Billy Mullin and Patrick Heesom attended as observers

IN ATTENDANCE:
Chief Executive; Chief Officer (Governance); Internal Audit Manager; Corporate Finance Manager; and Democratic Services Officer

Interim Finance Manager (Technical Accountancy) - for minute numbers 58 and 59

Corporate Business & Communications Executive Officer - for minute number 61

Wales Audit Office representatives
Mike Whiteley and Gwilym Bury

55. MEMBERSHIP

The Chief Officer advised that Councillor Axworthy was currently replacing Councillor Holgate on the Committee and that she had undertaken the necessary training.

56. DECLARATIONS OF INTEREST

None.

57. MINUTES

The minutes of the meeting held on 15 February 2018 were received.

RESOLVED:

That the minutes be approved as a correct record and signed by the Chair.

58. TREASURY MANAGEMENT QUARTERLY UPDATE 2018/19

The Interim Finance Manager (Technical Accountancy) presented the quarterly update on matters relating to the Council's Treasury Management Policy, Strategy and Practices 2018/19 to the end of February 2019.

The update reflected the current strategy on borrowing which was under continued review as interest rates were predicted to rise later in the year. Potential changes to the credit ratings of UK banks were being monitored in accordance with guidance from the Treasury Management advisors. Detailed information was also provided on preparations for the Brexit process involving an action plan to manage three key risk areas in the event of 'no deal'.

Sally Ellis asked about the impact of further delays to Brexit. The Interim Manager detailed the main risk around security and liquidity of investments, and that the Council was maintaining its current position until there was more clarity on the completion of Brexit. Having received professional advice, the Clwyd Pension Fund Committee recognised the potential risks to the market which formed part of their broader risk management activities and was satisfied that the regulatory position would be maintained until the conclusion of post-Brexit negotiations.

The Chief Executive spoke about the difference between market performance as opposed to security of investments on which no national advice had been issued to date. Both risks would remain irrespective of further delays.

In response to questions from Councillor Johnson, the Chief Executive said that in the absence of national advice to public sector organisations, the Council could only plan within its remit to manage risks as best it could. This involved reviewing business continuity plans for services that could potentially be impacted by Brexit, separating long and short-term risks, noting that no significant change was expected to financial markets.

The Chief Officer advised that these reviews had identified a small number of specific and common risks, mainly relating to suppliers.

In referring to a recent Welsh Government (WG) seminar, Councillor Johnson expressed his gratitude to all those working to prepare for Brexit.

In response to questions from Councillor Dunbobbin, the Chief Executive said that the focus of Brexit was on the impact on communities, businesses and workforce, and that the economic impact would need to be resolved at Government level. Whilst the WG was open to discussions, there were too many unknown factors at this stage of the process.

RESOLVED:

That the Treasury Management 2018/19 quarterly update be noted.

59. WALES AUDIT OFFICE (WAO) AUDIT PLAN 2019

Mr. Mike Whiteley presented the Wales Audit Office (WAO) Audit Plan 2019 which set out the arrangements and responsibilities for proposed audit work for the Council.

In summarising the main points, he highlighted the key financial audit risks on the management override of controls as a generic risk, significant estimates

which were complex in nature and subject to judgements and the introduction of new accounting standards where there was open dialogue with Council officers on preparations. There was no proposed change to the audit fees which included work on the North Wales Residual Waste Joint Committee. As in previous years, the Audit Plan set out the controls in place to mitigate the potential independent threat set out in paragraph 30. Appreciation was given to Finance officers for assisting WAO colleagues to deliver the work in accordance with the proposed timetable.

During an overview of the performance audit programme, Mr. Gwilym Bury highlighted common areas such as financial sustainability across all Welsh councils and specific work on reducing rent arrears following welfare reform changes which was a particular issue for Flintshire. An update was also given on the status of ongoing performance audit work from the previous year's audit outline.

On the performance audit programme, the Chief Executive spoke about a shift in focus on localised issues and the proposed removal of council obligations under the Local Government (Wales) Measure 2009. The audit work on rent arrears was particularly welcomed in potentially highlighting contributing factors and the project on Household Recycling Centres would provide independent feedback on access quality. The Council's internal protocol (as set out in a later agenda item) provided a mechanism for reporting outcomes of regulatory reports.

On the financial audit programme, the Corporate Finance Manager said that earlier statutory deadline requirements would be met following preparations put in place last year. On a risks previously identified, he gave an update on transitional arrangements within the team prior to the return of the Finance Manager. The contributions of the Interim Finance Manager during the period were recognised by the Chief Executive and Committee Members who welcomed his appointment working on the Clwyd Pension Fund accounts.

Councillor Dunbobbin remarked on the duties placed upon the Council by the Well-being of Future Generations Act (Wales) 2015 at a time of financial austerity. The Chief Executive said that the national work on financial sustainability would highlight the responsibilities on Welsh Government which itself was subject to the obligations of the same legislation.

Councillor Dolphin questioned whether the audit fee represented value for money since the WAO opinions could not give absolute assurance. Mr. Whiteley explained that the approach to assess risk on sample work was standard practice for external auditors and that absolute assurance could not be given without assessing each individual transaction.

The Chief Officer noted that the audit fee was favourable in comparison to some other North Wales councils, which could be attributed to the quality of work undertaken by the Finance and Internal Audit teams. The Chief Executive said that audit fees provided value for money and had remained static for some time, and that there was a positive working partnership between the Council and WAO.

Sally Ellis asked about the approach to maximise outcomes from work by Internal Audit and WAO on rent arrears and the Digital Strategy. The Internal Audit

Manager advised that the scope of both reviews would be agreed in advance to avoid any duplication of work and deliver value for those services. In welcoming the work, the Chief Officer said that the digital project would focus on deliverables due to the complexities involved.

The Internal Audit Manager agreed to schedule the outcomes of regulatory reports into the Forward Work Programme when finalised.

RESOLVED:

That the Wales Audit Office report be noted.

60. CERTIFICATION OF GRANTS AND RETURNS 2017/18

The Corporate Finance Manager presented the Wales Audit Office (WAO) annual report on grant claim certification for the year ending 31 March 2018.

Whilst the findings did not present a major risk to performance, they did not reflect the standards expected and officers were continuing to work closely with WAO to improve the quality of claims. Work was underway on the detailed action plan and the report would be shared with the Accounts Governance Group and Chief Officers to ensure ownership and action. In providing context, the Corporate Finance Manager advised that the £11,151 net adjustment to claims was a small proportion of the overall grants total of £129m with no financial loss to the Council.

In summarising the key points, Mr. Mike Whiteley of WAO commented on the slight deterioration in performance where half of the audited claims were qualified and he recognised there was scope for improvement. The reduction in the number of grant claims for the period was due to the introduction of the Welsh Government (WG) Single Summary of Grants on which a number of errors had been made (in addition to WG issues with the guidance and template). Mr. Whiteley said that this was disappointing as the Council's processes and performance were generally sound, and suggested that the new arrangement may have caused confusion. He circulated a revised summary of certification work outcomes due to formatting issues on the published report. The recommendations had been accepted by management and teams were working with WAO to implement the actions.

In thanking WAO colleagues for the report, the Chief Executive said that whilst the individual issues were not significant, collectively they gave rise to concerns. Work had started on the agreed actions and would be monitored.

The Internal Audit Manager confirmed that a review of Corporate Grants had been included in the Audit Plan for 2019/20.

RESOLVED:

That the content of the Grant Claim Certification report for 2017/18 be noted.

61. EXTERNAL REGULATION ASSURANCE

The Corporate Business & Communications Executive Officer presented the summary report to give assurance that reports from external regulators and inspectors in 2017/18 had been considered by the relevant committees and actions taken in response to recommendations. This was in accordance with the agreed internal reporting protocol which was also shared.

Apart from one local report with no recommendations, the remainder were national reports showing the Council's response alongside any generic recommendations.

The Chief Executive spoke about the Council's positive practice of using national reports to add value. Mr. Gwilym Bury said that similar arrangements were in place in North Wales although not necessarily across Wales.

Sally Ellis referred to the reports on homelessness and Disabled Facilities Grants and asked whether progress on the recommendations was achieving outcomes for Flintshire residents. The Chief Executive asked that Sally be provided with recent reports showing good performance in both areas.

RESOLVED:

That the Committee notes how reports by external auditors, other regulators and inspectors have been dealt with during 2017/18.

62. INTERNAL AUDIT STRATEGIC PLAN

The Internal Audit Manager presented the three year Internal Audit Strategic Plan for 2019/20 to 2021/22. The approach to developing the Plan was detailed, involving an assurance mapping exercise and consultation with Chief Officers. The Plan was subject to variation and review, with high priority audits and reviews prioritised for 2019/20.

RESOLVED:

That the Flintshire Internal Audit Strategic Plan 2019-2022 be approved.

63. PUBLIC SECTOR INTERNAL AUDIT STANDARDS COMPLIANCE 2018/19

The Internal Audit Manager presented the results of the annual assessment of conformance with the Public Sector Internal Audit Standards (PSIAS). The outcome of the internal self-assessment for 2018/19 and external assessment for 2016/17 (through a peer review) indicated general conformance. The programme for external assessment for the next five years was in development.

RESOLVED:

That the report be noted.

64. INTERNAL AUDIT PROGRESS REPORT

The Internal Audit Manager presented the update on progress of the Internal Audit department including changes to the audit plan, action tracking and investigations.

No limited (red) assurance reports had been issued since the last meeting. As requested at the Chair's briefing, the reviews with Red and Amber/Red assurances would be indicated on the overall summary of opinions (Appendix C) on future reports. The concerns about delayed responses to action tracking had been raised with Chief Officers and had impacted positively on the figures; this would continue to be monitored.

On resources, the Committee was informed of the impending retirement of a Principal Auditor within Internal Audit.

The Chief Executive spoke about the value of advisory work undertaken by the team in addition to the core work, for example providing independent verification on the accuracy of method statements and assumptions which helped to provide additional assurance on complex matters.

Sally Ellis thanked the officer for raising the importance of Chief Officers providing updates on action tracking. She referred to the challenges of recruiting senior auditors and asked about capacity within the team. The Internal Audit Manager provided explanation on the recruitment process to date and the options available. The vacancy had been accommodated within the Audit Plan until July and the situation would be closely monitored with any concerns reported back to the Committee.

The Chief Executive said recruitment challenges across the professional sector in general meant that succession planning was an increasing risk.

In response to questions from Councillor Johnson, the Internal Audit Manager advised that Pensions administration formed part of audit work which provided further assurance to the Clwyd Pension Fund Committee. The Chief Executive spoke about the increased resources in the Pensions team to respond to complex changes and new statutory requirements.

On procurement, the Chief Officer referred to measures introduced on the contract register to provide controls and compliance, and the follow-up audit on contract management to ensure that the system was being used effectively.

Councillor Dolphin raised concerns about some of the reasons given for delayed actions and highlighted the importance of setting realistic deadlines, for example in Planning Enforcement where he felt additional resources were needed to meet workload. In acknowledging the various reasons for deferring actions, the Chief Executive said that those in Planning Enforcement were in progress and required a longer term resolution whilst Greenfield Valley involved an issue outside the Council's control.

RESOLVED:

That the report be accepted.

65. COMPOSITION OF AUDIT COMMITTEE

The Internal Audit Manager presented a report to consider the composition of the Audit Committee following discussion at a meeting of the Constitution & Democratic Services Committee. The report reflected the current membership arrangements and valuable contributions made by the current and previous lay members serving on the Committee. Any decision to change the size of the membership and/or increase the number of lay members would need to be through a recommendation to County Council to be determined at the Annual General Meeting.

The Chief Officer advised that the size of the Committee would need to be proportionate to the work undertaken and the nature of questioning at the meetings, which he recommended was better achieved by retaining a smaller sized membership. Whilst the Committee would need to be politically balanced, any change to represent all political groups would necessitate an increase to eleven (or possibly ten) councillors. On the resource implications, it was clarified that the pay entitlement for lay members was £99 per meeting rather than £128 which applied to a lay member chairing a meeting.

Councillor Dolphin spoke about the positive impact from the current lay member and suggested that an additional lay member would also be beneficial. In the interests of fairness, he said that all political groups should be represented and suggested that this could be done by way of the smallest group's seat (currently his own) being offered to the New Independent group.

Councillor Johnson said that the Committee was already fairly balanced between the ruling and opposition groups. He said that a smaller membership generally allowed an opportunity for all those present to contribute, and spoke in support of an additional lay member if any changes were to be made.

Councillor Dunbobbin was in agreement with Councillor Johnson, as the meetings were open for other Members to observe if they wished. He did not feel that increasing the number of councillors would add value to the Committee.

Following his earlier comments, Councillor Dolphin proposed that the group currently not represented on the Committee be appointed to replace the smallest group, with an additional lay member if agreed.

On this basis, the Chief Executive suggested that the proposal for recommendation to Council was for the number of councillors to remain the same and for the membership to be rotated to allow all political groups to participate, with the appointment of a second lay member. The rotation arrangements would be agreed with Group Leaders.

This was formally proposed by Councillor Johnson and seconded by Councillor Dunbobbin. On being put to the vote, it was carried.

RESOLVED:

That the Committee wishes to recommend to Council, via the Council's Annual Meeting, that the number of councillors on the Audit Committee be retained and the membership rotated to allow all political groups to participate. Also that an additional lay member be recruited.

66. ACTION TRACKING

The Internal Audit Manager presented the update report on actions arising from previous meetings, most of which were completed or in progress.

RESOLVED:

That the report be accepted.

67. FORWARD WORK PROGRAMME

In presenting the current Forward Work Programme for consideration, the Internal Audit Manager advised that no changes had been made since the previous meeting. The items on Corporate Grants and Wales Audit Office reports discussed during the meeting would be scheduled.

RESOLVED:

(a) That the Forward Work Programme, as amended, be accepted; and

(b) That the Internal Audit Manager, in consultation with the Chair and Vice-Chair of the Committee, be authorised to vary the Forward Work Programme between meetings, as the need arises.

68. ATTENDANCE BY MEMBERS OF THE PRESS AND PUBLIC

There were no members of the press or public in attendance.

The meeting commenced at 10am and finished at 11.35am

……..
Chair

AUDIT COMMITTEE

Date of Meeting	Wednesday 5 June 2019
Report Subject	Annual Governance Statement 2018/19
Report Author	Chief Executive

EXECUTIVE SUMMARY

Each financial year the Council is required to produce an Annual Governance Statement (AGS) as part of its final accounts. The AGS explains how the Council has complied with its Code of Corporate Governance, and fulfils the requirements of the Accounts and Audit (Wales) Regulations 2018.

The Chartered Institute of Public Finance and Accountancy (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) revised their detailed guidance note on the preparation and contents of an AGS – 'Delivering Good Governance in Local Government: Guidance notes for Welsh authorities' (December 2016). The AGS is based on the seven core principles of governance from that guidance note.

It is good practice for the AGS to be presented separately from the final accounts to be given due consideration.

RECOMMENDATIONS	
1	That the Committee review the Annual Governance Statement 2018/19 to be attached to the Statement of Accounts and recommended to Council for adoption.

REPORT DETAILS

1.00	EXPLAINING THE ANNUAL GOVERNANCE STATEMENT
1.01	Under the Accounts and Audit (Wales) Regulations 2018 each local authority must ensure it has a sound system of internal control. Each year they must conduct a review of the effectiveness of the system and prepare an Annual Governance Statement (AGS). The review must be considered and the AGS approved by a committee or members of the authority meeting as a whole.
1.02	The AGS accompanies the financial statements but is not part of them. As such it is not part of the statement on which the external auditors opinion is given. However, the auditors review the governance statement to confirm it is consistent with the audited financial statements and other information of which they are aware.
1.03	The preparation of the AGS has been coordinated by the Corporate Governance Working Group (CGWG) which has reported to the Chief Executive, the Monitoring Officer and the Section 151 Officer on its work.
1.04	The working group continued this year with the new format of the report - keeping it aligned to the revised seven core CIPFA/SOLACE principles. These are as follows: Principle A — Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law Principle B — Ensuring openness and comprehensive stakeholder engagement Principle C — Defining outcomes in terms of sustainable economic, social, and environmental benefits Principle D — Determining the interventions necessary to optimise the achievement of the intended outcomes Principle E — Developing the entity's capacity, including the capability of its leadership and the individuals within it Principle F — Managing risks and performance through robust internal control and strong public financial management Principle G — Implementing good practices in transparency, reporting, and audit to deliver effective accountability It is this set of principles on which the assessment questionnaires and the resultant final draft governance statement is based.
1.05	The corporate governance self-assessments have been reviewed and challenged amongst Chief Officers. Areas of strength are highlighted throughout the principles in green text. Areas for improvement are summarised separately and are derived from one of four sources:

	i) Self-assessment questionnaire reviewed by Chief Officers ii) Overview and Scrutiny Committee Chairs' questionnaires iii) Outstanding 'red' (major) risks contained within the Council Plan 2017/18 end of year report iv) Red / limited assurance internal audit reports issued during the year. The areas for improvement identified as part of the self-assessment all fall in the categories where there is either a need to improve further or there has been an increase in the significance of the respective risk issue. Examples of the "need to improve further" include: • Engaging with stakeholders / impact assessments • Workforce planning • Longer term planning These are marked on the AGS as * issues. Examples where the risk issue has increased in significance include: • Behaving with integrity • Demonstrating social and ethical values • Sustainability of outcomes within available resources • Resource prioritisation These are marked on the AGS as # issues.
1.06	Progress against mitigating actions against governance issues identified in the Annual Governance Statement last year (2017/18) has also been included, with an indication as to if the issues remain 'open' or 'closed'.
1.07	Audit Committee will receive a mid-year report on progress against the areas for improvement.

2.00	**RESOURCE IMPLICATIONS**
2.01	There are no direct resource implications related to this report.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	The Annual Governance Statement has been produced using information from all Statutory and Chief Officers, Service Managers and Chairs of all Overview and Scrutiny Committees.

4.00	RISK MANAGEMENT
4.01	The Annual Governance Statement lists all the significant governance issues arising from the self-assessment along with any outstanding 'red' (major) risks contained within the Council Plan 2018/19 end of year report. The Statement also describes actions taken against the governance issues reported in last year's Annual Governance Statement (2017/18).

5.00	APPENDICES
5.01	Appendix 1: Draft Annual Governance Statement 2018/19

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	Code of Corporate Governance 2018/19 **Contact Officer:** Karen Armstrong, Corporate Business and Communications Executive Officer **Telephone:** 01352 702740 **E-mail:** Karen.armstrong@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	**Corporate Governance:** the system by which local authorities direct and control their functions and relate to their communities. It is founded on the basic principles of openness and inclusivity, integrity and accountability together with the overarching concept of leadership. It is an inter-related system that brings together the underlying set of legislative requirements, governance principles and management processes. **Risk Management:** the process of identifying risks, evaluating their potential consequences and managing them. The aim is to reduce the frequency or likelihood of risk events occurring (wherever this is possible) and minimise the consequences if they occur. Opportunities are managed by identifying strategies to maximise the opportunity or reward for the organisation. **Financial Accounts / Statements:** The Council's annual finance report providing details of the Council's financial performance and position at the end of the financial year. The format is prescribed to enable external comparison with other public and private entities.

2018/19

Flintshire County Council – Annual Governance Statement

DRAFT V1.7

What is Governance?

"Governance is at the heart of public services. It underpins how resources are managed, how decisions are made, how services are delivered and the impact they have, now and in the future. It also infuses how organisations are led and how they interact with the public. Governance needs to be robust but it must also be proportionate. Well-governed organisations are dynamic and take well-managed risks; they are not stagnant and bureaucratic."[1]

The governance framework comprises the culture, values, systems and processes by which an organisation is directed and controlled. The framework brings together an underlying set of legislative requirements, good practice principles and management processes.

Flintshire County Council acknowledges its responsibility for ensuring that there is a sound system of governance. The Council has developed a Local Code of Corporate Governance that defines the principles that underpin the governance of the organisation. The Local Code forms part of the Council Constitution and can be accessed on the Council's website. A summary of the principles upon which it is based can be found later in this document.

The Council's governance framework supports its aim as a modern public body which has the **philosophy** of operating as a social business which refers to it:

- being lean, modern, efficient and effective
- being designed, organised and operated to meet the needs of communities and the customer; and
- working with its partners to achieve the highest possible standards of public service for the well-being of Flintshire as a County.

To meet these aspirations the Council has set the **standards** of:-

- achieving excellence in corporate governance and reputation.
- achieving excellence in performance against both our own targets and against those of high performing peer organisations.
- being modern and flexible, constantly adapting to provide the highest standards of public, customer, and client service and support.
- using its four resources - money, assets, people and information - strategically, effectively and efficiently.
- embracing and operating the leanest, least bureaucratic, efficient and effective business systems and processes.

[1] Wales Audit Office: "Discussion Paper: The governance challenges posed by indirectly provided, publicly funded services in Wales" 2017

To achieve these standards the Council's **behaviours** are:-

- showing strategic leadership both of the organisation and our partnerships.
- continuously challenging, reviewing, changing and modernising the way we do things.
- being as lean and un-bureaucratic as possible.
- using new technology to its maximum advantage.
- using flexible working to its maximum advantage.

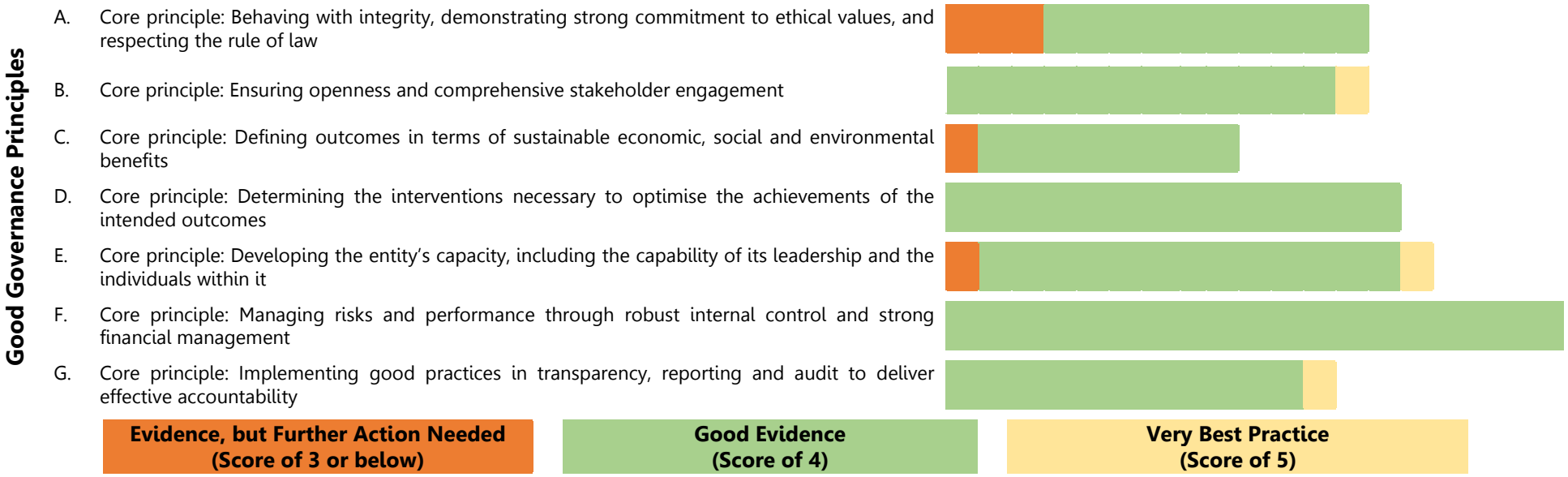
The Council is committed to the **principles** of being:-

- a modern, fair and caring employer.
- fair, equitable and inclusive in its policies and practices.
- conscientious in planning and managing its activities, and making decisions, in a sustainable way.

The Council is committed to specific values and principles in working with its key partners and partnerships. These cover strategic partnerships such as the Public Services Board and with the third sector such as agreeing a set of Voluntary Sector Funding principles.

In previous years the Council's Annual Governance Statement has covered the Clwyd Pension Fund. From 2018/19 the Clwyd Pension Fund will produce their own Annual Governance Statement which will be presented to the Clwyd Pension Fund Board for consideration and approval.

Dashboard : Effectiveness of the Council's Governance Framework



Annual Internal Audit Opinion 2018/19:

"For the year ending 31 March 2019, based on the work we have undertaken, my opinion is that Flintshire County Council has an adequate and effective framework of governance, risk management and control".

Internal Audit Manager, Flintshire County Council

Ares of Very Best Practice:

- Effective engagement external partners and board
- Corporate Governance and Regulatory Inspections
- Medium Term Financial Strategy Performance Management

What is the Annual Governance Statement?

The Council is required by the Accounts and Audit (Wales) Regulations 2018 to prepare a statement on internal control. Alongside many authorities in Wales, Flintshire refers to this as the 'Annual Governance Statement'. This is a public document that reports on the extent to which the Council complies with its own code of governance.

In this document the Council:

- acknowledges its responsibility for ensuring that there is a sound system of governance;
- summarises the key elements of the governance framework and the roles of those responsible for the development and maintenance of the governance environment;
- describes how the Council has monitored and evaluated the effectiveness of its governance arrangements in year, and on any planned changes in the coming period;
- provides details of how the Council has responded to any issue(s) identified in last year's governance statement; and
- reports on any significant governance issues identified from this review and provides a commitment to addressing them.

The annual governance statement reports on the governance framework that has been in place at Flintshire County Council for the financial year 2018/19 and up to the date of approval of the statement of accounts.

How has the Annual Governance Statement been prepared?

The initial review of the Council's governance framework was carried out by the Corporate Governance Working Group. This group prepared assessment questionnaires for each corporate Chief Officer and also for some specific governance functions such as finance, human resources and legal. The questionnaires were based on the seven principles that follow in the main part of this document and were assessed to identify any areas for improvement. Questionnaires were also completed by the Chairs of Overview and Scrutiny committees. In addition the Audit Committee undertakes a self-assessment of its own effectiveness which has also informed this work.

The preparation and content of this year's governance framework has been considered by the Chief Officer Team, with assurance support from Internal Audit, Audit Committee and External Audit (Wales Audit Office). The governance framework cannot eliminate all risk of failure to meet the targets in our policies, aims and objectives and can therefore only provide reasonable and not absolute assurance of effectiveness.

In preparing the Annual Governance Statement the Council has:

- reviewed the Council's existing governance arrangements against the local Code of Corporate Governance.
- updated the local Code of Corporate Governance where necessary, to reflect changes in the Council's governance arrangements and the requirements of the new CIPFA/Solace 2016 – Guidance Notes for Welsh Authorities.
- assessed the effectiveness of the Council's governance arrangements and highlighted any planned changes in the coming period.

The Chief Officer Team, which is led by the Chief Executive, have also considered the significant governance issues and principles facing the Council. These are evidenced in pages 6-12 of the document. Principles **highlighted in Green** reflect those which the Chief Officers assessed as being applied consistently well across the Council. Principles assessed as needing further improvement are detailed on pages 18-20.

The Council's Audit Committee, provides assurance to the Council on the effectiveness of its governance arrangements, risk management framework and internal control environment. As part of this role the Committee reviews and approves the Annual Governance Statement.

The six Overview & Scrutiny chairs have also considered and commented on issues within their respective committees' remit. They expressed general satisfaction with the Annual Governance Statement.

What are the key principles of the Corporate Governance Framework?

The Council aims to achieve good standard of governance by adhering the seven key principles of the new CIPFA/Solace 2016 – Guidance Notes for Welsh Authorities, which form the basis of the Local Code of Corporate Governance. The seven key principles are:

Principle A	Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law
Principle B	Ensuring openness and comprehensive stakeholder engagement
Principle C	Defining outcomes in terms of sustainable economic, social, and environmental benefits
Principle D	Determining the interventions necessary to optimise the achievement of the intended outcomes
Principle E	Developing the entity's capacity, including the capability of its leadership and the individuals within it
Principle F	Managing risks and performance through robust internal control and strong public financial management
Principle G	Implementing good practices in transparency, reporting, and audit to deliver effective accountability

Principle A

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

Sub Principles:

Behaving with Integrity

How we do this:

- The behaviour and expectations of Officers and Members are set out in the Council's Codes of Conduct, Constitution, and a suite of policies and procedures relating to Officers and Member induction, supervision, training and appraisals and leadership competencies.
- Case management both for Members and Officers.
- Codes of Conduct for Members and Officers specify the requirements around declarations of interests formally and at the beginning of meetings, gifts and hospitality etc.
- **The Council takes fraud seriously. Key policies are in place to prevent, minimise and manage such occurrences. Polices include:**
  - **Whistleblowing Policy**
  - **Anti-Fraud and Corruption Strategy**
  - **Fraud Response Plan**
  - **Financial and Contract Procedure Rules**
- Compliance with policies and protocols e.g. Contract Procedure Rules
- Enhanced profile of Internal Audit

Demonstrating strong commitment to ethical values

- A set of leadership competencies are deployed in each Portfolio and led by each Chief Officer.
- The Council's recruitment policy, training and competencies based appraisal processes underpin personal behaviours with ethical values.
- **Robust policies and procedures are in place, subject to formal approval prior to adoption by formal committees.**
- **All contracts and external service providers, including partnerships are engaged through the robust procurement process and follow the Contract Procedure rules regulations.**
- **Application of the corporate operating model; our way of being organised, working internally to promote high standards of professional performance and ethical behaviour to achieve**

Respecting the rule of law

- The Council ensures that statutory officers and other key officers and members fulfil legislative and regulatory requirements through a robust framework which includes: Scheme of delegation; induction, development and training of existing and new requirements; application of standing operating procedures; and engagement of early / external advice where applicable.
- **The full use of the Council powers are optimised by regular challenge and keeping abreast of new legislation to achieve corporate priorities and to benefit citizens, communities and other stakeholders e.g. alternative service models (ADM's)**
- Effective Anti-Fraud and Corruption framework supported by a suite of policies; any breaches are handled in accordance key legislative provision and guidance from appropriate bodies.
- **The Council's Monitoring Officer is responsible for ensuring the Council complies with the law and avoids maladministration. The Council's Constitution promotes high standards of conduct which is monitored by the Standards Committee.**
- Consistent application of risk assessments for both strategic, operational and partnership plans.

Green = Chief Officer assessed as being consistently well across the Council

Principle B

Ensuring openness and comprehensive stakeholder engagement

Sub Principles:

Openness

Engaging comprehensively with institutional stakeholders

Engaging stakeholders effectively, including individual citizens and service users

How we do this:

- **The Council is committed to having an open culture. This is demonstrated by:**
  - **Complaints and Compliments Procedure**
  - **Meetings are conducted in an open environment**
  - **Council's website**
- **The most appropriate and effective interventions / courses of action are determined using formal and informal consultation and engagement supported by:**
  - **Public consultation around the Medium Term, Financial Strategy (MTFS)**
  - **Consultation principles, e.g. School Modernisation Programme**
  - **Formal and informal engagement models with employee and communities e.g. alternative delivery models Member workshops**
  - **County Forum (Town and Community Councils)**
  - **Positive engagement with Trade Unions both formally and informally**

- **The Council effectively engages with stakeholders to ensure successful and sustainable outcomes by:**
  - **Effective application and delivery of communication strategies to support delivery**
  - **Targeting communications and effective use of Social Media**
  - **Formal and Informal meetings with key stakeholder groups**
  - **Effective stakeholder engagement on strategic issues**
  - **Service led feedback questionnaires and events**
- **Effective use of resources and achievement of outcomes is undertaken by the Council both through informal and formal partnerships:**
  - **Extensive range of partnerships to support the delivery of the Council's strategic priorities, including the Public Services Board**
  - **Open and productive partnership arrangements supported by an effective governance framework**
  - **Trust and good relations lead to delivery of intended outcomes e.g. community asset transfers**
  - **Partner representation at Scrutiny committees**

- The achievement of intended outcomes by services is supported by a range of meaningful guidance on consultation engagement and feedback techniques with individual citizens, service users and other stakeholders. This includes:
  - Range of customer channels
  - Undertaking Impact assessments
  - Results from satisfaction surveys to enhance service delivery where applicable
  - Complaints reviewed to assess organisational learning and change
  - Sharing soft intelligence and good practice
  - Committee reports portray all relevant feedback
  - **Services are assessed for value for money and opportunities for efficiencies**
  - **Taking account of the interests of future generations of tax payers and service users**
- The Council has appropriate structures in place to encourage public participation governed through the Communication and Social Media Policies. These include:
  - E-newsletters
  - The Council's website
  - Tenants Forums
  - Service user groups
  - Quality circles
  - Use of infographics

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Principle C

Defining outcomes in terms of sustainable economic, social, and environmental benefits

Sub Principles:

Defining outcomes

Sustainable economic, social and environmental benefits

How we do this

- **The Council has a clear vision describing the organisation's purpose and intended outcomes which is achieved through:**
  - **Linking of vision and intent to the MTFS which links to the Council Plan, Portfolio Business Plans and other plans and strategies with a focus on priorities for change and improvement**
  - **Organisational objectives are delivered through Programme Boards and political decision making processes**
  - Service Planning consideration including sustainability of service delivery

- Risk Management is applied consistently at project, partnership and business plan levels using the corporate performance system (CAMMS) which adheres to the Risk Management Policy and Strategy and ensures consistent application of risk registers and terminology.

- **Risk appetite is also considered whilst developing future scenarios and options with key staff.**

- The development of the County's Well-being Plan and delivery of the Public Services Board's priorities ensure that public services work effectively together to add value.

- The Council takes a longer term view and balances the economic, social and environmental impact of policies, plans etc. along with the wider public interest when taking decisions about service provision. This is supported by a range of governance approaches:
  - **Budget setting of the Capital Programme and MTFS and longer term business planning through the use of effective forecasting models**
  - **Setting longer term objectives regardless of political term**
  - **Delivering defined outcomes**
  - **Multi-disciplinary approach to policy development and wider public interest of economic, social and environment issues e.g. Welfare Reform, Corporate Safeguarding**
  - **Ensuring fair access to services**
  - Procurement strategy defines expectations around economic, social and environment benefits which inform service specifications, tenders and contracts.
  - Communication plans for public and community engagement
  - Clear documented record of route to change

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Principle D

Determining the interventions necessary to optimise the achievement of the intended outcomes

Sub Principles:

Determining interventions	Planning interventions	Optimising achievement of intended outcomes

How we do this

Determining interventions

- Good judgement in making decisions is achieved by ensuring decision makers receive objective and rigorous analysis of information and options to achieve intended outcomes including the related risks. This is achieved by:
  - **Full engagement with members on a longer term basis e.g. MTFS and Business Plans**
  - **Delivery of the MTFS and revenue and capital budget setting process providing options for the public, stakeholders and members to be engaged to consider modifications**
  - Development of forecasting models
  - Active engagement of key decision making in the development of initial ideas, options and potential outcomes and risks e.g. ADM Programme, Gateways
  - **Clear option appraisals detailing impacts, savings and risks to ensure best value is achieved**
  - Budget monitoring for each Portfolio and corporate considerations
  - **Managing expectation for key stakeholders**
  - Other key workforce strategies e.g. digital and procurement
  - Application of Impact Assessments

Planning interventions

- The Council has established and implemented robust planning and control cycles covering strategic and business plans, priorities, targets, capacity and impact. This is achieved through:
  - Co-design of service solutions with key stakeholders
  - **Application of risk management principles when working in partnership and collaboratively and the active use of risk registers**
  - **Regular monitoring of business planning, efficiency and reliability including feedback on business planning model**
- **Service performance is measured through national performance indicators and establishing a range of local indicators, which are regularly monitored, reported and used for benchmarking purposes**
- **Robust and inclusive methodologies are in place to formulate the MTFS which is an integral part of the Council's governance framework and Portfolio Business plans are linked to the Council Plan**

Optimising achievement of intended outcomes

- Resource requirements for the services are identified through the business planning process and detailed within the MTFPs highlighting any shortfall in resources and spending requirements.
- **To ensure the budget process is all-inclusive, taking into account the full cost of the operations over the medium and longer term, regular engagement and ownership of the budget through the Chief Officer Team and consultation with members through workshops and robust scrutiny process is undertaken.**
- Social values are achieved through the effective commissioning of services and compliance with Council procedures.
- Consultation and engagement around the content of the MTFS through public and employee events sets the context for residents and employees. In particular relating to ongoing decisions on significant delivery issues or responses to changes in the external environment

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Principle E

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

Sub Principles:

Developing the entity's capacity

How we do this:

- **We review our operations, performance, and use of assets on a regular basis to ensure their continuing effectiveness by:**
  - **Review of service delivery, performance and risks through team meetings and quarterly formal reporting,**
  - **Programme boards' development and monitoring**
- **The Council reviews the sufficiency and appropriates of resource allocation through techniques such as:**
  - **Benchmarking both internal and external review undertaken to identify improvements in resource allocation, including the use of national and local PIs**
  - **Internal challenge**
- **Benefits of collaborative and partnership working both regionally and nationally to ensure added value is achieved by linking services and organisation priorities to partnership working**
- Develop and maintain the workforce plan to enhance the strategic allocation of resources through the publication of regular workforce data reports and drawing intelligence from supervision and appraisal meetings.
- Future workforce and succession planning is undertaken in each portfolio to identify future workforce capability and progression.

Developing the capability of the entity's leadership and other individuals

- **Effective shared leadership which enables the Council to respond successfully to changing external demands and risks is supported by:**
  - **a range of management and leadership development programme, run in partnership with Coleg Cambria**
  - **'Development workforce' and 'leadership capacity' and 'managing performance' are two of the five priorities within the People Strategy 2016-2019**
  - **The Leader and the Chief Executive have clearly defined and distinct leadership roles**
- Individual and organisational requirements are supported through:
  - Corporate induction for new employees to the Council
  - Inductions for employees in new jobs
  - Continued learning and development for employees identified through the competency based appraisal system and one to one meetings
  - **A comprehensive range of training and development opportunities available, in partnership with Coleg Cambria and professional bodies.**
  - **Feedback and shared learning to the organisations both through reports and interactive sessions such as the 'Academi'**
- **To support and maintain the physical and mental wellbeing of the workforce a range of interventions is provided including: Occupational Health Service, Signposting employees and Members to Care First (independent Counselling support), Management Awareness and Support, internal training and awareness sessions to support stress related absences**

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Principle F

Managing risks and performance through robust internal control and strong public financial management

Sub Principles:

Managing risk	Managing performance	Robust internal control	Managing data	Strong public financial management

How we do this:

Managing risk

- Risk Management is an integral part of all activities and decision making through:
  - **Application of risk management policy and strategy**
  - Identification of all risks and appropriate mitigations and transitional plans reported to Committees
  - **Clear allocation of management for risk responsibility with oversight by senior management and chief officers**
  - **Assurance by Internal Audit and Audit Committee**
  - Established the Chair and Vice Chair Liaison Group

Managing performance

- **Members and senior management are provided with regular reports on service performance against key performance indicators and milestones against intended outcomes**
- **Members are clearly and regularly informed of the financial position and implications including environmental and resource impacts**

Robust internal control

- **Internal Audit provide the authority, through the Audit Committee, with an annual independent and objective opinion on the adequacy and effectiveness of the Council's internal control, risk management, governance arrangements and associated policies.**
- The Council is dedicated to tackling Council detailed within the Anti-Fraud and Corruption Strategy, Fraud Response Plan, and Whistleblowing Policy

Managing data

- **The Council has effective strategic direction, advice and monitoring of information management with clear policies and procedures on personal data and provides regular training to ensure compliance with these.**
- The Council requires Information Sharing Protocols to be in place in respect for all information shared with other bodies.
- **The quality and accuracy of data used for decision making and performance monitoring is supported by a guidance from a range professional bodies.**
- **Internal Audit review and audit regularly the quality and accuracy of data used in decision making and performance monitoring.**

Strong public financial management

- **The authority's financial management arrangements support both the long term achievement of outcome and short term financial performance through the delivery of the MTFS**
- Setting a prudent Minimum Revenue Provision for the repayment of debt
- The integration of all financial management and control is currently being reviewed as part of the finance modernisation project.

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Principle G

Implementing good practices in transparency, reporting, and audit to deliver effective accountability

Sub Principles:

Implementing good practice in transparency

Implementing good practices in reporting

Assurance and effective accountability

How we do this:

- The Council has recently improved the layout and presentation of its reports in order to improve the presentation of key information to decision-makers.
- The Council is mindful of providing the right amount of information to ensure transparency.
- A review of information sharing protocols has been undertaken and new principles adopted.

- **The Council reports at least annually on the achievement and progress of its intended outcomes and financial position. This is delivered through the:**
  - **Annual Performance report assessing performance against the Council Plan**
  - **Annual Statement of Accounts demonstrate how the Council has achieved performance, value for money and the stewardship of its resources**
  - **Progress against the Well-being Plan**
- **The Annual Governance Statement is published following robust and rigorous challenge to assess and demonstrate good governance.**

- Through robust assurance mechanisms the Council can demonstrate effective accountability. These mechanisms include:
  - **Internal Audit undertakes independent reviews to provide an annual assurance opinion of the Council's control, risk management, and governance framework. To allow this Internal Audit has direct access to Chief Officer and members of the Council.**
  - **All agreed actions from Internal Audit reviews are monitored regularly with reports to Chief Officers monthly and each Audit Committee.**
  - **Any 'limited/red' assurance opinion are reported to Audit Committee in full and progress monitored closely**
  - **Peer challenge and inspection from regulatory bodies and external compliance reviews. The outcomes from these inspections are used to inform and improve service delivery**
  - Through effective commissioning and monitoring arrangements and compliance with Council's procedures, the Council gains assurance on risk associated with delivering services through third parties and any transitional risks.
  - Reports are presented to Cabinet and an annual report to Audit Committee of external feedback

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Contributors to an effective Governance Framework

Council	– Approves the Council Plan – Endorses the Constitution – Approves the policy and financial frameworks
Cabinet	– Primary decision making body of the Council – Comprises of the Leader of the Council and Cabinet members who have responsibility for specific portfolios
Audit Committee	– Help raise the profile of internal control, risk management and financial reporting issues within the Council, as well as providing a forum for the discussion of issues raised by internal and external auditors
Standards & Constitution & Democratic Services Committee	– Standards Committee promotes high standards of conduct by elected and co-opted members and monitors the operation of the Members' Code of conduct. – Constitution & Democratic Services Committee considers and proposes changes to the Constitution and the Code of Corporate Governance.
Portfolio Programme Boards	– Track efficiencies, highlighting risk and mitigating actions to achievement – Consider the robustness of efficiency planning and forecasting and consider resourcing of planned delivery – Plan communication and engagement activity
Overview & Scrutiny Committees	– Review and scrutinise the decisions and performance of Council, Cabinet, and Committees – Review and scrutinise the decisions and performance of other public bodies including partnerships – Assists the Council and Cabinet in the development of the Budget and Policy framework by in-depth analysis of policy issues. – Established the Chair/Vice Chair Liaison Group
Chief Officers Team & Service Managers	– Set governance standards – Lead and apply governance standards across portfolios – Undertake annual self-assessment
Internal Audit	– Provide an annual independent and objective opinion on the adequacy and effectiveness of internal control, risk management and governance arrangements – Investigates fraud and irregularity

How does Flintshire Council monitor and evaluate the effectiveness of its governance arrangements?

The Council annually reviews the effectiveness of its governance framework including the system of internal control. The key elements of assurance that inform this governance review are detailed below:

Chief Officers Team

- Corporate oversight and strategic planning
- Annual Corporate Governance Assessment
- Implement and monitor regulatory and other governance protocols

Monitoring Officer

- Legal and regulatory assurance
- Monitors the operation of the Constitution
- Ombudsman investigations

Section 151 Officer

- Proper administration of the Council's financial affairs

Information Governance

- Designated Senior Information Risk Owner (SIRO)
- Data Protection procedures including GDPR
- Information Security & Records Management procedures

Internal Audit

- Annual opinion report on adequacy of internal controls, risk management and governance arrangements
- Internal Audit plan and report tracking / performance by Audit Committee
- Provision of advice & consultancy
- Undertake Investigation and proactive Fraud work

Overview & Scrutiny

- Policy review and challenge
- Overview & scrutiny of topics
- Corporate & Portfolio Performance & Risk monitoring

Audit Committee

- Self-assessment of Audit Committee
- Review effectiveness of internal and external audit
- Consider the adequacy of the internal control, risk management and Governance arrangements

Risk Management

- Risk Management Policy and Strategy
- Quarterly monitoring and reporting of Strategic Risks

External Audit / Inspections

- Financial statements audit
- Thematic & national reviews
- Other external inspections

Counter Fraud

- Anti-Fraud and Corruption & Whistleblowing arrangements
- Codes of Conduct for Officers and Members
- Financial and Contract Procedure Rules

How has the Council addressed the governance and strategic issues from 2017/18?

The 2017/18 Annual Governance Statement contained 14 key improvement areas as i) Internal Council Governance issues – those derived from the portfolio, Overview and Scrutiny and Audit Committee annual self-assessments that affect the internal governance arrangements of the Council; and, ii) Strategic Council Plan issues – those that were identified as part of the Council Plan for 2017/18 which remained un-mitigated i.e. a 'Red' risk status.

The issues and how they were addressed are below:

(i) Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
Views and experiences of citizens, service users and organisations of different backgrounds including reference to future needs are taken into account.	• Service planning does not take into account service user's needs in the future. • Legal and or judicial challenges. • Lack of effective feedback mechanisms to inform stakeholders how their views have been taken into account: stakeholders remain uninformed and less likely to support service change. • Lack of structures to encourage public	• Development of an integrated impact assessment approach to inform budget decisions and longer term sustainability of services. • Communication strategies developed and actioned for all major decisions affecting the public. • Ensure that effective feedback mechanisms are built into communication strategies, taking into account the diversity of	Integrated impact assessments (IIA) now developed and used to inform 2018/19 business planning. CAMMS system been updated with IAA for all relevant efficiency projects and policies; process to be fully operational from May 2019. Although the Council has policies and procedures to ensure the lawfulness of its decisions the potential for legal and judicial challenges remain an ongoing risk to the authority. Communication strategies have been developed for policy change and other major decisions affecting the public, including feedback mechanisms.	Open Integrated Impact Assessment needs to be consistently embedded within business planning. Integrated Impact Assessment process has been developed and has been used manually. Full conversion to digital system tested. New refined reporting process to better capture 'Impact' risks to be trialled from June. Communication strategies have been developed, but need to

(i) Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
	participation	communication methods.		be consistently applied.
Identifying and managing risks to the achievement of outcomes.	• Risks are not mitigated during transitional or implementation phases. • Outcomes are under-achieved.	• Consistent application of the Council's risk management approach across all strategic, operational and partnership working.	Risks are well managed during transitional and implementation phases. An implementation template has been developed to track implementations and associated risks. Early indications identify that risks are well managed throughout all phases of strategic delivery. Outcomes have been achieved as demonstrated by regular performance monitoring. The Council's Risk Management Policy and Strategy has been reviewed to reflect consistency of approach across all strategic, operational and partnership working.	Open Risks managed well in practice and Policy and Strategy been updated including escalation protocol; however, not yet consistently embedded. New risk register approach for management oversight been developed for regular monitoring.
Ensuring capacity exists to generate the information required to review service quality regularly.	• Reduction in service quality. • Inability to benchmark and compare service quality.	• Ensure that service reform, succession and workforce planning takes into account information requirements.	Services review where benchmarking is going to improve information to inform service quality. The Council has corporate membership of APSE Performance Networks and other benchmarking bodies providing the opportunity for a high number of services to	Open Improvements made during 2018/19. However, risk to be kept open for further improvement.

(i) Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
			benchmark.	
Developing and maintaining an effective workforce plan to enhance strategic allocation of resources.	• Sustainability of service provision. • Ineffective allocation of resources. • Reputational damage following reduction in quality of service.	• Workforce planning for senior levels within each portfolio assessing workforce demographics, changing requirements and market demand. • Development of a succession plan, identifying areas of talent and additional support for growth and continued service delivery.	Comprehensive workforce planning continues to be carried out across the authority. The risk to the sustainability of service provision remains moderate.	Open Improvements made during 2018/19. However, risk to be kept open for further improvement.
Effective arrangements for safe collection, storage, use and sharing data.	• Legal challenge and fines. • Personal confidentiality breached.	• Provision of clear guidelines, awareness and appropriate training. • Oversee and supervision of arrangements by managers.	Policies and procedures remain in place covering all aspects of data protection. These have been reviewed as part of the implementation of the General Data Protection Regulation (GDPR) From May 2019 the financial penalties increased to 20 million Euros and data subjects can seek compensation. Despite mitigation the risk of legal challenges and fines relating to a breach of data protection remains a risk for the Council.	Open Significant progress has been made in developing protocols etc and in monitoring arrangements. Needs to remain open as insufficient evidence that all is embedded consistently across all portfolios.

(i) Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
Performance management: (Identified by Overview and Scrutiny Committee chair).	• Council's approach to performance management and monitoring is not fully understood; leading to ineffective challenge and scrutiny.	• Member workshop: understanding the Council's performance management approach and supporting systems.	A workshop explaining the Council Plan and it's measures in relation to performance management was held in 2018.	Open Additional workshops focussing on the Council Plan 2019/20 and performance management to be held during 2019.
Agreed actions within the Red / limited (4) assurance Internal Audit reports are implemented.	• Failure to address control and governance issues identified as part of the audit work undertaken.	• Detailed action plans in place to address the findings, including the establishment of a joint audit and scrutiny liaison group.	Joint Audit and Scrutiny Liaison Group established.	Open Liaison group in early stages; further development needed to secure outcomes.

(ii) Strategic Issues from the 2017/18 Council Plan	Risk	Mitigation	Management Comment	Current Status
Supportive Council: Availability of sufficient funding to resource key priorities – with particular reference to Disabled Facilities Grants (DFGs).	• Demand for DFGs and adaptations are not met due to budget availability. • DFGs are not delivered in a timely manner; under-performance nationally.	• Response to Internal Audit recommendations to improve processes.	Oversight Board established to review and monitor progress. Improvements in process and timeliness evidenced in last half of the year.	Open Ensure improvements continue during 2019/20.
Supportive Council: Demand outstrips supply for residential and nursing home care bed availability.	• Lack of residential and nursing home care bed availability leading to more hospital stays. • Increased stress on carers. • Primary care resources stretched further.	• Expansion of Marleyfield to support the medium term development of the nursing sector is ongoing. • Re-phasing of Integrated Care Fund capital to fit in with the Council's capital programme has been agreed by Welsh Government. • Other active workstreams, including the development of resources to support the sector, diagnostic reviews for providers and Care Conferences.	The expansion of Marleyfield to support the medium term development of the nursing sector continues under the direction of the Programme Board. A review for Programme Board of demand and supply in light of the new capital developments has been undertaken.	Open Risk rating continued to be high throughout the year.
Supportive Council: • Knowledge and awareness of safeguarding not	• Lack of optimisation of using the Council's resources and workforce to support safeguarding.	• Inclusion of safeguarding in Corporate Induction. • Employee training opportunities provided on	Safeguarding e-learning model is to be implemented during 2019. Additional training has been made available to the	Closed Risk rating has reduced

(ii) Strategic Issues from the 2017/18 Council Plan	Risk	Mitigation	Management Comment	Current Status
sufficiently developed in all portfolios. • Failure to implement safeguarding training may impact on cases not being recognised at an early stage.		a regular basis. • Mentor support provided by senior managers and link officers.	Safeguarding Panel. Periodic Safeguarding bulletins are published alongside regular workforce news items.	following the implementation of the mitigating actions.
Learning Council: Numbers of school places not matching the changing demographics.	• Unfilled school places do not meet national targets. • Increased repair and maintenance burden.	• School modernisation programme. • Council and schools work to consider innovative ways for reduction in capacity.	Reducing unfilled school places via school organisation change is an ongoing process. School change projects can take between three and five years from inception to delivery before reductions of unfilled places can be realised. This continues to be an ongoing process linked to the school modernisation programme.	Closed Risk level reduced from 'red' due to progression of the school modernisation programme.
Learning Council: Limited funding to address the backlog of known repair and maintenance work in Education and Youth assets.	Fabric of Education and Youth buildings will continue to decline leading to an increase in health and safety issues and imbalance between surplus and unfilled places.	• Condition surveys continue to identify priorities for investment. • Implement County Policy for School re-organisation and modernisation.	The School Modernisation Programme is one of the strategic options to address the repairs and maintenance backlog. Capital business cases for improvement and repair and maintenance projects in schools are considered through the Council's business case process.	Open This continues to be a financial risk to support the school infrastructure.

(ii) Strategic Issues from the 2017/18 Council Plan	Risk	Mitigation	Management Comment	Current Status
Learning Council: Sustainability of funding streams.	Reductions to Education Improvement Grant and other grants at short notice lead to reduced service delivery, when demand for pupil support is increasing.	• Collective working with Head Federations to consider options and opportunities. • Internal and external campaigning for a reversal of WG policy.	Was a live and significant risk to grant funding for education at the start of the year. Some of the areas of concern included: • Clarity of Teachers' Pay Award for 19/20. • Teachers' employers' pensions cost. • MEAG (Minority Ethnic Achievement Grant).	Closed Confirmation of funding streams during the year has reduced this risk.
Green Council: Funding will not be secured for priority flood alleviation schemes.	Flood alleviation schemes will not be delivered leading to increased risks of damage to infrastructure and community disturbance.	Review our approach to funding capital projects.	Flintshire's local risk management strategy contains an action to 'identify projects and programmes that are affordable, maximising capital funding from internal and external sources'. A service review is intended to create a more effective approach / structure that balances the ability to secure funding for flood elevation works with the delivery of statutory duties under the flood and water management act.	Open New Strategic Urban Drainage Scheme (SUDS) legislation needs to be implemented. Due to increase pressure of statutory duties the status of risks still lie within the red RAG rating.

(ii) Strategic Issues from the 2017/18 Council Plan	Risk	Mitigation	Management Comment	Current Status
Green Council: Adverse weather conditions on the highway network.	• Road conditions across the Council are adversely affected.	• Resurfacing and permanent patching schemes prioritised for summer period. • Timely responses to repair network as defects identified.	The previous year's increase in risk has been mitigated by a number of schemes of works that have been undertaken to improve the condition of the carriageway overall. Repairing the Council's roads is a priority for the service and resources were provided to identify and then prioritise the roads in need of repair.	Closed Planned maintenance works during the year have reduced the significance of this risk.
Serving Council: The scale of the financial challenge.	The Council has insufficient funding to meet its priorities and obligations.	• The Council's Medium Term Financial Strategy and efficiency programme. • National negotiations on local government funding.	The Council's budget setting process and management of the Medium Term Financial Strategy enabled the Council to set a balanced budget for 2019/20. The future of Council funding however, remains uncertain.	Open The initial forecast for 2019/20 was considered by Cabinet in April 2019 and will continue to be closely monitored.

Those risks closed are shown in blue text

What are the significant governance and strategic issues identified during 2018/19?

The review of the effectiveness of the Council's governance framework has identified the following significant issues that will need to be addressed during 2019/20. These are categorised as:

i) Internal Council Governance issues – those derived from the portfolio, Overview and Scrutiny and Audit Committee annual self-assessments that affect the internal governance arrangements of the Council.

NOTE: Issues marked * have been retained as high profile for further work, even though the risk score was 3 or above.

Issues marked # show risk issues which have increased in risk significance, even though they still retained a score of 3 or above

ii) Strategic Council Plan issues – those that have been identified as part of the Council Plan for 2018/19 which remain un-mitigated i.e. a 'Red' risk status.

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
(A1,A2,A3) Behaving with integrity. # (E54) Developing the capability of the entity's leadership and other individuals – developing protocols to ensure that elected and appointed leaders negotiate their respective roles early on in the relationship and that a shared understanding of roles and objectives is maintained. #	• Protecting the reputation of the Council. • Members not leading by example on the values for the organisation.	• Refresh training and advice. • Sustained work with Group Leaders and the Chair of the Council. • The Council has approved the Flintshire Standard which sets expectations about behaviour. • The Council regularly sends members on the WLGA Leadership Programme which will explain the roles of elected members and officers. • There is a process of induction for councillors who are new to positions of responsibility within the council (e.g. committee chair or

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
		cabinet member). This explains the remits of elected councillors and officers. • Council procedures further reinforce the respective roles.
(A8) Demonstrating strong commitment to ethical values. #	• Under realisation of external service providers to provide social value benefits that communities can gain from.	• Review of expectations of external providers, both voluntary and contractual, as part of the implementation of a new Social Value Strategy (endorsed Cabinet March 2019). • Initial focus is to generate social value through procurement.
(B23,24,25) Engaging stakeholder effectively, including individuals citizens and service users. * (E61) Developing the capability of the entity's leadership and other individuals – ensure that there are structures in place to encourage public participation. * (F69) Managing performance – making decisions based on relevant, clear objective analysis and advice pointing out the implications and risks inherent in the organisation's financial, social and environmental position and outlook. *	• Ensuring that impacts, both negative and positive are fully understood when making Council decisions. • Public participation is not built into consultation and communication strategies, leading to mis-communication and difficulties in implementing change.	• Template and guidance for all committee reports to ensure that both communications and risk are comprehensively considered and reported on as part of the Integrated Impact Assessment. captures Specific issues which may be of consequence for protected groups and other issues of impact need to be considered and captured. • New format for reporting to be introduced Summer 2019. • Increased use of tools such as Gov. Delivery and Customer Accounts.

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
(C27,29) Defining outcomes in terms of sustainable economic, social and environmental benefits. #	• Expectations of delivery in accordance with the Future Generations and Wellbeing Act have been raised. • Service planning does not take into account service user's needs in the future. • Legal and or judicial challenges.	• Part of the review of the Council Plan 2019/20 and the review of the current set of Well-Being Objectives (both due to be reported in June/July 2019). • Reflect within provisions made in the Medium Term Financial Strategy.
(C30,31) Defining outcomes – identifying and managing risks to the achievement of outcomes and making best use of the resources available. *	• Risk management not fully related to the achievements of all that we do. • Inconsistent application of the risk management strategy across all portfolios. • Risks are not mitigated during transitional or implementation phases. • Outcomes are under-achieved.	• Improvement still needed in this area to ensure that risk management is related fully and comprehensively to the achievement of outcomes in all that we do. • Ensure that within the new risk register that arrangements are in place to risk assess the achievement of outcomes.
(D38,39) Planning interventions - establishing and implementing robust planning and control cycles that cover strategic and operational plans, priorities and targets. * Planning interventions – Engaging with internal and external stakeholders in determining how services and other interventions can best be delivered. *	• Inconsistent application of planning methodologies to ensure effective delivery of outcomes. • Ensuring that impacts, both negative and positive are fully understood when making Council decisions. • Lack of effective feedback mechanisms to inform stakeholders how their views have been taken into account: stakeholders remain uninformed and less likely to support service change. • Lack of structures to encourage public participation.	• Provide and apply a comprehensive set of tools and guidance to ensure that strategic and operational plans are maintained to inform other strategies such as the MTFS.

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
(D43) Planning interventions – Ensuring capacity exists to generate the information required to review service quality regularly. *	• Lack of appropriate information to inform service quality and policy decisions.	• Review of the information available to inform service quality, as part of the Members' Workshop on Performance Management.
(E53) Developing the entity's capacity – Developing and maintaining an effective workforce plan to enhance strategic allocation of resources. *	• Sustainability of service provision. • Ineffective allocation of resources. • Reputational damage following reduction in quality of service.	• Whilst the Council already has individual Portfolio workforce plans, these need to be consolidated into one Council workforce plan in accordance with the People Strategy.
(E58) Developing the capability of the entity's leadership and other individuals – Ensuring employees have access to appropriate induction, with ongoing training and development matching individual and organisational requirements is available and encouraged. *	• Employees unable to carry out their roles effectively following recruitment. • Employees not provided with the values and objectives of the organisation. • Changes to policies, technologies, practices, legislation not understood; leading to inefficiency and under productivity.	• Ensure that Induction sessions are a carried out in a timely fashion and that all new employees attend. • Introduce monitoring of the corporate induction process as a quarterly report to CRO&SC and Cabinet to monitor effectiveness and ensure compliance.
(E64) Developing the capability of the entity's leadership and other individuals – Ensuring arrangements are in place to maintain the health and wellbeing of the workforce and support individuals in maintaining their own physical and mental wellbeing. *	• Resilience of workforce is impacted by capacity and changing demands.	• Next stage of development of the Mental Health and Wellbeing Plan for the workforce as one of the commitments within the People Strategy.

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
(F68,F69) Managing performance – Monitoring service delivery effectively including planning, specification, execution and independent post implementation review. *	• Outcomes following implementation may not have been delivered. • Lessons not learned nor shared.	• Inclusion of post implementation reviews in Scrutiny Forward Work Programmes. • Work with Scrutiny Chairs and vice-chairs and the Liaison Group to ensure that risks and performance are 'cornerstone' items of O&S FWPs. • Ensure risks are adequately covered in committee reports. • Brief committees on risk issues using half hour slots before meetings where necessary.
(F71) Managing performance – Providing members and senior management with regular reports on service delivery and on progress towards outcome achievement. *	• Lack of timeliness of reporting leading to out of date information upon which to make decisions / assess risks.	• Continue with Council Plan reporting on historical factual information within 2 months of the quarterly period, but with current updates contained within the report. • Use of the most up to date data to inform reports for decision making. • Members to be involved in what is valuable to be measured within portfolios (Performance Management workshop).
(F78) Managing Data – Ensuring effective arrangements are in place for the safe collection, storage, use and sharing of data, including processes to ensure the security of personal data used. *	• Legal challenge and fines. • Personal confidentiality breached.	• Continue with monitoring processes and procedures set out for compliance with GDPR, until evidence that consistent approaches are being undertaken in each portfolio.

i) Internal Council Governance issues for 2018/19	Risk	Mitigation
Agreed actions within the Red / limited (2) assurance Internal Audit reports are implemented.	• Failure to address control and governance issues identified as part of the audit work undertaken.	• Detailed actions plan in place to address the finding.

ii) Strategic Issues from the 2018/19 Council Plan	Risk	Mitigation
Supportive Council Debt levels will rise if tenants are unable to afford to pay their rent or council tax.	• Council will not recover income to offset costs. • Tenants will fall into more categories of debt. • Potential rise in homelessness presentations.	• Early intervention for tenants claiming Universal Credit to tackle rent arrears and encourage payment of rent. • Avoid new or escalating arrears to ensure that homelessness is prevented where possible.
Supportive Council Demand outstrips supply for residential and nursing home care bed availability.	• Lack of residential and nursing home care bed availability leading to more hospital stays. • Increased stress on carers. • Primary care resources stretched further .	• Expansion of Marleyfield to support the medium term development of the nursing sector is ongoing. • Re-phasing of Integrated Care Fund capital to fit in with the Council's capital programme has been agreed by Welsh Government. • Other active workstreams, including the development of resources to support the sector, diagnostic reviews for providers and Care Conferences.

ii) Strategic Issues from the 2018/19 Council Plan	Risk	Mitigation
Learning Council Limited funding to address the backlog of known repair and maintenance works in Education & Youth assets.	• The fabric of Education and Youth buildings will continue to decline.	• Condition surveys identify priorities for investment. County policy for school re-organisation.
Green Council Funding will not be secured for priority flood alleviation schemes.	• Inability to secure the WG grant funding and/or FCC capital funding necessary to deliver priority flood alleviation schemes.	• Review our approach to funding capital projects.
Serving Council The scale of the financial challenge.	• Reduction in funding of Revenue Support Grant leading to challenging financial position for the Council in its ability to set a balanced budget.	• The Medium Term Financial Strategy (MTFS) continues to be reviewed to forecast the financial resources to be available to the Council during the period based on the best available intelligence and identification of solutions available. • National and local solutions for addressing the budget gap continue to be explored.

Certification

The review provides good overall assurance that Flintshire County Council's arrangements continue to be regarded as fit for purpose in accordance with the governance framework requirements for Local Authorities within Wales.

Opportunities to maintain and develop the Council's governance arrangements have been identified through this review. We pledge our commitment to addressing these issues over the coming year and we will monitor their implementation and operation as part of our next annual review.

Signed on behalf of Flintshire County Council

Colin Everett – Chief Executive

Cllr. Ian B Roberts – Leader of the Council

Flintshire County Council Corporate Governance Framework
Principal Statutory Obligations and Organisational Objectives

Behaving with integrity, demonstrating strong commitment to ethical values & respecting the rule of the Law	Ensuring Openness & Comprehensive Stakeholder Engagement	Defining Outcomes in terms of Sustainable Economic, Social & Environmental Benefits	Determining the Interventions to optimise the achievements of the intended outcomes
Developing the Council's capacity, including capability of its leadership & individuals within it	Managing risks & performance through robust internal control & strong financial management	Implementing good practices in transparency, reporting & audit to deliver effective accountability	Assurance Statement

Corporate Governance comprises the systems and processes, cultures and values, by which Flintshire County Council are directed and controlled and through which they account to, engage with and, where appropriate, lead their communities

Public Key Documents: Annual Review / Production

- Annual Governance Statement
- Annual Outturn Finance Report
- Annual Performance Report
- Annual Information Governance Statement
- Capital Strategy and Asset Management Plan
- Code of Corporate Governance
- Code of Ethical Practice on Procurement
- Contract Procedure Rules
- Digital Strategy
- Financial Regulations
- Council Plan
- Medium Term Financial Strategy
- Members' Allowance Scheme
- Overview and Scrutiny Annual Report
- People Strategy
- Portfolio Business Plans
- Public Services Board Wellbeing Plan
- Statement of Accounts
- Strategic Equality Plan
- Strategic Risk Register
- Treasury Management Strategy
- Annual Audit Report

Key Documents: Ad-hoc Review / Production

- Anti-Fraud Work plan
- Business Continuity Plans
- Communications Principles
- Constitution
- Data Protection Policy
- Equality and Diversity Policies
- HR Policies
- Health & Safety Policies
- Internal/External Audit Protocol
- IT Policies
- Members Code of Conduct
- Officers Code of Conduct
- Procurement Strategy
- Social Media Policy
- Welsh Language Standards
- Whistle Blowing Policy

Contributing Processes Regulatory Monitoring

- Appraisal and Supervision
- Attendance management
- Audit Committee
- Budget Monitoring Reports
- Comments, Complaints and Compliments
- Corporate Governance
- Corporate Health & Safety
- Council (Plan) Governance Framework
- Council Meetings
- Engagement and Consultation
- External Audit
- FCC Web site
- Induction
- Inspectorate Reports
- Internal Audit
- Job Descriptions
- Manager Toolkits
- Member Training
- Monitoring Officer
- Partnership Self Assessments
- Performance Management
- Risk Management
- Scrutiny Framework
- Staff induction
- Your Council newsletter

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday, 5th June 2019
Report Subject	Internal Audit Annual Report
Report Author	Internal Audit Manager
Type of Report	Assurance

EXECUTIVE SUMMARY

The Internal Audit Manager is required to deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement.

The annual report must incorporate:

- The opinion;
- A summary of the work that supports the opinion; and
- A statement on conformance with the Public Sector Internal Audit Standards (PSIAS), and the results of the quality assurance and improvement programme (QAIP).

This report fulfils that requirement. The audit opinion is that Flintshire has an adequate and effective framework of governance, risk management and control. Audit work undertaken throughout the year is summarised within the report. A self-assessment against the PSIAS, including a review of QAIP was undertaken and reported to the Committee in March 2019. This showed that Internal Audit generally conforms to the Standards, and the QAIP is in operation and effective in promoting continual improvement.

The report and opinion has been used to inform the Annual Governance Statement, presented in another paper to this Committee.

RECOMMENDATIONS	
1	The Committee is requested to consider the report and receive the internal audit annual opinion.

REPORT DETAILS

1.00	EXPLAINING THE INTERNAL AUDIT PROGRESS REPORT
1.01	The Internal Audit Manager is required to prepare a report giving the annual internal audit opinion and summarising the outcome of all internal audit work undertaken during the year. This is part of the framework of assurance that assist the Council in preparing the Annual Governance Statement for 2018/19.
1.02	It also aids the Audit Committee in its role to review the effectiveness of the Authority's systems of corporate governance, internal control and risk management and to make reports and raise actions to the Council on the adequacy and effectiveness of those arrangements.
1.03	The report outlines the role of the Internal Audit team and the professional standards it must meet. It includes a statement that the team generally conforms to the PSIAS. It then gives the annual audit opinion. **For the year ending 31 March 2019, based on the work we have undertaken, my opinion is that Flintshire County Council has an adequate and effective framework of governance, risk management and internal control.**
1.04	The report covers the governance framework. In details this covers corporate governance, information governance, risk management and internal controls. The report highlights where independent external assurance is received which supports the adequacy of the Council's governance arrangements.
1.05	The report gives the level of coverage of the audit team during the year and summarises the work undertaken in 2018/19. Summary information by Portfolio is provided on the assurance levels given to the reviews, together with the categorisation and the number of agreed actions to address control weaknesses.
1.06	The work on investigations and advisory work is outlined in the report. During 2018/19 the Whistleblowing Policy, Anti-Fraud and Corruption Strategy and Fraud and Irregularity Response Plan were reviewed, updated and approved by Audit Committee.
1.07	The overall performance of the team throughout the year against targets is then given.

2.00	RESOURCE IMPLICATIONS
2.01	None as a result of this report.

3.00	CONSULTATIONS REQUIRED / CARRIED OUT
3.01	None required.

4.00	RISK MANAGEMENT
4.01	Internal Audit operate to a risk-based plan designed to enable the annual opinion to be delivered. The report includes an opinion on risk management within the Council.

5.00	APPENDICES
5.01	Appendix A – Internal Audit Annual Report.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None. **Contact Officer:** Lisa Brownbill, Internal Audit Manager **Telephone:** 01352 702231 **E-mail:** Lisa.brownbill@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	**PSIAS, Public Sector Internal Audit Standards:** a set of standards that all Internal Audit teams working in the public sector must comply with. **Corporate Governance:** the system by which local authorities direct and control their functions and relate to their communities. It is founded on the basic principles of openness and inclusivity, integrity and accountability together with the overarching concept of leadership. It is an inter-related system that brings together the underlying set of legislative requirements, governance principles and management processes. **Risk Management:** the process of identifying risks, evaluating their potential consequences and managing them. The aim is to reduce the frequency of risk events occurring (wherever this is possible) and minimise the severity of their consequences if they occur. Threats are managed by a process of controlling, transferring or retaining the risk. Opportunities are managed by identifying strategies to maximise the opportunity or reward for the organisation. **CAMMS:** an integrated planning, risk management and programme/project management and reporting system.

Mae'r dudalen hon yn wag yn bwrpasol

Internal Audit Annual Report

2018/19

CYNGOR Sir y Fflint
Flintshire
COUNTY COUNCIL

Contents

1 Introduction

1.1 The Definition and Role of Internal Audit

The definition of Internal Auditing in the Public Sector Internal Audit Standards (PSIAS) is as follows:

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

The role and responsibilities of the Flintshire County Council's Internal Audit Service are outlined in the Internal Audit Charter, which has been approved by the Audit Committee and is part of the Constitution. It also specifies the department's independence, authority, scope of work and reporting arrangements. All audit work is carried out in accordance with the contents of the Charter.

The role of Internal Audit is to provide an independent and objective opinion to the organisation on the overall adequacy and effectiveness of the framework of internal control, risk management and governance. Internal audit is therefore a key part of Flintshire County Council's assurance cycle, and if used effectively, can inform and update the organisation's risk profile. Internal Audit is just one of the sources of assurance available to the Council and Audit Committee, that assists the Council prepare the Annual Governance Statement.

1.2 Professional Standards

The professional responsibilities for Internal Auditors are set out in the International Standards for the Professional Practice of Internal Auditing, published by the Chartered Institute of Internal Auditors (CIIA) in the UK and Ireland. Public Sector Internal Audit Standards (PSIAS) are based on these Standards.

The Standards require the Audit Manager to develop a Quality Assurance and Improvement Programme (QAIP), designed to enable an evaluation of Internal Audit's conformance with the Standards. The QAIP must include both internal and external assessments. External assessments must be completed at least every five years. Internal assessments must include:

- Ongoing monitoring of the performance of the Internal Audit activity; and
- Periodic self-assessments

Ongoing monitoring of performance is in place. The quality of audit work is ensured by the use of an audit manual, ongoing supervision and management of staff and the review of all audit work. Performance targets are set and actual performance reported to quarterly Audit Committee meetings.

An external assessment of Flintshire's Internal Audit Service against the Standards is required every five years. This was undertaken in March 2017 by the Chief Internal Auditor, Ceredigion County Council and the final external assessment report was presented to audit committee in June 2017.

The external assessment advised that the Internal Audit Service is currently conforming to 329 standards, with four partial conformance, one non-conformance and five suggestions for further improvement. The area of non-conformance had already been identified during the internal

self-assessment, as the need to undertake assurance mapping within the Council. This was completed during 2018/19.

A self-assessment against the Standards has been completed and the results reported to the Audit Committee in March 2019. The Internal Audit Service was self-assessed as being generally conforming. The Internal Audit service maintains a quality assurance improvement programme (QAIP). The programme includes the evaluation of the Internal Audit service's conformance with the Standards and an evaluation of whether internal auditors apply The Institute of Internal Auditor's Code of Ethics and the QAIPS components to ensure continuous improvement.

QAIP reflects the actions following the external assessment and the annual self-assessment. This was presented to audit committee in March 2019 and within Appendix C of this report.

Overall internal and external assessment concluded:

Following both the internal self-assessment and the external assessment, the Internal Audit Service Generally Conforms to the Standards.

That means that the relevant structures, policies and procedures for the department, as well as the processes by which they are applied, comply with the requirements of the standards and of the Code of Ethics in all materials respects.

General Conformance does not require complete / perfect conformance, the ideal situation etc.

1.3 Declaration of Independence

During the year 2018/19, all Auditors have acted with integrity and objectivity. At no point has their independence been compromised.

Annually each Auditor completes and independence and pecuniary interest declaration to identify any pecuniary or non-pecuniary interests they have. Where declarations are made work is allocated on the basis to ensure a conflict does not exist.

Internal Audit is well positioned within the Council to ensure independence remains. The Internal Audit Manager reports direct to the Chief Officer, Governance and the Council's Monitoring Officer and has direct access to and meets bimonthly with the Chief Executive.

2 Internal Audit Assurance for 2018/2019

2.1 Context

The Internal Audit Service to Flintshire County Council is required to provide the Council (through the Audit Committee) with an opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In giving that opinion it should be noted that assurance can never be absolute. The most that the Internal Audit Service can provide to the Council is a reasonable assurance that there are no major weaknesses in risk management, governance and control processes.

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

There have been no limitations made on the scope of Internal Audit coverage during the year.

2.2 Resources

At the start of the year in April 2018, the department was fully staffed and we were also successful in our application for a graduate trainee who started within the service in September 2018. At the end of the year the Principal Auditor who was already working a flexible retirement arrangement retired from the Council after 42 years. We have experienced difficulties in recruiting to this post and in the interim this is being covered by the remaining Principal Auditor and the Audit Manager. Overall the team had sufficient resources within the team to draw a reasonable conclusion on the adequacy and effectiveness of Flintshire County Council's governance, risk management and internal control arrangements.

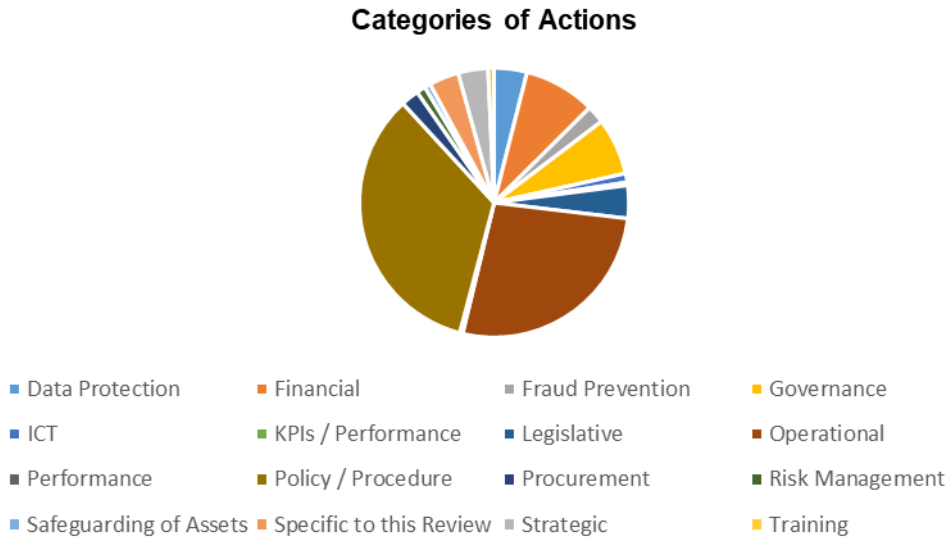
2.3 Internal Audit Opinion

For the year ending 31 March 2019, based on the work we have undertaken, my opinion is that Flintshire County Council has an adequate and effective framework of governance, risk management and internal control.

Two audits were given a 'Red / Limited' assurance level during the year (2017/18, three audits, 2016/17 four audits & 2015/16 six audits), where an urgent system revision was required. These audits were spread across portfolios indicating that weaknesses are not concentrated in any one area. Whilst these audits indicated areas where controls needed to be improved, they are not significant in the context of the Authority's whole control environment.

Overall 75% of assurance opinions issued were either Green or Amber Green providing the Committee assurance that of the audits undertaken this year in the main there are effective arrangements in place for governance, risk management and internal Control.

An analysis of the category of actions raised during 2018/19 primarily relate policy and or operational matters of the service. The graph on the following page provides you with a further information of the other category of actions raised during 2018/19.



From the graph above the majority of actions raised during 2018/19 relate to operational matters and policy and procedures.

2.4 Scope of the Internal Audit Opinion

In arriving at that opinion, I have taken into account:

- The results of all internal audits undertaken during the year ended 31 March 2019 (see Appendix B for a summary of audit opinions and number of agreed actions);
- The results of follow-up action taken in respect of audits from previous years;
- The appropriateness of the proposed action by management to address control weaknesses and consequent risks;
- Matters arising from previous reports or other assurance providers to the Audit Committee and/or Council;
- No limitations have been placed on the scope of Internal Audit;
- No resource constraints have been imposed upon us which may have impinged on our ability to meet the full internal audit needs of the organisation; and
- Where weaknesses have been identified I am happy that appropriate action plans are in place to address those weaknesses and to mitigate risks.
- During 2018/19, 244 actions were raised and 178* (73%) were implemented to date. The remaining have not reached the due date.
  ** Some may relate to previous years audit reviews.*

2.5 The Basis of the Opinion

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

Corporate Governance

A Corporate Governance Working Group operated during the year and were charged with updating and co-ordinating the annual governance self-assessment, and preparing it in line with the seven principals from the CIPFA/SOLACE guidance on ‘delivering good governance’ in Local Authorities in Wales released in 2016.

The group was chaired by the Corporate Business & Communications Executive Officer, and members included the Internal Audit Manager, Democratic Services Manager, Corporate Business and Communications Support Officer, IT Business Services Manager, Senior Manager Human Resources and Organisational Development and a Principal Accountant. The group updated the Council's Code of Corporate Governance, then prepared and drafted the Annual Governance Statement. The group issued corporate governance self-assessment assurance questionnaires to Chief Officers and Chairs of Overview and Scrutiny Committees, reviewed and challenged the responses and reported the results. This process provided an opportunity for senior officers to consider the effectiveness of governance arrangements. The group also considered the overall assurance framework.

The Annual Governance Statement explains how Flintshire County Council complies with its own Code of Corporate Governance, in line with the seven principles and also meets the requirements of the Accounts and Audit (Wales) Regulations 2018. The Annual Governance Statement includes actions to cover:

- Emerging risks and areas for improvement following a review against the Code of Corporate Governance.
- Enhance on the performance already made
- Strategic risks of the Council.
- Those audits issued with a Red / Limited assurance during the year.

A mid-year report on the actions within the Annual Governance Statement is to be provided to Cabinet and Audit Committee for consideration.

The Council is subject to external inspections by WAO, Estyn, and CIW. Assessments undertaken by WAO are both on a local and national level where the Council may be part of thematic review. Regardless of whether the Council is directly involved, the Council performs a self-assessment against the reports' findings. All actions from external inspections are monitored. The Council has not subject to any inspections from Estyn or CIW during 2018/19.

The Annual Improvement Report (AIR) summarises the audit and regulatory work undertaken at the Council by the Wales Audit Office. At the time of this report, the final 2018-19 AIR had not been published; however, the draft AIR report from WAO has confirmed that there are no significant issues arising which would raise concern.

No formal recommendations have been made during the year and there are four new voluntary proposals for improvement. An executive response to the reviews is set out.

Information Governance

Information Governance is a major component to the overall governance framework of the Council. To ensure the Council's IT infrastructure is secure, IT Services is subject to a number of external inspections and these are detailed in the table on the following page.

Area of IT Independently Assessed	Independent Assessor	Supporting Information
IT Infrastructure:	Public Services Network (PSN)	To assess the Council's infrastructure and ensure it is meeting best practices as define by the Cabinet Office in Line with National Cyber Security Centre (NCSC) Guidance. The assessment is undertaken annually. The last assessment was completed in March 2019 where the Council was compliant with the PSN requirements.
IT Infrastructure:	Cyber Essentials Plus (CEP)	There are two elements to this independent assessment. Cyber Essentials is a desktop self-assessment and the plus element is an independently verified element of the assessment. The target date from Welsh Government for all Local Authorities to achieve this is April 2020. The Council has opted for this date, undertaken a desktop assessment and identified a number of areas that require attention. The service is currently in the process of setting up a Cyber Security Group across IT Services where a combined action plan for PAN and Cyber Essential Plus will be developed to ensure work is coordinated and have oversight where one assessment may impact on another.
Information Management & Address Standards:	Geoplace	Monthly assessment undertaken of the Council's address data to ensure the addresses used to populate the National Land and Property Gazetteer meet the required Standards. The Council has been award the Gold Standard for this assessment.
Information, Processes and Procedures around Financial Systems	Wales Audit Office	As part of the annual audit, WAO considers the adequacy of the Council's security and interfaces with the Council's financial systems. No actions have been raised following this review.
Website Accessibility	SOCITM	Better Connected Accessibility testing, it is undertaken independently externally and doesn't use a pass or fail outcome. However the external assessor scores and uses a traffic light system to give a general picture. This score takes in to consideration a range of features including; Accessibility, Functions, Links, Code Quality, Performance and Brand. Flintshire achieved an overall score of 5.2 with an amber assessment in December 2018. An action plan has been developed to improve this and website content improvement forms a key element of the Council's Digital Strategy.

Any actions arising from these external assessments are monitored and managed by IT services ensuring any developments required are implemented to support and complement the role out of the Digital Strategy.

Risk Management

Revised Risk Management Policy and Strategy was issued during 2017/18, with an enhanced risk escalation process included. Quarterly progress reports against the Council Plan have been presented to Overview and Scrutiny Committees. During the year a new risk structure for management oversight has been adopted to cover four areas; these being Corporate Strategy, Corporate Governance, Portfolio Strategy and Portfolio Operational. The Corporate Governance risks include those identified within the Annual Governance Statement.

All Council Plan risks are monitored through CAMMS, the Council's performance and risk management system, and reported to Corporate Resources Overview Scrutiny Committee and Audit Committee quarterly.

During the year the Chairs and Vice Chairs Liaison Group was established. Whilst in its infancy the group will consider the Council's risk and emerging risks, allocating responsibility for the monitoring between the relevant Overview and Scrutiny Committees and Audit Committee.

The Strategic Risks are consideration when identifying the audit work for the forthcoming year. My annual opinion is also informed by the number of risk based audit assignments completed during the year review.

Internal Control

Audits were carried out in all areas of the Council during the year. The overall level of control found in audit assignments this year was good. 75% of audits resulted in a 'green' or 'amber green' assurance level. No area stood out as being worse than the others. In all cases the findings were reported to the Audit Committee. During 2018/19, 244 actions were raised to improve the internal control, risk management and governance arrangements across the authority of which 178* (73%) of actions have been implemented (67% implemented during 2017/18). Implementation of actions continue to show a high degree of compliance with the agreed timescales. All actions are monitored and progress reported to Chief Officers monthly and at each Audit Committee meeting. Summary results are given in Appendix B, together with definitions of the assurance levels (Appendix A). ** some of these action may relate to previous years audits.*

2.6 Level of audit coverage during the year

The number of reviews / audit work in each area of the Council is detailed in the table below.

Audit Coverage							
Review Type	**High**	**Medium**	**Annual**	**A&C**	**New**	**Deferred**	**Total**
Corporate	4	2	1	1	2	5	5
Education and Youth	7	2	1		1	1	10
Governance	4	2	3	1		2	8
Housing & Assets	4	6	4			3	11
People and Resources	4	5	4		2	2	13
Planning, Environment & Economy	2	2	1		2	2	5
Social Services	1	4	1			2	4
Streetscene and Transportation	2	1	1		1		5
External	1		2		1		4
Total	**29**	**24**	**18**	**2**	**9**	**17**	**64**
	73						

The original annual plan showed 73 audits / areas of work to be undertaken. The approach to managing the audit plan changed for 2018/19 and this was approved by Audit Committee in March 2018. It was agreed that the plan would be reviewed quarterly with Chief Officers and their senior management team. All high priority audits would be undertaken and any new requests for audit assistance would be considered and replace (where applicable) medium priority audits. This approach worked well again. In total 9 new requests for additional advisory / consultancy / audit work were received and undertaken. During the year, changes to the plan were reported back to audit committee.

Status of 2018/19 Audit Plan						
Priority	**Completed**	**Draft Report**	**In Progress**	**Deferred**	**Ongoing ***	**Total**
High	17	2	4	6		29
Medium	8	1	5	10		24
Annual / Follow Up	11	4	2	1		18
Advice & Consultancy	1				1	2
Position Original Plan	**37**	**7**	**11**	**17**	**1**	**73**
New Requests	7		1		1	9

* Due to the nature of this work, the advice and consultancy is provided on an ongoing basis e.g. membership of a working group.

There is always a time lag in terms of the dates of audits. The audit plan for the following financial year will always include work carried over.

Carried forward work, additional audits and deferrals always make a comparison of actual work completed against the plan more difficult. However, within 2018/19, including carry forward work, 63 final reports were brought to the Audit Committee and at the time of this report a further seven have been issued or due to be issued as draft awaiting finalisation and eight reviews were near completion. Overall the 2018/19 plan was substantially completed.

All the deferred audits were considered during the planning meetings for the 2019/20 to 2022/23 audit strategic plan and included as part of the risk assessment when forming the strategy.

2.7 Assurance Levels

The definitions for the assurance levels are given in Appendix A of this report. The tables in Appendix B show the assurance opinions and number of agreed actions made in 2017/18.

2.8 Other Internal Audit Work

In addition to the reviews analysed in the Appendix B, we have also carried out the following internal audit work during the year.

Area of Work	Comments
Schools Control Risk Self-Assessment (CRSA)	CRSA Self-Assessment carried out. Responses received from 64 Primary schools and 12 Secondary Schools
Schools Audits	5 school audits
Investigations	See 2.9 below
National Fraud Initiative	11 days on work relating to National Fraud Initiative
Advisory work	91 days on advisory work in the year
Grant audits	4 audit of grants

2.9 Anti-Fraud and Corruption and Investigations

During 18/19 the Whistleblowing Policy, Anti-Fraud and Corruption Strategy and the Fraud and Irregularity response Plan was reviewed, updated and approved by Audit Committee in January.

At the start of the year there were four live investigations. During the year ten more were started and eleven were completed leaving four ongoing investigations at the end of the year. Out of the ten investigations, five investigations were as a results of whistleblowing, two following complaints received and the remaining three were following a referral from management. In total 64 days was spent on investigations. The nature of these investigations covered in the table below:

Nature of the Investigations	No.
Procurement: Tender Evaluation, Award of Contracts and Variations to Contracts	5
Submission of Invoices	1
Recruitment	2
Mileage	1
Operational and Procedural	1

Of the ten new investigations, six were within Streetscene and Transportation, one related to Community and Enterprise, one Planning, Environment and Economy and one within Social Services.

2.10 Advisory / Consultancy work

This includes work that, in some cases, does not result in an audit report and or assurance opinion however adds value to the Authority by contributing to working groups or providing advice. Examples include:

- Advice on GDPR Project Group and Board
- Membership of the Corporate Governance Working Group
- Membership of Accounts Governance Group
- Membership of the E-Procurement Board
- Membership of the Programme Co-ordinating Group
- Advice to County Hall Campus Working Group
- Advice on the Council's approach to method and forecasting statements
- Review of Method Statements
- Pay modelling
- Disabled Facility Grants (DFG) oversight board

It should be noted that the number of days spent on advisory work (91 for 2018/19) continues to remain high over the last three years (124 days for 2017/18, 79 days for 2016/17) and demonstrates the noticeable rise in requests for Internal Audit to become involved in emerging issues and working with the organisation to ensure a robust control environment is in place.

2.11 Audit of Third Parties

Following the transformation changes of services and the creation of Aura Leisure and Libraries and NEWydd in 2016/17 the Internal Audit Service has a 3 year SLA to deliver an internal audit service to these organisations. Given we are now entering the last year of the SLA with the third Party discussions will be held soon requiring their future requirements.

During 2018/19 20 days Audit Service was delivered to Aura Leisure and Libraries and 10 days delivered to NEWydd. In both organisations the audit reports were received and accepted by their respective Boards.

2.12 Internal Audit Performance

The performance of the department against performance measures and targets is set out below.

Performance against target is reported to each quarterly Audit Committee, and is summarised in the table below. Overall apart from two targets all were achieved or exceeded the internal targets. Performance is reported to Audit Committee on a quarterly basis.

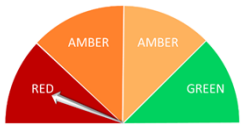
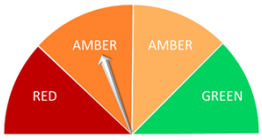
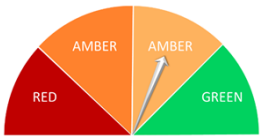
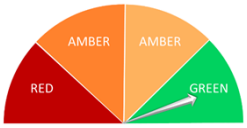
There continues to be a decline in the number of questionnaire returned and in the time taken for departments to return draft reports. This however is more a reflection of the detailed work undertaken and greater stakeholder involvement and should not be seen negatively.

Internal Audit Performance Indicators

Performance Measure	Q1	Q2	Q3	Q4	18/19 Total	18/19 Target
Reported to Committee	June 18	Sept 18	Jan 19	Mar 19		
Audits completed within planned time	87%	86%	83%	67%	**81%**	80%
Average number of days from end of fieldwork to debrief meeting	7	11	9	9	**9**	20
Average number of days from debrief meeting to the issue of draft report	1	3	1	5	**3**	5
Days for departments to return draft reports	3	0	1	2	**3**	7
Average number of days from response to issue of final report	1	2	2	2	**2**	2
Total days from end of fieldwork to issue of final report	19	33	21	30	**26**	34
Productive audit days	80%	79%	78%	82%	**80%**	75%
Client questionnaires responses as satisfied	100%	100%	100%	100%	**100%**	95%
Return of client satisfaction questionnaires	40%	86%	40%	75%	**60%**	80%

Levels of Assurance – Standard Audit Reports Appendix A

The audit opinion is the level of assurance that Internal Audit can give to managements and all other stakeholders on the adequacy and effectiveness of controls within the areas audited. It is assessed following the completion of the audit and is based on the findings from the audit. Progress on the implementation of agreed actions will be monitored. Findings from **Red** assurance audits will be reported to the Audit Committee.

Level of Assurance	Explanation
Red – Limited 	**Urgent system revision required (one or more of the following)** • Key controls are absent or rarely applied • Evidence of (or the potential for) significant financial / other losses • Key management information does not exist • System / process objectives are not being met, or are being met at a significant and unnecessary cost or use of resources. Conclusion: a lack of adequate or effective controls.
	Follow Up Audit - <30% of actions have been implemented. Unsatisfactory progress has been made on the implementation of high priority actions.
Amber Red – Some 	**Significant improvement in control environment required (one or more of the following)** • Key controls exist but fail to address all risks identified and / or are not applied consistently and effectively • Evidence of (or the potential for) financial / other loss • Key management information exists but is unreliable • System / process objectives are not being met, or are being met at an unnecessary cost or use of resources. Conclusion: key controls are generally inadequate or ineffective.
	Follow Up Audits - 30-50% of actions have been implemented. Any outstanding high priority actions are in the process of being implemented.
Amber Green – Reasonable 	**Key Controls in place but some fine tuning required (one or more of the following)** • Key controls exist but there are weaknesses and / or inconsistencies in application though no evidence of any significant impact • Some refinement or addition of controls would enhance the control environment • Key objectives could be better achieved with some relatively minor adjustments Conclusion: key controls generally operating effectively.
	Follow Up Audit: 51-75% of actions have been implemented. All high priority actions have been implemented.
Green – Substantial 	**Strong controls in place (all or most of the following)** • Key controls exist and are applied consistently and effectively • Objectives achieved in a pragmatic and cost effective manner • Compliance with relevant regulations and procedures • Assets safeguarded • Information reliable Conclusion: key controls have been adequately designed and are operating effectively to deliver the key objectives of the system, process, function or service.
	Follow Up Audit: 75%+ of actions have been implemented. All high priority actions have been implemented.

Categorisation of Actions	Actions are prioritised as High, Medium or Low to reflect our assessment of risk associated with the control weaknesses
Value for Money	The definition of Internal Audit within the Audit Charter includes 'It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper economic, efficient and effective use of resources.' These value for money findings and recommendations are included within audit reports.

Internal Audit Opinions and Recommendations 2018/19

Appendix B

Auditable Area	Number of Reports & Audit Opinions						Priority & Number of Agreed Actions			
	Red	Amber -	Amber +	Green	Advisory / Grant - No Opinion Given	In Total	High	Medium	Low	In Total
Corporate					4	4	-	-	-	-
Education and Youth			10	4	2	16		21	48	69
Governance	1	1	3	1		6	3	28	8	39
Housing & Assets		2	4		2	8	2	11	15	28
People and Resources	1	2	5		4	12	5	23	31	59
Planning, Environment & Economy		1		1	2	4	2	2	3	7
Social Services			4			4		6	8	14
Streetscene and Transportation		2			2	4		11	8	19
External		1	1		3	5	1	2	6	9
Total	**2**	**9**	**27**	**6**	**19**	**63**	**13**	**104**	**127**	**244**

PSIAS –Quality Assurance Improvement Programme (QAIP)

Appendix C

Actions from External Assessment (EA) March 2017 and Self-Assessment (SA) February 2019 (questions not scored as conforming)

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
2120 (SA)	Has the internal audit activity evaluated the potential for fraud and also how the organisation itself manages fraud risk?	Partial	Improve awareness of fraud. Collect data on fraud risk.*(2120)*	LB	Implemented Implemented Implemented March 2020	Fraud risk analysis is undertaken as part of each audit review. Whistleblowing training has been delivered to Social Services. Anti-Fraud and Corruption Strategy and Fraud Response Plan has been updated and presented to audit Committee in February 2019. Once approved by Council this will be launched on Council's Infonet and website. Develop an online reporting solution which would support digital and customer strategies during 2019/20. This has been delayed from 2018/19 action.
2400 (EA)	Communicating Results- The Service cited a benefit of allowing one of the 'timing' performance indicators (PIs) to run over the set target.	Suggestion	The Service should consider reviewing the performance indicator to ensure it is meaningful.*(2400)*	LB	Implemented Ongoing	The PI's were reviewed in September 2017 and two were amended to reflect ways of working. As part of the Welsh Chief Internal Auditors group a separate review will be undertaken to assess the effectiveness of all PIs. The committee will be updated

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
						once this review has been completed.
2050 (SA & EA)	Has the CAE carried out an assurance mapping exercise as part of identifying and determining the approach to using other sources of assurance?	Non Compliance	Assurance mapping to be completed in 2017.*(2050)*	LB	Implemented	An Assurance Mapping exercise was undertaken as part of the development of the 2019/20-2021/22 Strategic Audit Plan.
1000 (EA) (SA)	The internal audit charter does not define the term 'senior management', for the purposes of the internal audit activity. (EA) The Audit Charter does not make reference to auditing a third party. (SA)	Partial	(EA) The Service could insert a definition in the Independence & Authority (para 6, point 5) of the IA Charter, or revise the Charter by inserting a catch-all statement such as "For the purposes of Internal Audit activity, the Audit Committee is equivalent to the 'Board' and the Chief Officers' Team constitutes 'Senior Management'. *(1000) LGAN* (SA) Following the transfer out of Leisure & Libraries and Cleaning & Catering Services, the Charter needs to be updated to define the nature of the assurance provided to Aura and NEWydd. *(1000.A1)*	LB	Implemented	The Charter has been updated and presented to Audit Committee in June 2019 to: • Define the term of Senior Management. Deferred from March 2018 to July 2018. • Include reference to auditing a third party (Aura / NEWydd).

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
1110 (EA)	The PSIAS specifically requires the Chief Executive to undertake, countersign, contribute feedback to or review the Audit Manager's performance appraisal (PSIAS 1110 – S/A point 6). It is required that feedback is also sought upon the appraisal from the Chair of the Audit Committee (PSIAS 1110 – S/A point 7).	Partial	The issue has been discussed with the Interim Internal Audit Manager. It is acknowledged that due to the governance structure of the Authority, the current procedure has been deemed sufficient. However, this may be re-addressed to achieve full conformance with the PSIAS in future.*(1110)*	LB	Ongoing	The current procedure has been deemed sufficient given the Chief Officer Governance and the Chief Executive attend each Audit Committee meeting. Direct contact is also in place between the Internal Audit Manager with the Chief Officer, Governance, the Chief Executive and the Chair and Vice Chair of the Audit Committee. Any performance issues would be addressed immediately rather than wait for a formal appraisal. This point will be picked up for future appraisals. In relation to the appointment of the Internal Audit Manager, the Chair of the Audit Committee, Chief Executive, and Chief Officer, Governance were involved.
2110 (SA & EA)	Internal Audit reviews the activities in place that manage and monitor the effective implementation of the organisation's ethics and values.	Partial	(SA) Review as part of CGWG – review of Code of Corporate Governance. (EA) The Service needs to undertake a review to evaluate the design, implementation and effectiveness of the Council's ethics related objectives, programs & activities. *(2110.A1)*	LB	Ongoing	Audit work is based on the Council's objectives and priorities and covers areas in the Code of Corporate Governance such as organisational, performance management, and communication of risk and control information. Whilst ethics is considered as part of routine audits, a specific review on ethics and values has been included within the 2019/20 audit plan.

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
1120 (EA)	The regular rotation of work between officers has not been documented in the Service's Charter.	Suggestion	The Service could insert an additional statement under the 'Independence and Authority' section of the Charter confirming regular rotation of work is usually adhered to in order to further enhance independence and objectivity. *(1120)*	LB	Implemented	Whilst the Audit Charter has been updated and presented to Audit Committee in June 2019, it should be acknowledged that ensuring independence and objectivity is a priority within the team; however, in some instances a conscious decision has been made to use the same auditor for key system reviews to develop expertise and specialism within the team as this adds value to the audit and reduces resources.
2110 (EA)	ICT projects are included in the audit plan, which, together with other ICT assurances, support the organisation's strategies and objectives. However, this is not currently noted in the Annual Report.	Suggestion	To support the annual opinion further, the Section could consider noting the assurance gained from the ICT audit work undertaken during the year in the 'Governance' section of the Annual Report. *(2110.A2)*	LB	Implemented	Reference to external assurance was included within the Annual Report since 2017/18 and will be included in all future annual reports.
2330 (EA)	The Service has its own documentation retention policy which is currently a stand-alone document.	Suggestion	The Section could consider inserting the audit retention policy in full in the Audit Manual which is the document that ensures all internal audit staff are adequately informed on the Service's methodology, policies and procedures.*(2330.C1)*	LB	Implemented	The document retention policy has been reviewed and included an appendix within the Audit Manual.

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
2120 (SA)	Internal auditors address risk during consulting engagements consistently with the objectives of the engagement?	Generally Comply Identified opportunity for further improvement	There is further opportunity to develop the process for delivering consultancy / advisory work to have a more structured approach.	LB	March 2020	New action for 2018/19.
2210 (SA)	Value for money criteria has been considered, including the organisation's main types of resources been considered, e.g. money, people and assets?	Generally Comply Identified opportunity for further improvement	Include as part of future scopes whether management are making best use of resources.	LB	March 2020	New action for 2018/19.

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday, 5th June 2019
Report Subject	Internal Audit Charter
Report Author	Internal Audit Manager
Type of Report	Assurance

EXECUTIVE SUMMARY

Public Sector Internal Audit Standards (PSIAS) require that the role, scope, independence, authority and responsibility of Internal Audit be formally defined in a charter. The charter must be reviewed periodically and approved by the Audit Committee. The current charter has been reviewed to ensure the charter continue meets all legal and regulatory requirements. This paper shows the results of that review.

RECOMMENDATIONS	
1	The Committee is requested to consider and approve the updated Internal Audit Charter.

REPORT DETAILS

1.00	EXPLAINING THE INTERNAL AUDIT PROGRESS REPORT
1.01	Internal Audit has had a charter since 2002. It was last updated in 2015 to reflect the changes set out on in the updated Public Sector Internal Audit Standards (PSIAS) and the Accounts and Audit (Wales) Regulations 2018 which has been published, all of which relate to Internal Audit. The current review takes into account the requirements of the acts and the suggestions made during the recent external assessment of service compliance with the PSIAS.
1.02	There has been some movement of sections within the Charter however few changes have been made to the policy apart from bringing it up to date with the requirements of the PSIAS and to reflect current ways of working, terminology and positions within the Council, which are listed below.

	The Charter update also incorporates the suggested improvements following the external assurance assessment. To aid review the new areas included within the Charter are detailed below: **Section** — **New to the Charter** Section 2 — This section has been updated to reflect the new mission statement of the Chartered Institute of the Internal Audit (CIIA). Para 4.5 — To demonstrate independence reference has been made to the Audit Manager's direct access to the Chief Executive and the Council's Leader. Para 4.8 — To further demonstrate independence, the expectations of the auditors have been noted. Para 6.1 — Aligned the Charter to the recently updated Whistleblowing policy in reference to members and third party individuals. Para 9.2 — Audit Training – included the requirement for auditors to undertaken 30 hrs training if they hold the CIA qualification. Para 10.6 — Included the reporting responsibilities of the Audit Manager. Section 12 — Included a new section on the Quality Assurance and Improvement Programme. Section 13 — Included a new section on Third Party Auditing.
1.03	The Charter meets the requirements of the PSIAS standards. It gives the mission, definition and legal background to Internal Audit. It shows the code of ethics that auditors must comply with. It includes the independence and authority of Internal Audit; the role, scope and responsibility of the activity including fraud-related work. It also outlines the resources of the team, training requirements and reporting requirements.
1.04	Within Flintshire, the Charter is part section 26 of the Constitution. After approval by the Audit Committee, it is intended to submit the Charter to the Constitution and Democratic Services Committee for approval.
1.05	To aid clarity and transparency two copies of the Internal Audit Charter are included. Appendix A shows where the changes have occurred, using tracked changes, whilst Appendix B shows the revised Charter without tracked changes.

2.00	**RESOURCE IMPLICATIONS**
2.01	None as a result of this report.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	The draft Charter has been shared with the Chief Executive, Monitoring Officer and Corporate Finance Officer (s151 Officer) for consideration.

4.00	RISK MANAGEMENT
4.01	Internal Audit provides an independent, objective assurance to the Council by evaluating the effectiveness of risk management, control and governance processes. To do so it needs to be independent and have the necessary authority to fulfil that role, which helps reduce the overall risk to the Council. The Charter ensures that the internal audit service has sufficient independence and authority within the Council.

5.00	APPENDICES
5.01	Appendix A – Internal Audit Charter including tracked changes. Appendix B – Internal Audit Charter without tracked changes.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None. **Contact Officer:** Lisa Brownbill, Internal Audit Manager **Telephone:** 01352 702231 **E-mail:** Lisa.brownbill@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	**PSIAS, Public Sector Internal Audit Standards:** a set of standards that all Internal Audit teams working in the public sector must comply with. **Corporate Governance:** the system by which local authorities direct and control their functions and relate to their communities. It is founded on the basic principles of openness and inclusivity, integrity and accountability together with the overarching concept of leadership. It is an inter-related system that brings together the underlying set of legislative requirements, governance principles and management processes. **Risk Management:** the process of identifying risks, evaluating their potential consequences and managing them. The aim is to reduce the frequency of risk events occurring (wherever this is possible) and minimise the severity of their consequences if they occur. Threats are managed by a process of controlling, transferring or retaining the risk. Opportunities are managed by identifying strategies to maximise the opportunity or reward for the organisation.

Mae'r dudalen hon yn wag yn bwrpasol

Contents

1. Introduction

1.1 The internal audit charter is a formal document that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the Internal Audit Manager's functional reporting relationship with the 'board'; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the 'board'.

1.2 Internal Audit is a statutory requirement for local authorities. The two pieces of legislation that impact upon internal audit in local authorities are:

- Section 5 of the Accounts and Audit (Wales) Regulations ~~2015~~ 2018 states that "a relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance".

- Section 151 of the Local Government Act 1972 requires every authority to make arrangements for the administration of its financial affairs and to ensure that one of the officers has responsibility for the administration of those affairs. CIPFA has defined 'proper administration' in that it should include 'compliance with the statutory requirements for accounting and internal audit'.

2. Purpose and Mission

~~1.3~~2.1 The purpose of Flintshire County Council's (the Council's) Internal Audit service is to provide independent, objective assurance and consulting services designed to add value and improve the Council's operations. This mission of internal audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice, and insight. The internal audit service helps the Council accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

~~1.4~~2.2 Internal Audit objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper economic, efficient and effective use of resources. It may also undertake consulting services at the request of the Council, subject to there being no impact on the core assurance work and the availability of skills and resources within the team.

3. Standards for the Professional Practice of Internal Auditing

3.1 Public Sector Internal Audit Standards (PSIAS) published in 2013 and updated in 2016, 2017 and 2018 provide a definition, mission and core principles for internal audit and the activity and standards that must be met. They include a Code of Ethics which Internal Auditors must conform to, covering integrity, objectivity, confidentiality and competency. They are mandatory for all internal audit departments in the UK public sector. The Internal Audit Manager will report periodically to Chief Officers and the Audit Committee regarding the internal audit service's conformance to the Code of Ethics and Standards.

3.2 PSIAS state that the charter must:

- Define the terms 'board' and 'senior management' for the purposes of internal audit activity. For the purpose of this Charter the board will be known as the Audit Committee.
- Cover the arrangements for appropriate resourcing;
- Define the role of internal audit in any fraud related work; and
- Include arrangements for avoiding conflicts of interest if internal audit undertakes non-audit activities.~~Mission and Definition of Internal Audit~~

~~The PSIAS state that the Mission of Internal Audit is 'To enhance and protect organisational value by providing risk-based and objective assurance, advice and insight'. Internal auditing is defined as 'an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.'~~

~~It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper, economic, efficient and effective use of resources. It may also undertake consulting services at the request of the organisation, subject to there being no impact on the core assurance work and the availability of skills and resources.~~

~~Code of Ethics~~

~~Anyone delivering internal audit work for the Council must comply with the PSIAS Code of Ethics. This covers:~~

~~Integrity~~	~~The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement.~~

	~~Internal Auditors:~~ ~~- Shall perform their work with honesty, diligence and responsibility~~ ~~- Shall observe the law and make disclosures expected by the law and the profession~~ ~~- Shall not knowingly be a party to any illegal activity, or engage in acts that are discreditable to the profession of internal auditing or to the organisation~~ ~~- Shall respect and contribute to the legitimate and ethical objectives of the organisation~~
~~Objectivity~~	~~Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements.~~ ~~Internal Auditors:~~ ~~- Shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation~~ ~~- Shall not accept anything that may impair or be presumed to impair their professional judgement~~ ~~- Shall disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review~~
~~Confidentiality~~	~~Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so.~~ ~~Internal Auditors:~~

	- Shall be prudent in the use and protection of information acquired in the course of their duties - Shall not use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the organisation
Competency	Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services. Internal Auditors: - Shall engage only in those services for which they have the necessary knowledge, skills and experience - Shall perform internal auditing services in accordance with the International Standards for the Professional Practice of Internal Auditing - Shall continually improve their proficiency and effectiveness and quality of their services

2.4. Authority, Independence and AuthorityObjectivity

4.1 PSIAS state that 'Organisational independence is effectively achieved when the Internal Audit Manager reports functionally to the 'board.' Within Flintshire the Audit Committee is equivalent to the 'Board' and the Chief Officers Team constitutes 'Senior Management'. The Within Flintshire the **Audit Committee** fulfils most of the roles of the 'board'. It is responsible for:

- approving the internal audit charter;
- approving the internal audit Strategic and Operational plans;
- receiving reports from the Internal Audit Manager on the departments performance relative to its plan and other matters; and
- making appropriate enquiries of management and the Internal Audit Manager to determine whether there are inappropriate scope or resource limitations.

4.2 The department's Internal Audits budget is approved annually as part of the Council's overall budget. Remuneration and arrangements for the appointment and removal of the Internal Audit Manager are managed in accordance with the Council's adopted HR policies.

4.3 The Internal Audit department is part of the Governance Portfolio. The Internal Audit Manager reports administratively to the Chief Officer Governance (the Monitoring Officer).

4.4 To further ensure the independence of the Internal Audit Manager, the Chief Executive and Chair of the Audit Committee provide feedback into ~~his~~ her annual appraisal.

4.5 The Internal Audit Manager has direct access to the Chief Executive and the Leader of the Council and meets with the Chief Executive bimonthly.

4.6 Internal Audit is independent of the activities that it audits to ensure the unbiased judgements essential to its proper conduct and impartial advice to management.

4.7 To ensure independence, Internal Audit operates within a framework that gives it the authority to:

- have unrestricted access to all activities undertaken in the Council;
- have full and unrestricted access to all functions, records and property, including those of partner organisations. In very exceptional circumstances if the "responsible officer" (Section 151 Officer) and Monitoring Officer believe this would constitute a breach of the laws of confidentiality, or the provisions of the Human Rights Act, or the Data Protection Act the matter will be referred to the Audit Committee for consideration;
- have full and free access to the Audit Committee via the Internal Audit Manager, and an annual private meeting with the committee;
- have full and free access to the Chief Executive, Corporate Finance Manager (S151 Officer)~~Head of Finance~~, Monitoring Officer, Chair and Vice Chair of the Audit Committee and External Auditors via the Internal Audit Manager;
- have unrestricted access to senior management, members and all employees;
- require any employee or m~~M~~ember to provide any information and explanation considered necessary concerning any matter under consideration;
- require any employee or m~~M~~ember to produce or account for cash, stores or any other Council asset or asset of a third party under his or her control;
- allocate resources, set timeframes, define review areas, develop scopes of work and apply techniques to accomplish the overall audit objectives; and
- issue audit reports in its own name.

4.8 The Internal Auditors will:

- Disclose any impairment of independence or objectivity, in fact or appearance to appropriate parties;
- Exhibit professional objectivity in gathering, evaluating and communicating information about the activity or process being examined;
- Make balanced assessments of all available and relevant facts and circumstances; and
- Take the necessary precautions to avoid being unduly influenced by their own interests or by others' informing judgements.

4.9 The Internal Audit Manager will confirm to the Audit Committee, at least annually, the organisational independence of the Internal Audit services.

4.10 The Internal Audit Manager will disclose to the Audit Committee any interference and related implications in determining the scope of internal auditing, performing work, and / or communicating results.

~~Every effort is made to preserve objectivity by ensuring that all members of internal audit staff are free from any conflicts of interest and do not undertake any non-audit duties. Internal Audit has complete segregation from Council operations and is not responsible for the management of areas that are audited. The Internal Audit Manager and internal audit staff are not authorised to:~~

- ~~perform any operational duties associated with the Authority;~~
- ~~initiate or approve accounting transactions on behalf of the Authority; and~~
- ~~direct the activities of any employee unless specifically seconded to Internal Audit.~~

4.11 However, in strict emergency situations only, audit personnel may be called upon to carry out non-audit work on a temporary basis. If a request is made the decision to allocate resources will be the Internal Audit Manager's, who will agree clear terms of reference. The Audit Committee Chair or Vice Chair, the Chief Officer Governance and the s.151 officer will be advised.

4.12 In order to further enhance independence and objectivity a regular rotation of work is usually adhered to. ~~in order to further enhance independence and objectivity.~~ It should be acknowledged that ensuring independence and objectivity is a priority within the team; however, in some instances a conscious decision has been made to use the same auditor for key system reviews to develop expertise and specialism within the team as this adds value to the audit and reduces resources.

4.13 Where the Internal Audit Manager has or is expected to have roles and / or

responsibilities that fall outside of internal auditing, safeguards will be established to limit impairments to independence or objectivity.

5. ~~Role and~~ Scope of Internal Audit

5.1 Internal Audit must provide the Authority, through the Audit Committee, with an annual independent and objective opinion on the adequacy and effectiveness of internal control, risk management and governance arrangements. To that end, the department reviews, appraises and reports on:

- The adequacy and effectiveness of the systems of financial, operational and management control and their operation ~~in practice~~ in relation to the business risks to be addressed;
- The extent of compliance with and relevance of, policies, standards, plans and procedures established by the ~~County~~ Council and the extent of compliance with external laws and regulations, including reporting requirements of regulatory bodies;
- The extent to which the assets and interests are acquired economically, used efficiently, accounted for and safeguarded from losses of all kinds arising from waste, extravagance, inefficient administration, poor value for money, fraud or other cause, and that adequate business continuity plans exist;
- The suitability, accuracy, reliability and integrity of financial and other management information and the means used to identify, measure, clarify and report such information;
- The integrity of processes and systems, including those under development, to ensure that controls offer adequate protection against error, fraud and loss of all kinds; and that the process aligns with the Council's strategic goals;
- The follow-up action taken to remedy weaknesses identified by Internal Audit review, ensuring that good practice is identified and communicated widely;
- The operation of the Council's corporate governance arrangements; and
- The potential within the Council for fraud and other violations through the analysis of systems of control in high-risk operations.

5.2 The Internal Audit ~~department~~ service completes advisory / consultancy work in agreement with Chief Officers and Senior ~~Managers~~ Accountable Officers by responding to requests for audit reviews and by contributing to projects and working groups throughout the Authority.

5.3 Where the Authority has entered into a partnership with other organisations the

partnership arrangement will be subject to review. In addition, where ~~Flintshire~~ the ~~County~~ Council is the lead authority of a partnership or collaboration, the work undertaken will be subject to review by Flintshire Internal Audit.

6. Fraud and Irregularity

6.1 All managers are responsible for applying controls to reasonably prevent and detect fraud. Furthermore, internal audit is not responsible for identifying fraud, instead ~~however~~ it will assess and ~~the risk of fraud and~~ be aware of the risk of fraud when planning and undertaking any internal audit work. All actual or suspected incidents of fraud, corruption or impropriety should be reported without delay to Internal Audit. The internal audit department investigates fraud and irregularity in terms of:

- The undertaking of investigations into reports of violations of the Council's regulations or criminal activities i.e. fraud against the Council; and

- The undertaking of investigations of reports from staff, and third party individuals (partners, consultants, suppliers, volunteers, contractor and employees of Council suppliers and contractors, who are employed to deliver a service / goods to the Council)~~other persons engaged in activities on behalf of the Council and members of the public~~, reporting perceived cases of possible violations of rules or regulations, mismanagement, misconduct, or fraudulent abuse of authority.

6.2 Referrals to the police are made if there is suspected criminal activity, in accordance with the Anti-Fraud and Corruption ~~Policy~~ Strategy and the Fraud and Irregularity Response Plan, following consultation with the Monitoring Officer or Human Resources where appropriate.

6.3 Internal Audit is responsible for maintaining the Anti-Fraud and Corruption ~~Policy~~Strategy, the Fraud and Irregularity Response Plan and the Whistleblowing Policy. They also administer the National Fraud Initiative. The Internal Audit Manager is a named contact within the Whistleblowing Policy.

7. Audit Responsibility

7.1 The ~~existence~~ presence of Internal Audit does not diminish the responsibility of management to establish systems of internal control to ensure that activities are conducted in a secure, efficient and well-ordered manner.

7.2 The primary task of Internal Audit is to review the systems of internal control operating throughout the authority, and in doing this it will adopt a predominantly risk-based approach to audit.

7.3 The Internal Audit Manager is required to manage the provision of a complete audit service to the Council that will include systems, regularity, computer and advisory audit in addition to the investigation of potential fraud and irregularity. In discharge of this duty, the Internal Audit Manager has a responsibility to:

- prepare a rolling strategic risk-based audit plan after consultation with senior management and the Chief Officer Team, for formal approval by the Audit Committee. This strategic plan is regarded as flexible rather than as an immutable expression of audit policy;
- translate the strategic plan into annual plans for Chief Officers and the Audit Committee;
- implement the audit plan as approved, including any additional work requested by management and the Audit Committee;
- ensure that the scopes of individual audit assignments are agreed with ~~departmental~~ Chief Officers and Senior ~~management~~Management;
- prepare and adhere to the service's own internal policies and procedures to ensure ~~maintain an Audit Manual detailing departmental procedures and~~ standards are maintained;

~~ensure a system of close supervision of audit work, and maintain a Quality Assurance and Improvement Programme including annual internal assessments and external assessments at least every five years;~~

~~report the results of assessments to the Audit Committee, and state that the department conforms with the standards or disclose any non-conformance;~~

- ensure the internal audit service collectively possesses or obtains the knowledge, skills, and other competencies needed to meet the requirements of the internal audit charter; ~~maintain knowledge, skills and expertise within the section specifically for the investigation of fraud and irregularity;~~
- ensure principles of integrity, objectivity, confidentiality and competency are applied and upheld;
- bring a systematic disciplined approach to evaluate and report on the effectiveness of risk management, internal control and governance processes;
- highlight control weaknesses and required associated improvements together with corrective action ~~recommended~~ to management based on an acceptable and practicable timeframe;

- undertake follow up reviews and action tracking to ensure management has implemented agreed internal control improvements within specified and agreed timeframes;
- liaise with the external auditor for the purpose of providing optimal audit coverage to the Authority;
- work with the external auditor to provide consistent advice to management and the Audit Committee; and
- prepare annual report on audit, including ~~and~~ special investigation activities for presentation to the Audit Committee, and such other reports on audit issues as may be required by the Chief Officer Governance or the Audit Committee.

8. Audit Resources

8.1 The staffing structure of the section ~~will~~ comprises of qualified Internal Auditors, Accounting Technicians and part qualified Accountants with a mix of professional specialisms to reflect the varied functions of the section.

8.2 Each year the ~~departmental~~ sections resources are assessed against the needs of the plan, in order to ensure there is sufficient coverage to arrive at the annual audit opinion.

8.3 The Internal Audit Manager, Audit Committee and ~~s151 Officer~~Corporate Finance Manager (s151 Officer) all have a responsibility to ensure Internal Audit has sufficient resources to enable it to fulfil its mandate. Significant matters that jeopardise the delivery of the plan or require changes to the plan will be identified, addressed and reported to the Audit Committee.

8.4 Upon request from the ~~Head of Finance~~Corporate Finance Manager (s151 Officer), appropriate specialists from other ~~Directorates~~ Portfolios and ~~departments~~ services should be made available to take part in any audit review requiring specialist knowledge.

9. ~~Audit~~ Training

9.1 Internal auditors must enhance their knowledge, skills and other competencies through continuing professional development. The Internal Audit Manager carries out a continuous review of the development and training needs of all audit employees through the Authority's appraisal system and will arrange, within budget

provision, in-service training covering both internal and external courses.

9.2 To comply with the qualification 'Certificate of Internal Audit', those practicing Internal Auditors holding this qualification are required to undertake 40 hours of continued professional development.

9.3 Specific resources are devoted to specialised training in relation to computer audit, contract audit and fraud investigation to keep abreast of developments.

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10.1 All standard audit assignments are the subject of formal reports. Discussion draft reports are issued to the manager of the area under review. Debrief meetings are ~~then~~ held for agreement of ~~to the~~ factual accuracy of the findings and the necessary actions. After agreement, final reports are issued. The Internal Audit Manager considers the release of special investigations audit reports for disciplinary purposes on a case-by-case basis. Access to audit files is restricted to the Chief Officer Governance (Monitoring Officer) and External Auditor.

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10.3 The Internal Audit Manager reports to the Audit Committee on the progress of investigations into possible fraud and irregularity and also briefs the Audit Chair on any high profile investigations.

10.4 The assignment opinions that audit provides during the year are part of the framework of assurance~~s~~ that assists the Authority in ~~to~~ preparing~~e~~ an informed Annual Governance Statement.

10.5 Internal Audit provides the Authority with an opinion on the adequacy and effectiveness of the Authority's governance, risk management and control arrangements in support of the Annual Governance Statement. In giving the opinion it should be noted that assurance can never be absolute; the most that can be provided is a reasonable assurance that there are no major weaknesses in governance, risk management and control processes. The annual opinion is provided in the Annual Internal Audit Report after the year end.

10.6 Overall the Internal Audit Manager will report periodically to the Audit Committee and Senior Accountable Officers (where relevant audit) regarding:

- The internal audit service's purpose, authority and responsibility;

- The internal audit service's conformance with The IIA's Code of Ethics (Appendix A) and Standards, and action plans to address any significant conformance issues;
- Significant risk exposures and control issues, including fraud risks, governance issues, and other matters requiring the attention of, or requested by the Audit Committee;
- Results of audit engagements or other activities;
- Resource requirements; and
- Any response to risk management that may be unacceptable to the Council.

11. Performance ~~Reporting~~

11.1 Performance Indicators for Internal Audit are reported at each Audit Committee meeting.

11.2 The department participates in benchmarking within the Wales Chief Auditors Group. Results are reported to the Audit Committee.

12. Quality Assurance and Improvement Programme

12.1 The Internal Audit service will maintain a quality assurance improvement programme. The programme will include an evaluation of the Internal Audit service's conformance with the Standards and an evaluation of whether internal auditors apply The Institute of Internal Auditor's Code of Ethics. The programme will also assess the efficiency and effectiveness of the internal audit service and identify opportunities for improvement.

12.2 The Internal Audit Manager will communicate to Chief Officers and the Audit Committee on the Internal Audit service's quality assurance and improvement programme, including the results of internal assessments (both ongoing and periodic) and external assessments conducted at least once every five years by a qualified, independent assessor or assessment team from outside of the Council.

13. Third Party Auditing

13.1 The Internal Audit Manager ensures Service Level Agreements are in place with third parties to whom internal audit provides a service. The internal audit service ensures independence and objectively is maintained at all times.

14. Related Documents

14.1 This document is one of a series that, together, constitute the policies of the Council in relation to anti-fraud and corruption measures. The other documents are:

- Financial Procedure Rules and Contract Procedure Rules;
- Corporate Anti-Fraud and Corruption ~~Policy~~Strategy;
- Fraud and Irregularity Response Plan;
- Whistleblowing Policy; and
- Disciplinary Procedure

15. Signatures

Internal Audit Manager Date

Audit Committee Chair Date

Chief Executive Date

Appendix A

Code of Ethics

Anyone delivering internal audit work for the Council must comply with the PSIAS Code of Ethics. This covers:

Integrity	The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement. Internal Auditors: • Shall perform their work with honesty, diligence and responsibility • Shall observe the law and make disclosures expected by the law and the profession • Shall not knowingly be a party to any illegal activity, or engage in acts that are discreditable to the profession of internal auditing or to the organisation • Shall respect and contribute to the legitimate and ethical objectives of the organisation
Objectivity	Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements. Internal Auditors: • Shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation • Shall not accept anything that may impair or be presumed to impair their professional judgement • Shall disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review
Confidentiality	Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so. Internal Auditors: • Shall be prudent in the use and protection of information acquired in the course of their duties • Shall not use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the organisation

Competency	Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services. Internal Auditors: • Shall engage only in those services for which they have the necessary knowledge, skills and experience • Shall perform internal auditing services in accordance with the International Standards for the Professional Practice of Internal Auditing • Shall continually improve their proficiency and effectiveness and quality of their services

Mae'r dudalen hon yn wag yn bwrpasol

Contents

1. Introduction

1.1 The internal audit charter is a formal document that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the Internal Audit Manager's functional reporting relationship with the 'board'; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the 'board'.

1.2 Internal Audit is a statutory requirement for local authorities. The two pieces of legislation that impact upon internal audit in local authorities are:

- Section 5 of the Accounts and Audit (Wales) Regulations 2018 states that "a relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance".

- Section 151 of the Local Government Act 1972 requires every authority to make arrangements for the administration of its financial affairs and to ensure that one of the officers has responsibility for the administration of those affairs. CIPFA has defined 'proper administration' in that it should include 'compliance with the statutory requirements for accounting and internal audit'.

2. Purpose and Mission

2.1 The purpose of Flintshire County Council's (the Council's) Internal Audit service is to provide independent, objective assurance and consulting services designed to add value and improve the Council's operations. This mission of internal audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice, and insight. The internal audit service helps the Council accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

2.2 Internal Audit objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper economic, efficient and effective use of resources. It may also undertake consulting services at the request of the Council, subject to there being no impact on the core assurance work and the availability of skills and resources within the team.

3. Standards for the Professional Practice of Internal Auditing

3.1 Public Sector Internal Audit Standards (PSIAS) published in 2013 and updated in 2016, 2017 and 2018 provide a definition, mission and core principles for internal audit and the activity and standards that must be met. They include a Code of Ethics which Internal Auditors must conform to, covering integrity, objectivity, confidentiality and competency. They are mandatory for all internal audit departments in the UK public sector. The Internal Audit Manager will report periodically to Chief Officers and the Audit Committee regarding the internal audit service's conformance to the Code of Ethics and Standards.

3.2 PSIAS state that the charter must:

- Define the terms 'board' and 'senior management' for the purposes of internal audit activity. For the purpose of this Charter the board will be known as the Audit Committee.
- Cover the arrangements for appropriate resourcing;
- Define the role of internal audit in any fraud related work; and
- Include arrangements for avoiding conflicts of interest if internal audit undertakes non-audit activities.

4. Authority, Independence and Objectivity

4.1 PSIAS state that 'Organisational independence is effectively achieved when the Internal Audit Manager reports functionally to the 'board.' Within Flintshire the Audit Committee is equivalent to the 'Board' and the Chief Officers Team constitutes 'Senior Management'. The **Audit Committee** fulfils most of the roles of the 'board'. It is responsible for:

- approving the internal audit charter;
- approving the internal audit Strategic and Operational plans;
- receiving reports from the Internal Audit Manager on the departments performance relative to its plan and other matters; and
- making appropriate enquiries of management and the Internal Audit Manager to determine whether there are inappropriate scope or resource limitations.

4.2 The Internal Audits budget is approved annually as part of the Council's overall budget. Remuneration and arrangements for the appointment and removal of the Internal Audit Manager are managed in accordance with the Council's adopted HR

policies.

4.3 The Internal Audit department is part of the Governance Portfolio. The Internal Audit Manager reports administratively to the Chief Officer Governance (the Monitoring Officer).

4.4 To further ensure the independence of the Internal Audit Manager, the Chief Executive and Chair of the Audit Committee provide feedback into her annual appraisal.

4.5 The Internal Audit Manager has direct access to the Chief Executive and the Leader of the Council and meets with the Chief Executive bimonthly.

4.6 Internal Audit is independent of the activities that it audits to ensure the unbiased judgements essential to its proper conduct and impartial advice to management.

4.7 To ensure independence, Internal Audit operates within a framework that gives it the authority to:

- have unrestricted access to all activities undertaken in the Council;
- have full and unrestricted access to all functions, records and property, including those of partner organisations. In very exceptional circumstances if the "responsible officer" (Section 151 Officer) and Monitoring Officer believe this would constitute a breach of the laws of confidentiality, or the provisions of the Human Rights Act, or the Data Protection Act the matter will be referred to the Audit Committee for consideration;
- have full and free access to the Audit Committee via the Internal Audit Manager, and an annual private meeting with the committee;
- have full and free access to the Chief Executive, Corporate Finance Manager (S151 Officer), Monitoring Officer, Chair and Vice Chair of the Audit Committee and External Auditors via the Internal Audit Manager;
- have unrestricted access to senior management, members and all employees;
- require any employee or member to provide any information and explanation considered necessary concerning any matter under consideration;
- require any employee or member to produce or account for cash, stores or any other Council asset or asset of a third party under his or her control;
- allocate resources, set timeframes, define review areas, develop scopes of work and apply techniques to accomplish the overall audit objectives; and
- issue audit reports in its own name.

4.8 The Internal Auditors will:

- Disclose any impairment of independence or objectivity, in fact or appearance to appropriate parties;
- Exhibit professional objectivity in gathering, evaluating and communicating information about the activity or process being examined;
- Make balanced assessments of all available and relevant facts and circumstances; and
- Take the necessary precautions to avoid being unduly influenced by their own interests or by others' informing judgements.

4.9 The Internal Audit Manager will confirm to the Audit Committee, at least annually, the organisational independence of the Internal Audit services.

4.10 The Internal Audit Manager will disclose to the Audit Committee any interference and related implications in determining the scope of internal auditing, performing work, and / or communicating results.

4.11 However, in strict emergency situations only, audit personnel may be called upon to carry out non-audit work on a temporary basis. If a request is made the decision to allocate resources will be the Internal Audit Manager's, who will agree clear terms of reference. The Audit Committee Chair or Vice Chair, the Chief Officer Governance and the s.151 officer will be advised.

4.12 In order to further enhance independence and objectivity a regular rotation of work is usually adhered to. It should be acknowledged that ensuring independence and objectivity is a priority within the team; however, in some instances a conscious decision has been made to use the same auditor for key system reviews to develop expertise and specialism within the team as this adds value to the audit and reduces resources.

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Audit Committee Chair Date

Chief Executive Date

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Objectivity	Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements. Internal Auditors: • Shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation • Shall not accept anything that may impair or be presumed to impair their professional judgement • Shall disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review
Confidentiality	Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so. Internal Auditors: • Shall be prudent in the use and protection of information acquired in the course of their duties • Shall not use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the organisation

Competency	Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services. Internal Auditors: • Shall engage only in those services for which they have the necessary knowledge, skills and experience • Shall perform internal auditing services in accordance with the International Standards for the Professional Practice of Internal Auditing • Shall continually improve their proficiency and effectiveness and quality of their services

AUDIT COMMITTEE

Date of Meeting	Wednesday, 5 June 2019
Report Subject	Internal Audit Progress Report
Report Author	Internal Audit Manager
Type of Report	Assurance

EXECUTIVE SUMMARY

Internal Audit produces a progress report for the Audit Committee every quarter. This shows the position of the team against the plan, changes to the plan, final reports issued, action tracking, performance indicators and current investigations. This meets the requirements of the Public Sector Internal Audit Standards, and also enables the Committee to fulfil the Terms of Reference with regards to Internal Audit.

The current progress report is attached.

RECOMMENDATIONS	
1	To consider and accept the report.

REPORT DETAILS

1.00	EXPLAINING THE INTERNAL AUDIT PROGRESS REPORT
1.01	Internal Audit gives a progress report to the Audit Committee every quarter as part of the normal reporting process. The report is divided into several parts.
1.02	The level of audit assurance for standard audit reviews is detailed within Appendix A. All reports finalised since the last Committee meeting are shown in Appendix B.
1.03	Appendix C provides an oversight to Audit Committee on the cumulative assurance throughout the year, however it should be noted this will be fluid. At the request of the Committee in March, a footnote has been included to list those reports issued with Red / Amber Red assurance.

1.04	Since the last Committee meeting in March there has been one report issued with Red / Limited assurance for Accounts Payable. Details of this review is detailed within Appendix D. Appendix E shows those reports with a Red Amber / Some Assurance given. Copies of all final reports are available for members if they wish to see them.
1.05	The automated tracking of actions is completed through the use of the integrated audit software. All actions are tracked automatically and the system allows Managers and Chief Officers to monitor their own teams' outstanding actions and confirm they are being implemented. E-mail alerts are generated by the system and sent to the responsible officer and their manager before the action is due. In the event an action is not completed within the agreed date, an e-mail is also sent to the responsible officer, their manager and copied to Chief Officer for awareness. Monthly reports are also sent to Chief Officers informing them of outstanding actions for their teams. The monthly report to Chief Officers now identifies the date of the last update provided (if any) for each action. Each Chief Officer is requested to review this. Appendix F shows the current situation. Of 921 actions entered into the system, 817 have been cleared and 105 remain live. There are 9 overdue actions to be reported, listed in Appendix G. Appendix H lists all actions with a revised due date of six months from the original due date and a note on how the risk is being managed. For each revised due date entered onto the system, the officer is required to provide a reason to support this change. To avoid repetition in the report, where an action is older than six months and overdue this action will be included within the Appendix G, Actions Overdue.
1.07	Appendix I shows the status of current investigations into alleged fraud or irregularities. The table includes the start date of the investigations.
1.08	Appendix J shows the range of performance indicators for the department. Overall performance continues to meet the current targets set; however, there has been a slight reduction in the number of days from responses received to the issue of the final reports and for departments to provide comments to their reports and the number of questionnaires returned overall. This level of performance will be monitored.
1.09	Appendix K shows the current position of work being finalised from the 2018/19 audit plans. Since the last audit one review on Collaborative / Partnership Arrangements of the Adoption Service has needed to be deferred. This is due to an external report required to form the basis of the review being currently unavailable.

1.10	Appendix L shows the current position of the 2019/20 plan. The plan will continue to be reviewed with Chief Officers on a quarterly basis and reprioritised to accommodate any new requests for work or to respond to emerging issues. Since the plan was approved in March 2019 there have been three new requests for additional work. These are: • Corporate Credit Cards • DFG Valueworks Framework – Value for Money • Care and Repair SLA

2.00	**RESOURCE IMPLICATIONS**
2.01	None as a direct result of this report.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	None required.

4.00	**RISK MANAGEMENT**
4.01	The work of Internal Audit provides assurance to the Council that adequate and effective controls are in place to mitigate risks.

5.00	**APPENDICES**	
5.01	Appendix A	Levels of Audit Assurance
	Appendix B	Final Reports Issued Since March 2019
	Appendix C	Audit Assurance and Priority of Actions
	Appendix D	Red / Limited Assurance Reports Issued since March 2019
	Appendix E	Amber Red / Some Assurance Reports Issued since March 2019
	Appendix F	Action Tracking – Portfolio Statistics
	Appendix G	Over Due Actions (including actions older than 6 months if overdue)
	Appendix H	Actions with Revised Due Date Six Months Beyond Original Due Date and not overdue
	Appendix I	Investigation Update
	Appendix J	Performance Indicators
	Appendix K	Operational Plan 2018/19 (Carry Forward)
	Appendix L	Operational Plan 2019/20

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS	
6.01	**Contact Officer:** **Telephone:** **E-mail:**	Lisa Brownbill, Internal Audit Manager 01352 702231 Lisa.brownbill@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	**Wales Audit Office:** works to support the Auditor General as the public sector watchdog for Wales. They aim to ensure that the people of Wales know whether public money is being managed wisely and that public bodies in Wales understand how to improve outcomes. **Corporate Governance:** the system by which local authorities direct and control their functions and relate to their communities. It is founded on the basic principles of openness and inclusivity, integrity and accountability together with the overarching concept of leadership. It is an inter-related system that brings together the underlying set of legislative requirements, governance principles and management processes. **Operational Plan:** the annual plan of work for the Internal Audit team.

Flintshire Internal Audit

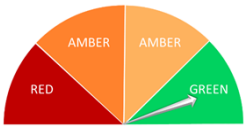
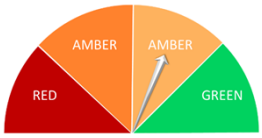
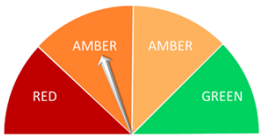
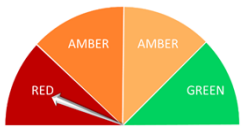
Progress Report

June 2019

Contents

Levels of Assurance – Standard Audit Reports Appendix A

The audit opinion is the level of assurance that Internal Audit can give to management and all other stakeholders on the adequacy and effectiveness of controls within the area audited. It is assessed following the completion of the audit and is based on the findings from the audit. Progress on the implementation of agreed actions will be monitored. Findings from **Red** assurance audits, and summary findings from Amber Red audits will be reported to the Audit Committee.

Level of Assurance	Explanation
Green – Substantial 	**Strong controls in place (all or most of the following)** • Key controls exist and are applied consistently and effectively • Objectives achieved in a pragmatic and cost effective manner • Compliance with relevant regulations and procedures • Assets safeguarded • Information reliable Conclusion: key controls have been adequately designed and are operating effectively to deliver the key objectives of the system, process, function or service.
	Follow Up Audit: 85%+ of actions have been implemented. All high priority actions have been implemented.
Amber Green – Reasonable 	**Key Controls in place but some fine tuning required (one or more of the following)** • Key controls exist but there are weaknesses and / or inconsistencies in application though no evidence of any significant impact • Some refinement or addition of controls would enhance the control environment • Key objectives could be better achieved with some relatively minor adjustments Conclusion: key controls generally operating effectively.
	Follow Up Audit: 51-85% of actions have been implemented. All high priority actions have been implemented.
Amber Red – Some 	**Significant improvement in control environment required (one or more of the following)** • Key controls exist but fail to address all risks identified and / or are not applied consistently and effectively • Evidence of (or the potential for) financial / other loss • Key management information exists but is unreliable • System / process objectives are not being met, or are being met at an unnecessary cost or use of resources. Conclusion: key controls are generally inadequate or ineffective.
	Follow Up Audits - 30-50% of actions have been implemented. Any outstanding high priority actions are in the process of being implemented.
Red – Limited 	**Urgent system revision required (one or more of the following)** • Key controls are absent or rarely applied • Evidence of (or the potential for) significant financial / other losses • Key management information does not exist • System / process objectives are not being met, or are being met at a significant and unnecessary cost or use of resources. Conclusion: a lack of adequate or effective controls.
	Follow Up Audit - <30% of actions have been implemented. Unsatisfactory progress has been made on the implementation of high priority actions.

Categorisation of Actions	Actions are prioritised as High, Medium or Low to reflect our assessment of risk associated with the control weaknesses
Value for Money	The definition of Internal Audit within the Audit Charter includes 'It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper economic, efficient and effective use of resources.' These value for money findings and recommendations are included within audit reports.

Final Reports Issued Since March 2019

Appendix B

The following reports and advisory work have been finalised since the last Audit Committee. Action plans are in place to address the weaknesses identified. The 2018/19 audit work listed below contributes to the annual audit opinion for the year for 2018/19. The 2019/20 audit work will form the basis of the annual audit opinion for 2019/20.

Project Reference	Portfolio	Project Description	Audit Type	Level of Assurance	Actions		
					High	Med	Low
2018/19 Audit Work							
25-2017/18	P&R	Main Accounting - Accounts Payable	System Based	R	3	5	0
04-2018/19	P&R	Annual Leave	Risk Based	AR	0	5	2
51-2018/19	H&A	Property Valuations	Risk Based	AR	0	2	3
35-2018/19	PE&E	Minerals and Waste Governance Arrangements	Risk Based	AR	2	2	1
20-2017/18	S&T	Integrated Transport Unit	Risk	AR	1	6	6
33-2018/19	S&T	Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment (Streetscene & Transportation)	Risk Based	AR	0	4	2
15-2018/18	H&A	Welsh Housing Quality Standards (WHQS)	Risk Based	AG	0	3	4
09-2018/19	H&A	Housing Benefits	System Based	AG	0	0	4
39-2018/19	SS & E&Y	Children out of County Care & Education	Risk Based	AG	0	0	3
43-2018/19	P&R	Payroll	System Based	AG	0	0	8
62-2018/19	E&Y	Trelogan Primary School	Risk Based	AG	0	0	4

Project Reference	Portfolio	Project Description	Audit Type	Level of Assurance	Actions		
					High	Med	Low
58-2018/19	E&Y	St David's High School	Risk Based	AG	0	1	5
60-2018/19	E&Y	Owen Jones Primary School	Risk Based	AG	0	2	9
61-2018/19	E&Y	Ysgol Merllyn	Risk Based	AG	0	2	4
59-2018/19	E&Y	Hawarden Village Voluntary Aided Primary School	Risk Based	AG	0	1	3
32-2018/19	P&R	Occupational Health Unit	Risk Based	AG	0	2	5
33-2018/19	SS	Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment (Social Services)	Risk Based	AG	0	1	2
57-2018/19	E&Y	Risk Based Thematic Reviews	Risk Based	AG	0	3	13
33-2018/19	PE&E	Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment (Corporate Health & Safety)	Risk Based	G	0	0	2
52-2018/19	EXT	Aura	External – SLA	Advisory	-	-	-
AC12-2018/19	P&R	Exist Packages	Advisory	Advisory	-	-	-
40-2018/19	EXT	North Wales Residual Waste Project	Advisory	Advisory	-	-	-
19/20 Audit Plan Work							
14-2019/20	SS	Supporting People	Grant	Advisory	-	-	-

Audit Assurance Summary

Appendix C

Portfolio	Number of Reports & Assurance						Priority & Number of Agreed Actions			
	Red	Amber Red	Amber Green	Green	Advisory / Grant - No Opinion Given	In Total	High	Medium	Low	In Total
Corporate						0				0
Education & Youth					1	1				0
Governance						0				0
Housing & Assets						0				0
People & Resources						0				0
Planning, Environment & Economy						0				0
Social Services						0				0
Streetscene & Transportation						0				0
External						0				0
Total	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**

Footnote:	
Red Assurance:	
Amber Red Assurance:	

RED / Limited Assurance Opinion

Appendix D

Main Accounting– Accounts Payable and P2P

An audit of Accounts Payable (AP) and the Purchase to Pay (P2P) systems was undertaken as part of the approved internal audit annual plan for 2017/18. The audit reviewed and considered the adequacy and effectiveness of the operating system and management controls in mitigating the following risks:

- Failure to meet payment timescales as per Welsh Government (WG) Prompt Payment Legislation;
- Inability to identify duplicate payments prior to the funds being released;
- Inability to prevent fraudulent vendors being added to the system;
- Inability to detect fraudulent invoices set up to facilitate payments;
- Delayed or inaccurate payments may be made due to the incorrect use of the procurement software; and
- No mechanism in place to periodically review the effectiveness of the AP activity.

The review identified that significant improvements in the control environment were required. Specifically, the monthly report generated through the fiscal system; a key system control to highlight potential duplicates for investigation by Accounts Payable; had not been run from 01 January 2017 to 30 September 2017 due to the fiscal upgrade and the financial system migration. Management have advised that the Fiscal license could not be renewed until Masterpiece had been migrated to the new platform, which took longer than originally anticipated. During this time, an alternative control was not introduced and as such duplicates were not identified in a timely manner in order for monies to be recovered.

Further investigation into the monthly fiscal report has highlighted that the whilst the inbuilt fiscal risk categories are used to generate the report, an effective methodology, based on risks to the Council, to interrogate the dataset and identify material duplicates is not in place. This report is a detective control as it is ran subsequent to a payment run and is only generated by one officer within the AP & AR team.

The method for recording actions taken in relation to duplicate payments was incomplete as the spreadsheet for recording duplicates is only documented by recovery through AP. Recovery of duplicate monies through AR was not captured by management on the same spreadsheet .

Subsequent to the internal audit closure meeting, the Finance Manager highlighted to the Internal Audit Manager that a duplicate payment had been made to a contractor totalling £180.3K. This duplicate payment was identified through a report provided by an external third party service provider. This service provider had approached the Council and offered to review council payments for duplicate payments. Data between 2014/15 up to 14/12/2017 was supplied and the third party service provided a report highlighting potential duplicate payments to the Council a month prior to the closing meeting. This

report contained approximately 200 entries totalling a potential gross overpayment of £939,164. Management subsequently investigated and identified the total duplicate amount of £373,581 of which a specific contractor was £180,343. The report was later provided to internal audit three months following its receipt by Accounts Payable. This was subject to review and sample testing by internal audit and is the reason for the delay in issuing the draft report from the original closing meeting.

Initially whilst it was not expected that the full £939k was due to the Council at the time of the audit, management was not able to demonstrate that each duplicate payment highlighted by the report had been investigated and monies recovered. In addition, at the time of the audit it was unclear whether management had been able to effectively identify duplicate payments since 14/12/2017 given the findings in relation to the review of the fiscal report. As such it is difficult to quantify the volume and value potential loss to the Council as a result of duplicate payments other than that suggested by the report.

System constraints within the Council's financial system Masterpiece have also been identified. Specifically, an audit trail is not available in all instances and the current reports on amendments are not interrogated or verified by management. Management have agreed to implement this additional control to prevent the potential for changes to go undetected and for fraud to occur.

The Public Contracts Regulation 2015 provides statutory guidance for public sector buyers and suppliers on paying undisputed, valid invoices within 30 days down the public sector supply chain. Management information has shown that for the last financial year, the Council has only paid 86% of all undisputed invoices within 32 days. It has been advised this is primarily due to the large volume of retrospective invoices. Although initiatives have been implemented and others are being developed to address the issue of retrospective invoices, the KPI indicating the effectiveness of these initiatives has remained unchanged across the last two years. The Council has yet to publish annual payments performance data as required of all public sector buyers from March 2016.

Lastly, enhancements are required to some processes such as new vendor authenticity to ensure a full audit trail is available for management to identify any lack of procedural adherence or conduct an investigation in the event fraud were to occur.

Overall Conclusion:

The audit review identified inadequate and/or ineffective controls in place within the service which has resulted in a ‘red’/limited assurance opinion being given. The impact of this assurance opinion requires urgent service revision to address the issues identified. Specifically, weaknesses were found in relation to the identification, processing and recovery of duplicate payments in a timely manner. As such, the scope for 18/19 AP P2P review has been agreed with management to focus on the system, process and officer controls around duplicate payments as a whole given the findings highlighted in this report. Control weaknesses were also identified in relation to the new vendor process, specifically system controls within the Masterpiece Finance system in recognising duplicate vendors when a new supplier is added as well as system restrictions to enforce segregation of duties. A number of meetings have been held with management to discuss and agree appropriate actions to mitigate the issues identified in the review. The service area has advised that following further analysis the number of potential duplicates which were investigated from the third party provider report totalled £490,044. Of this,

£373,581 were identified as duplicate payments. The service advised there is only £416.50 left to recover of which £265 was written off and the remaining balance of £151.50 has been recommended for write off. A number of the agreed actions have been completed and have been validated by internal audit for adequacy. They are as follows:

- The format of the fiscal reporting spreadsheet has now been amended to provide a full audit trail of the work completed including the outcome of each entry reviewed, the reason for establishing if the entry is a duplicate or not together with the name of the reviewer.
- The fiscal reports are now run on daily basis prior to the pay run and the roles and responsibilities within the team have been reviewed with segregation of duties introduced.
- A documented procedure has been drafted to assist with the analysis of the Fiscal Report. Feedback has been provided to the service area on additional information to include to mitigate recurrence of previous issues. Once this has been finalised and the procedure is being adhered to, this should reduce the risk of duplicate payments not being identified.
- Accounts payable staff have been reminded of the requirement to follow procedure and ensure invoice numbers are checked to source documentation.
- Amendments have been made to the new supplier database to provide evidence of the vendor validity checks completed.
- Performance on the timeliness of payments to suppliers will now be included and reported via the corporate Medium Term Financial Strategy Performance Indicators.

The issues identified within the audit were escalated to the Chief Executive and Corporate Finance Manager at an early stage and the introduction of the additional controls identified above significantly reduces the risk of future duplicate payments being made. The controls also provide assurance that any potential duplicate payments in the future are dealt with in a timely manner.

It is important to note that there was no evidence of collusion with vendors or fraud as a result of the findings identified.

The Corporate Finance Manager (Section 151 Officer) will provide a full verbal update to Audit Committee, however in the interim, The Corporate Finance Manager (Section 151 Officer) has provided the following statement *"I have worked closely with the team to understand the issues that contributed to the duplicate payments being made. I am assured that the additional and more robust preventative controls that have now been put in place will help detect any future potential duplicates in advance of payment being made. With the exception of an amount of £416.50 all duplicate payments have now been recovered. I will continue to monitor closely the progress of all of the changes that have been implemented as a result of the audit".*

The main findings and actions for this review are detailed in the table below.

Main Accounting– Accounts Payable and P2P Action Plan

No.	Findings and Implications	Agreed Action	When
1(R)	**Duplicate Payment Processing** Monthly reports are ran through the fiscal software to identify potential duplicate payments. These reports are reviewed by management and those identified as potential duplicates are recorded on the current fiscal reporting spreadsheet. Review of this spreadsheet identified that enhancements are required as it does not provide an audit trail of who reviewed the transactions, when this was completed, the reason to support why an action would not be required and in the event where funds are required to be recovered, whether the appropriate actions had taken place. Due to the volume of entries within the report, the report may need to be worked by various members of the team to facilitate a timely completion. Where this is the case the report is sent on paper rather than electronically, preventing an efficient reconciliation that all entries appearing on the report have been worked effectively.	The format of the fiscal reporting spreadsheet has now been amended to provide a full audit trail. All reports are supported by copy documents of original transactions. The reporting spreadsheet will be amended further to include the outcome of each entry reviewed to record the reason for establishing if a duplicate or not together with the name of the reviewer. Additionally, as a result of the fiscal upgrade and financial system migration, the report had not been ran for a period of time which led to a large volume of entries requiring review which was worked on by various members of the team due to the volume of the transactions. The fiscal reports are now run on daily basis and the roles and responsibilities within the team have been reviewed with segregation of duties introduced between the technician and team manager to ensure the output is analysed and then reviewed. Due to financial system constraints, the FISCAL report is run on the previous day's data. The FISCAL report is checked prior to the deadline (noon) for recalls of any identified duplicates to be made. URN 02295	Complete Complete Complete
2(R)	**Contractor Duplicate Payment** The Finance Manager highlighted to the Internal Audit Manager after the closure meeting of 17/18 AP P2P review that a duplicate payment had been made to a contractor totalling £180.3K. This duplicate payment was identified		

No.	Findings and Implications	Agreed Action	When
	through a report provided by an external a consultancy company, and not through the Council's internal monitoring and reporting systems. Our testing of the report identified the following control weaknesses in relation to this contractor: • A duplicate copy of the payment certificate and accompanying contractor invoice was received by AP for processing on 20 March 2017 and on 23 March 2017. • On the second submission, the invoice number completed on the payment certificate within capital works did not match that of the invoice. The invoice ID on the payment certificate was not verified against the actual invoice as per the defined AP process, before processing. Matching against duplicate invoice numbers is a fundamental part of the inbuilt system control which would have alerted the processor to a possible duplicate and prevented the payment being made. However, if an invoice number is completed incorrectly or not checked, the system control will not operate. • Payments to the contractor are not made via the P2P system. Invoices from Capital works are accompanied by the Certificate of Payment, and various pages of documentation from Procure Plus. Not all of this documentation is required by AP to process the invoice and some of the pre populated fields on the Payment Certificate are in need of review. There is a risk that key control checks are compromised by the inclusion of additional or incorrect information on supporting documentation. • A second system control, the fiscal report had not been run from 01 January 2017 to 30 September 2017. Management have advised that this was due to the fiscal	All staff have been reminded of the requirement to ensure that invoice numbers are checked to source documentation. To ensure this is in place regular sample tests will be undertaken by the AP/AR Team Leader on a monthly basis and the outcome recorded together with follow up action where necessary. The process for capital works payments will be reviewed to ensure that payment certificates are correctly populated and that appropriate supporting documentation is attached. Due to the migration of the financial system, no alternative system was considered available at this time. The intention was	Complete 31/07/2019 30/06/2019

No.	Findings and Implications	Agreed Action	When
	upgrade and the financial system migration. However, no specific action was taken to replace this key control in the interim period. It was during this period that the contractor payment was processed twice.	to review all historical transactions upon completion of migration and with the new system in place.	
	• The fiscal report was run on 26/10/2017 as a catch up report. The report did highlight the contractor payment as a potential duplicate. Management have advised that this was not picked up by the checking methodology used to analyse the output from the fiscal report. There is no documented procedure for analysing the fiscal report.	A documented procedure is now in place for analysing the Fiscal report. This is currently being reviewed to incorporate feedback from audit on the risk categories and process.	31/07/2019
	• The checking methodology applied by management relies on a visual check of risk categories 1, 2, 3. However a detailed definition of the sub categories was not available. A visual check of significant rows of data is prone to error and inaccuracy.	Details of the risk categories identified by the Fiscal report are identified within the procedure. Every category is now reviewed on a daily basis as per the new procedure.	31/07/2019
	• As a result of inconsistent checking of invoice numbers before processing, the contractor payment was not matched by invoice number and appeared on the report as a risk category 5B.	Due to Financial system constraints, the FISCAL report is run on the previous day's data. The FISCAL report is checked prior to the deadline (noon) for recalls for any identified duplicates to be made. It is checked by an AP technician in the absence of the manager so that any identified duplicates can be recalled.	Complete
	• The fiscal report is only worked by the AP&AR manager and there is no business continuity in the event the AP&AR manager is on annual leave or otherwise absent.		
	• A monthly HRA report is sent to capital works from Finance detailing all spend against cost codes for management to review and advise of any errors which need to be investigated and resolved. The 2016/17 HRA Period 12 13.04.17 report highlighted the contractor duplicate payment; however we have been unable to evidence the analysis of this report was completed by the then manager nor that the duplicate payment had been identified in 2017 and had been flagged for pursuance by	The Finance team sends transactional information on a monthly basis. Further controls to check transactions report will be put in place by the Capital Works team.	30/06/2019
		The Housing Finance team will undertake regular reviews of the monitoring undertaken by the Capital Works team to ensure transactional reports are reviewed as part of monitoring.	31/07/2019

No.	Findings and Implications	Agreed Action	When
	capital works. The above issues pose a risk that duplicate payments may not be identified prior to payment and once made as occurred in the contractor example. Whilst the Council's system controls operated effectively to highlight that the potential duplicate, managements' analysis of the system outputs (fiscal report and HRA report) in both AP and Capital works was insufficient resulting in the overpayment of £180K which was undetected by the Council's own processes until highlighted by the third party service provider.	URN 02433	
3(R)	**Recovery of Duplicate Payments** Once a duplicate payment is identified, a credit requisition is raised by AP to recover the funds. This information is captured on a spreadsheet in AP. At the time of the review, 50 credit requisitions had been raised this financial year totalling £17.2K for duplicate payments. For the same period, a total of 97.7K invoices were processed totalling £186.9 million. This equated to 0.0005% of the overall value of all invoices processed. The third party service provider report, received by AP on 2 August 2018 identified potential duplicates of a more significant level than that identified by the AP spreadsheet. (Approximately 200 entries totalling a potential gross overpayment of £939,164.47 of which the contractor was £180,343.22). As Management acknowledged the spreadsheet was incomplete we requested a further updated AP recovery	Included within the total of £939,164.47 were entries totalling £449,120.78 which related to similar references which were confirmed as non-duplicates. Further analysis of this figure shows that the number of potential duplicates totalled £490,043.69. Of this remaining figures £373,580.63 were identified as duplicate payments of which all monies have been recovered with the exception of £265 which was written off and a further balance of £151.50 which has been recommended for write off.	Complete

No.	Findings and Implications	Agreed Action	When
	spreadsheet in November. It starts from April 2018, has 93 items and amounts to a potential duplicate loss of £113,048.26, the contractor payment is not recorded on this spreadsheet. Our testing has identified the following: • Management has updated the third party service provider report that monies have been "recovered". The potential stated by management as recovered or in the process of recovering is estimated as £225,918.24 (net).		
	• At the time of writing a sample of 78 was reviewed, this included all duplicates that management had stated had been recovered or were in the process of recovering. Out of this sample audit were able to evidence 38 lines (49%) of duplicates as recovered from the credit requisition evidenced via the Mpower report. The amount evidenced by audit stands at £53,710.69 (net) however management advise that all items have been worked through and their update is accurate.	This work is now complete with all evidence for recovery identified.	Complete
	• At the time of writing we are unable to provide assurance that the remaining duplicates have been recovered or attempted to be recovered. This is because the monies may have been received and recorded via masterpiece or may have been netted off the subsequent invoice provided by the supplier. Further testing in this area will be carried out during the 18/19 AP P2P review.	See above	
	• The earliest recovery request date (Invoice date) was 24/08/2018 and the latest 22/11/2018, this indicates that no recovery attempts took place before the third party service provider report. There is a risk that management	See above. This work is now complete and supported by evidence.	Complete

No.	Findings and Implications	Agreed Action	When
	were unaware of the duplicate payments before they were highlighted by the third party service provider. • It is unclear as to whether all the data appearing in the third party service provider report has been assessed to identify the volume and value of duplicates, number of invoices which have been raised to recover funds and how much has been recovered to date. • Once the credit requisition attempt is exhausted, recovery is attempted by way of invoice and legal pursuance. It is unclear from management which duplicate payment are subject to this pursuance and if these have been successful. Recovery attempts via invoice are not recorded on management's spreadsheet, nor have that monies been received. Further testing in this area will be carried out during the 18/19 AP P2P review. Given that management appears reliant on an external party's analysis of a specific dataset however an effective action plan to resolve the findings of the third party service provider report (August 2018) is not in place. This provide assurance that the potential loss to the Council is quantified and being effectively managed. There is a risk that Management's internal processes do not provide an accurate picture of the scale of the issue, and there are limitations to the actions taken by management to recoup duplicate payments.	The recording of duplicate payments and subsequent attempts at recovery is now recorded on the Duplicate Payments and Latest Position spreadsheet. The reporting spreadsheet will be amended further to include the outcome of each entry reviewed to record the reason for establishing if a duplicate or not together with the name of the reviewer. This occurred as a result of the migration of the finance system to a new operating platform which meant the Fiscal report was unable to be run. This was a one off and in future the report is run and assessed for duplicates each day prior to payment being received by the supplier. A new system of management oversight will be introduced to review the duplicate process and the performance of the revised systems put in place. URN 2434	31/07/2019 30/09/2019
4 (A)	**Prompt Payment Regulatory Adherence** The Accounts Payable processes to facilitate the payment invoices are not fully compliant with the prompt payment regulatory requirements.	Flintshire County Council does not have the facility to record receipt of invoice date. As such, reporting is based on the date of invoice and two days are added for postage i.e. 32 days. Calculations are based on invoice date and paid date.	

No.	Findings and Implications	Agreed Action	When
	Specifically, invoices paid within 30 days are not tracked from the date the invoice is received but instead is tracked two days from the invoice date. A KPI is in place to monitor performance of this; however, the authority has yet to achieve the 95% target for undisputed invoices paid within the 32 days. Within the last financial year, this KPI ranged from 82.8% to 86%. Also, the Council does not track and report the amount of interest paid to suppliers due to late payment which is one of the prompt payment regulatory requirements. Lastly, statistical payment performance data is not published on the internet as required. As such, the Council is currently not compliant with elements of the prompt payment regulatory requirements.	A new expenditure code has been requested to facilitate discussion relating to the amount of interest paid to suppliers due to late payment at the practitioners group. An implementation plan will be devised to roll out this expenditure code across the authority. Council no longer publish this data but it is available and from 2019/20 it will be included in the Key Performance Indicators reported as part of the MTFS. URN 02274	30/11/2019 30/09/2019
5 (A)	**New Vendor Process** **System Controls** The Masterpiece system is limited in that it does not automatically recognise duplicated entries and does not have the sophistication to check bank details in a live setting. There is currently no preventative control to highlight a fraudulent new supplier has been added to the system. There is high reliance on staff and procedure operating effectively. **Segregation of Duties** Currently all AP staff are able to add new vendors on to the Masterpiece system. We acknowledge that this task is	Since the audit a new profile has been created and is now active to assist with segregation of duties.	Complete

No.	Findings and Implications	Agreed Action	When
	usually carried out by two AP Technicians however there is no system restriction to the access of other staff to ensure sufficient segregation of duties. **Vendor Validity Checks** The new vendor validity check procedure does not prescribe which credibility checks should be completed in any specific order. Options to check include 192.com alongside higher credibility checks such as Companies House, EU Commission VIES VAT number validation and Google. There is a risk that an insufficient check is completed before adding a new vendor. **Evidence of Vendor Checks** Currently compliance checking of the new vendor process is not carried out on a periodic basis to ensure new vendors have been correctly validated before being added to the system. Evidence of checks completed as part of this key control is no longer retained via a spreadsheet due to time constraints. The risk is that management are unable to demonstrate evidence of the new vendor checks completed as part of their system of control. The findings highlight that the overall system of control could be strengthened to ensure the risk of fraudulent new vendors being added to the system is both prevented and detected.	All new vendors are checked thoroughly for authenticity. Staff carry out checks with companies' house, VAT validation, google website, etc. Amendments have been made to the new supplier database to include and record the checks carried out to assist with the evidencing of these checks. Documented procedures are in place to support this process and a quarterly check of a sample of suppliers with be undertaken to ensure compliance. URN 02339	Complete 31/07/2019
6 (A)	**Duplicate Vendor Identification** The Masterpiece system is incapable of identifying duplicate vendors. Reliance is placed on staff spotting duplicates whilst processing and the biennial NFI analysis carried out by internal audit.	A quarterly check by management will be added to the plan to assist with the identification of duplicates on a more regular basis. URN 02327	31/12/2019

No.	Findings and Implications	Agreed Action	When
	IDEA software was used to test for duplicates vendors on the system. A sample of 12 duplicates was further analysed, it was found the majority were not duplicates but rather different NNDR accounts and projects payments to various services in a large organisation. Two actual duplicated vendors were identified and brought to the attention of the AP/AR Team leader for rectification, who ensured the duplicate accounts were closed. A periodic check by management using AP's Fiscal software could help the service identify duplicates vendors on a more regular basis and take action where appropriate. Duplicate vendor accounts increase the risk of duplicate payments and disguise payments already made. It can also produce inaccurate management data when reporting spend by vendor.		
7 (A)	**Fraud Prevention Controls** The masterpiece system does not have an audit trail functionality to identify collectively what actions have been taken and by whom. Additionally the vendor creation report, which is utilised to identify the changes made to vendor records, does not detail the nature of the change. The bank account report is generated daily and highlights all changes made to bank account records, who facilitated this change and the new bank account information. This report is reviewed to ensure the format of the sort code and bank account number is	Since the audit changes to procedures have been made whereby these control reports are downloaded by an officer without access to amend any of the details. When details are added or amended, they are verified by someone who does not have access to carry out the amendments to further demonstrate a segregation of duties.	Complete

No.	Findings and Implications	Agreed Action	When
	correct. Reports on amendments are not interrogated or verified by management. As such, there is the potential for changes to go undetected and for fraud to occur.	As part of the monthly quality assurance process, a sample of the changes made to bank accounts will be reviewed and reconciled to the bank change requests to ensure process adherence and the request was valid. URN 02286	31/12/2019
8 (A)	**P2P – Usage and Retrospective Invoices** Monthly or periodic orders on long term contracts are being raised on new purchases orders, failing to use the purchase order which has been assigned to the original contract. From a sample test of 10, 3 were incorrectly allocated new purchase orders. This risks delayed or duplicate payments as well as inefficient use of resource as AP staff have to ensure the order is linked to the correct purchase order, which has to be authorised again. The rate of retrospective invoices raised through the P2P is at circa 70% and has been at this level despite efforts to reduce it over the past few years. This is having an impact on the achievement of the payments made within 30 days KPI and is hindering the introduction of a fast pay scheme which would see reduced costs to the Council. Although issues with retrospective invoices has been raised and discussed in E-Procurement Board, as of May 2018 the reporting requirements and strategies had not yet been defined and agreed. This will further delay the achievement of the payments made within 30 days KPI which is a regulatory requirement and may cause reputational damage to the Council.	Monthly reports will be sent to Chief Officers to highlight recurring issues so that remedial action can be taken within the service with the aim of reducing the number of retrospective orders. A mid-year review will be undertaken by COT to assess the level of improvement. URN 02277	30/06/2019

Amber Red Assurance Opinions

Appendix E

People & Resources – Annual Leave

Areas Managed Well	Areas Identified for Further Improvement
• An up to date Annual Leave Policy is in place for the period 2018 – 2021 which the Trade Unions have been consulted on. • Guidance on Annual Leave is available on the Council's infonet to assist employees and managers in the use and management of annual leave. This includes a Bank Holiday Calculator which is also able to work out pro rata holidays that are owed / to be deducted when an officer leaves the authority. • There is a reporting facility within Etarmis and Imperago which allows managers to monitor and review annual leave. • Training was provided to managers when the Annual Leave Policy was introduced in 2015. • General training on this policy is also available to managers on an individual basis via HR advisors. • The approach of taking holiday in hours allows greater flexibility for both employees and the Council as well as aligning to various work patterns.	Opportunities for improvement to the control environment have been identified to ensure the objectives are met. Our review identified: • The Annual Leave & Bank Holiday Calculator: which is available on the Council's infonet to assist in the calculation of annual leave and bank holiday entitlement requires input and provides output information in decimals. Etarmis and Imperago operates in hours and minutes. This causes confusion to some Line Managers which in turn increases the risk of errors occurring and incorrect annual leave and bank holiday entitlements. **Agreed Management Actions**: Consideration will be given as to whether the Annual Leave & Bank Holiday Calculator can be reconfigured to output in hours and minutes. The guidance for managers will be reviewed to ensure it provides a clear conversion to real time for Etarmis. Due Date for Implementation: October 2019. • New Starters**:** In the majority of the cases sampled the annual leave entitlement of new starters was calculated correctly. However in a few cases Line Managers placed reliance upon Etarmis operators to check their calculations, in some cases the calculations provided were incorrect and had to be returned to the Line Managers. Furthermore the annual leave entitlement of new starters is not always correctly calculated by Line Managers which could lead to employees having inaccurate annual leave entitlements. **Agreed Management Action:** Review existing guidance and send out a communication to line managers re-iterating that it is their responsibility to accurately calculate the annual leave entitlement of new starters under their control. The calculation of annual leave for new starters should be reviewed and consideration given to whether this is calculated upfront and notified to Etarmis by Employment Services. Due Date for Implementation: October 2019. • Changes in Hours: Line Managers are not always calculating an individual's annual leave entitlement following a change in hours of working but instead are leaving it to the individual employee, Business Support Services and or HR to calculate. This may lead to inconsistencies in the calculation of annual leave across the Authority.

	Agreed Management Action: Review existing guidance and send out a communication to line managers re-iterating that it is their responsibility to accurately calculate the changes in hours and subsequent annual leave entitlement of officers under their control. Due Date for Implementation: October 2019. • Etarmis/Imperago weaknesses: The Etarmis and Imperago systems do not prevent an employee from requesting more annual leave than then their entitlement. However, it is the employee's Line Manager who is responsible for authorising the request for annual leave. **Agreed Management Action:** Assurances should be sought from Etarmis/Imperago that in the future it will not be possible for officers to request more annual leave than they are entitled to take as per their annual leave allocation i.e. request a 'hard stop' for both systems. Due Date for Implementation: June 2019. • Systems used to Record and Administer Annual Leave: There are approximately 2,792 employees (excluding schools) of which 1,967 officers are using various electronic systems to administer and record annual leave and approximately 825 non-school employees using other manual systems to control and record their annual leave. It should be noted that the visibility, monitoring, control, reconciliation and reporting on the annual leave of these employees is limited. **Agreed Management Action:** A review should be carried out to ascertain which officers are not using electronic systems to administer and record their annual leave with a view to ensuring that these officers, where possible, will do so in the future. For the remaining officers who use manual systems to administer and record their annual leave, scope out the guidance required to ensure that it is consistent with electronic systems and a consistent set of controls to include an annual return to HR. Due Date for Implementation: March 2020.

Planning, Environment and Economy – Minerals & Waste Governance Arrangements

Areas Managed Well	Areas Identified for Further Improvement
• The Minerals & Waste Team are highly qualified and experienced individuals. • Legislation is adhered to and no breaches have occurred since the inception of the service. • Annual invoicing occurs and income is collected.	The audit review identified that significant improvements in the control environment are required, which has resulted in an amber/red, (some) assurance and a conclusion of key controls are generally inadequate or ineffective. Our review identified: • There are two types of charge the fixed contributions and the Pay as you go (PAYG) service. The service is using two PAYG rates currently, these are £250 for PAYG Partners & £350 per day for non-PAYG Partners. The funding formula for the £250 PAYG daily rate and the fixed contribution rate for partners have not been reviewed since the start of the service in 2011 although the CPI rate of inflation and annual pay awards have increased. We are unable to provide assurance whether Flintshire County Council may be subsidising the service financially as there is no meaningful data to be reconciled, to ensure the fees charged actually cover the cost of delivering the service. **Agreed Management Action:** A review of the funding formula for both the PAYG and contractual rates will be carried out to ensure they reflect the current value. Future monitoring of the shared service will be reviewed by the Service Manager to ensure the level of charging is adequate for the level of service provided. Due Date for Implementation: October 2019. • As this is a shared service it is important to be able to evidence time spent on specific projects, demonstrating transparency and the ability to reconcile to annual charges / fee charges under PAYG invoicing. The time recording system was replaced in December 2018 due to the decommissioning of an old lotus notes system. The Service Manager is unable to use the information within the new time recording system to assist in generating invoices, as evidence of actual time spent is not recorded and therefore unavailable. The NWPOG used to receive management information relating to time and cost analysis but this has not been produced since 2012. **Agreed Management Action:** All staff will be instructed to fully use the time recording system, including seconded post. The Service Manager will use the data to fully prepare invoices for partner authorities. Due Date for Implementation: May 2019. • Contract Management / SLA: Currently there is no live Service Level Agreement or Contract in place which details the relationship between the partners, how service will be delivered and costs managed. In particular there is nothing in place to secure the level of contribution made by individual partners

	nor manage the consequences of these not being paid or reduced. A North Wales Regional Minerals and Waste Service Contract has been drafted although yet to be finalised and shared with the current partners. **Agreed Management Action:** Draft contract is being prepared and finalised. A signed Contract will be obtained from Partners. Due Date for Implementation: December 2019. • Gwynedd Recharge: Under the current informal arrangement two members of the team have been based in Gwynedd County Council offices since 2011 due to the geographical nature and distance between Gwynedd and Flintshire. Gwynedd County Council's financial contribution towards the shared service is that they cover the salary costs for their seconded member of staff. Gwynedd charge Flintshire County Council for the use of the accommodation by the two members of the team which in 2017/18 cost £12,140.00. **Agreed Management Action:** The charges for accommodation with Gwynedd will be reviewed to ensure the apportionment of costs is appropriate. Due Date for Implementation: July 2019. • Business Plan: A new contract the "The North Wales Regional Minerals and Waste Service Contract" is currently being written which will include a Business Plan. If the foundations of the service are not detailed in writing then the service may fail and the collaboration may collapse. Current partners and potential new clients should be clear as to the services, charges and how the contractual relationship will be managed. **Agreed Management Action:** A business plan will be written including the objectives of the service, costs and performance measures to ensure strategic objectives are met. This will enable the aspirations of any future expansion of the service to be clearly recorded and presented professionally in order to expand the service to new Partners. Due Date for Implementation: December 2019.

Housing & Assets – Property Valuations

Areas Managed Well	Areas Identified for Further Improvement
• The Valuations and Estates Team operate to a Five Year Rolling Programme of asset valuation with the exception of those that require annual valuations. • The Valuations and Estates Team rotate the categories of valuations undertaken to ensure independence and consistency. • Regular meetings are held between Finance and the Valuations and Estates Team during the valuation process. • Technical and Capital Accounting provide an oversight of valuations and challenge those that appear incorrect. • A Master spreadsheet is maintained by Technical and Capital Accounting to ensure all valuations are captured.	Opportunities for improvement to the control environment have been identified to ensure the valuation process is strengthened. Our review identified: • The Primary schools had been undervalued by not using the Gross External Area measurements available from the Design and Cost Consultancy Service but using an assumption to uplift the Gross Internal Areas by 10%. The total undervaluation for primary schools was £926,744. Several broad assumptions used in the calculations were not clearly documented. **Agreed Management Action**: The Valuations Team will be reminded prior to the start of the valuation process to ensure that Gross External Area measurements are used and liaise with Design and Cost Consultancy to ensure the figures are available at the start of the process. Clearer documentation of any assumptions will be presented with the valuations and a sample check undertaken to ensure the correct methodology has been used and clarity of information provided. Due date for this action 31 October 2019. • Completed valuations had not been signed off as checked by the Manager prior to being made available for input to the Asset Register. As a result inaccurate valuations may compromise the integrity of the Asset Register. **Agreed Management Action:** All valuations will in future be signed by both the valuer and counter signed by the manager prior to the valuations being made available to finance. Due date for this action 31 December 2019.

Cross Cutting – Health and Safety Management - Use of Plant, Machinery & Equipment, incorporating Accidents. Incidents and Near Misses (Streetscene & Transportation)

Areas Managed Well	Areas Identified for Further Improvement
Streetscene and Transportation: • Risk Assessments are in place for all equipment used. • Comprehensive process for the reporting of Accidents/Incidents and Near Misses established which includes a dedicated phone line. • Tool Box Talks given which include HAVS awareness. • Staff Inductions now include a section on HAVS. • Introduction of a Red Amber Green (RAG) sticker process for vibration equipment to identify category rating on level of emissions.	Opportunities for improvement to the control environment have been identified to ensure the safe use of equipment and strengthening processes over the taking of plant and equipment from and back to site and maintaining it in good order. Our review identified: • An improved master training record would facilitate the identification of training required for updating and being able to establish whether all operatives, including agency and contractors, have had the necessary HAVS awareness training. **Agreed Management Action**: Job specific training requirements are clearly shown on the safe method of work document for each Streetscene task to ensure that operatives only undertake roles for which they are trained. HAV's awareness training attendance has now been recorded on the current skills matrix and documented on the individuals training file. Implement the migration of all training records to itrent to ensure data security and prompt reporting. Action due date 31 December 2019. **Agreed Management Action**: List of none attendees for training will be sent to line managers for justification and training to be rescheduled. Action due date 31 July 2019. • The Plant Inventory at the time of the review showed 198 items of equipment overdue for servicing and 124 items of small plant unaccounted for. This has implications for the safety of these items and possible implications for theft of the items unaccounted for. **Agreed Management Action**: The inventory is under review and all service schedules are being updated. Action due date: 30 September 2019. **Agreed Management Action**: A review of all RAG status will be undertaken as services are completed. Action due date: 31 March 2020. **Agreed Management Action**: Equipment in the workshop identified as requiring red stickers will be labelled and include clear instruction on maximum exposure times. Action due date: 30 June 2020. • A regular process for checking and calculating time operatives spend on using vibration equipment has not been embedded. Emission levels will need to be reviewed when all

	equipment has been serviced to ensure the accuracy of recorded emissions. Operatives showing signs of HAVS will need to be closely monitored on future use of vibration equipment. **Agreed Management Action:** The service monitors the exposure limit for the individual items of equipment to prevent over exposure. However this process needs to be reviewed to improve compliance. The current annual random monitoring will be increased in frequency for high risk groups to quarterly to tie in with safety day inspections. Action due date: 31 October 2019. **Agreed Management Action:** All employees have regular annual screening however higher level management information has been requested from Occupational Health. Action due date: 30 September 2019. • Equipment is not being signed in and out of Alltami nor is the process supervised which has implications for its whereabouts and also whether the equipment being selected for jobs is suitable for its intended purpose. Recently instigated gate checks have identified defective equipment being put on vans for use on jobs. **Agreed Management Action:** A full review will be undertaken to ascertain the best way forward to control equipment being selected for jobs and leaving site. Depot alterations have commenced which will assist in the allocation of plant in the coming months. Action due date 31 October 2019.

Streetscene & Transportation – Integrated Transport Unit – Procurement of Contracts

Areas Managed Well	Areas Identified for Further Improvement
• The correct procurement process was followed in accordance with Contract Procedure Rules. • Any contracts tendered for with an incorrect route recorded was identified and recalled appropriately. • All contracts that were re-tendered were submitted correctly.	Opportunities for improvement to the control environment have been identified to ensure the objectives are met. Our review identified: • There was insufficient time and resources planned for the procurement project. **Agreed Management Action.** This action is to be addressed by ITU in undertaking future DPS project and adequate timescales will be provided for the project. Whilst the existing DPS will end in 22/23 the contracts let under the current arrangement will have varying end dates. This will reduce the impact on the service and allow a staggered introduction of routes under the new DPS. The operators will also be more used to complete the necessary documentation prior to inclusion on the new DPS which will ensure this element of the next procurement will be completed more quickly. Action Due Date: 31 July 2019 • Suppliers were not moved to the DPS within PROACTIS at the time of approval. **Agreed Management Action.** Submissions from new suppliers can be sent at any time during the six year DPS project. There is an obligation to evaluate these responses within 10 working days. If a company is successful they are added into the contract and will automatically receive notifications of mini competitions or RFQ's going forward. The respective service area will be notified of all suppliers who have been approved and it will be their responsibility to ensure that the suppliers have been added to the contract. **This action has now been implemented.** • The documented PQQ process was inconsistent with operating practice in that one supplier was placed onto the DPS without completing the Insurance section and being marked as a FAIL. **Agreed Management Action.** The instructions to tenderers document and the evaluation questionnaires have been amended. The preamble has been changed and there is an additional question regarding not having the relevant insurances at the point of submitting the tender but being prepared to obtain them and that relevant insurances must be in place before any further contract is awarded. **This action has now been implemented.**

	• Inaccurate information was obtained from the ONE Education system which resulted in additional work being undertaken. **Agreed Management Action.** Management will ensure that the records held on the ONE system are as up to date as possible by working with Education team and tailoring a report for their specific needs. Support from Education colleagues will be required to achieve this position. Action Due Date: 31 August 2019 • There was a lack of documented procedures for Streetscene Staff brought in to assist with the process, in particular for the route optimisation process and the awarding of contracts. **Agreed Management Action.** Documented procedures will be produced for the route optimisation process to ensure that that the correct processes are followed. Action Due Date: 31 August 2019 • The process for managing charges / penalties for suppliers by ITU staff was unclear. **Agreed Management Action.** An exercise will be undertaken to ensure that all finances are appropriately managed, including reconciliation of income received. Action Due Date: 31 August 2019 • The performance of suppliers is only monitored by ITU staff when a complaint is received. **Agreed Management Action.** The team will be undertaking proactive monitoring of suppliers. Action Due Date: 31 August 2019

Appendix F

Action Tracking – Portfolio Performance Statistics

Portfolio	May 2018 Statistics: Number of Actions Raised Since January 2016	May 2018 Statistics: Actions Implemented since Jan 2016 *(including Actions No Longer Valid)*	May 2018 Statistics: % of Actions Cleared To Date	Live Actions - As at May 2018: Live Actions	Live Actions - As at May 2018: Actions Beyond Due Date *(excludes Actions with revised due date)*	Live Actions - As at May 2018: Actions with a Revised Due Date	Actions beyond Original due date: Actions between 6 & 12 months	Actions beyond Original due date: Actions Greater than 12 Months (13+)
							See Appendix G & H	
Chief Executives *	45	45		0	0	**0**	**0**	**0**
Education & Youth	65	62		3	2	**2**	**0**	**2**
Governance *	140	126		14	0	**12**	**1**	**4**
Housing & Assets *	152	112		40	0	**14**	**4**	**1**
People & Resources	160	142		18	4	**3**	**4**	**0**
Planning, Environment & Economy *	66	50	**89%**	16	3	**8**	**2**	**5**
Social Services	104	94		10	0	**4**	**0**	**0**
Streetscene & Transportation	75	75		0	0	**0**	**0**	**0**
External	27	25		2	0	**2**	**1**	**1**
Individual Schools	87	86		1	0	**1**	**0**	**0**
Total	**921**	**817**		**105**	**9**	**47**	**12**	**13**

* **Actions removed and relocated within External e.g. Clwyd Pension Fund**

* **Actions removed from Community & Enterprise and reallocated between Governance, Housing & Assets and Strategic Programmes & Planning, Environment & Economy**

Actions Overdue and Older than 6 months (where overdue) Appendix E

Audit	Ref	Action	Priority	Original Due Date	Revised Due Date	Age of Action from Original Due Date (Months)	Last Update Provided	Reason for Revised Due Date and Current Position	How Risk is Being Managed
Education & Youth									
Youth Justice 2016/17	2013	A nominate resource from social services for children is not in place. Review to be completed with the Children Services Executive Board Representatives to implement solution in line with the Crime and Disorder Act 1998.	M	31/03/2018	31/12/2018	13	06/09/2018	Matter to be raised to the YJS Executive Delivery Group and Executive Management Board.	Commenced discussions with Children's Services Senior Managers. However at present Children's Services are unable to provide us with an allocated social worker. Action not met. Matter to be raised to the YJS Exec
Youth Justice (2016/17)	2045	Devise a contingency business case to identify and mitigate risks against statutory and non-statutory grants to assist with the business continuity. Review opportunities identified by the external review to develop a succession	M	31/03/2018	31/08/2018	13	06/09/2018	Discussions has commenced with Chair of Exec Board but awaiting for final budget confirmation (final grant amount from YJB pending). Discussions ongoing.	A Business Case to Chief Officer, Education & Youth and Chief Executive has been submitted for consideration. Ann Roberts has commenced these discussions with Chair of Exec Board but awaiting for final budget confirmation (final grant amount from YJB

		plan. Approval to be obtained for both of these initiatives from the Chief Executive.							pending). Discussions ongoing.
People and Resources									
Working Time Regulations 2017/18	2120	Payroll records were examined covering a 17 week period (April 2017 to July 2017) to determine if any employee had worked on average over the maximum 48 hours as defined within the regulations. This review included identifying employees contracted hours, overtime, additional hours worked and sleep ins. The review did not include employees leave or sickness during this period and therefore the outcome is an indicator over the actual figure. A total of 106 employees were identified as working on average over 48	M	31/07/2018	-	9		We prepared working time leaflets in advance of preparing and launching the policy. The policy is on the Infonet and from memory went out originally via workforce news. Managing working time is a management responsibility so we have targeted managers rather than staff. The TUs adopt the same approach. As you might expect, effort is concentrated on the areas where there are lots of additional hours and/or overtime worked - some services do not have any spend recorded in this record. We also run reports periodically to establish average hours worked over the 17 week reference period. The policy agreed with the TUs enables us to increase the reference period to accommodate seasonal	

		hours per week from April 2017 to July 2017 and therefore in breach of the regulations.						peaks (for example Panto season, winter maintenance) which should mean going forward that there are fewer opportunities for non-compliance. This is an area that will remain under scrutiny as it is critical from a health and well-being perspective, especially when stress is recorded as the number one reason for absence (as working regular, long hours without the required rest breaks contributes).	
Working Time Regulations 2017/18	2123	An analysis of the 106 employees identified the majority of these employees working within two Portfolios (Social Services and Streetscene). It was established that controls are in place for monitoring working hours within these Portfolios. A review of the controls within Social Services identified weekly monitoring of working hours using contracted hours, overtime and leave. Notifications are	M	31/07/2018	-	9		We prepared working time leaflets in advance of preparing and launching the policy. The policy is on the Infonet and from memory went out originally via workforce news. Managing working time is a management responsibility so we have targeted managers rather than staff. The TUs adopt the same approach. As you might expect, effort is concentrated on the areas where there are lots of additional hours and/or overtime worked - some services do not have any spend recorded in this record. We also run reports	

Tudalen 145		issued to management to ensure that limits are not exceeded. It was noted that time undertaken for sleep ins is currently excluded from the monitoring and an action has been made within 4(A) on the action plan. The monitoring of Streetscene employees differs as warning levels are also reporting to management where an employee is working close to the limit and any overtime is discouraged. This has resulted in fewer breaches occurring and from September 2017 to January 2018, only one breach had occurred. Without an effective monitoring process in place across all Portfolios there is a risk that a number of breaches could occur and the Council would fail to comply with the regulations.						periodically to establish average hours worked over the 17 week reference period. The policy agreed with the TUs enables us to increase the reference period to accommodate seasonal peaks (for example Panto season, winter maintenance) which should mean going forward that there are fewer opportunities for non-compliance. This is an area that will remain under scrutiny as it is critical from a health and well-being perspective, especially when stress is recorded as the number one reason for absence (as working regular, long hours without the required rest breaks contributes).	

Working Time Regulations 2017/18	2201	Flintshire Council has taken a uniform approach where all employees should be working within the Working Time Regulations and promotes a work life balance across the workforce. It was noted that working time for "sleep-ins" has been excluded from monitoring within Social Services as management feel that this would have a significant impact on the service. Working to the regulations will make it difficult to maintain the current level of service for service users as many more employees would be required to cover the shifts and continuity in the level of care would be unsettled. In accordance with the Working Time Regulations, Sleep-ins are recognised as	M	31/07/2018	-	9		No update provided	

		working time and should be counted towards the 48 working hour limit. Exceptions to the regulations for sleep-ins would not be possible as this would then have an effect on compensatory rest periods which must be adhered to. This is an issue across a number of Council's which People and Resource are aware of. Flintshire Council will need to be continually monitored for the position and options to support compliance with the regulations.							
Main Accounting GL 2018/19	2376	Regular reconciliation of Control, Holding and Suspense Accounts is an important control to maintain integrity of accounts and detect any issues early prior to year-end. Spreadsheets detailing all the Control, Holding and Suspense Accounts are maintained by an Accounting Technician in Technical and	L	31/03/2019	-	1	No Update Provided		

Tudalen 148		Capital Accounting for Balance Sheet accounts and an Accountant in Corporate Finance for Revenue Accounts. Portfolios are not required to send reconciliations monthly but only for periods 6, 9, 11 and 12 and often these are in the format of a report to indicate that the reconciliation has been undertaken and that the account has balanced. We noted that for many of the Revenue Holding, Control and Suspense accounts many of the required returns had not been received by Corporate Finance during the last financial year. We discussed these with the accountant responsible for maintaining the spreadsheet of accounts and return dates. Conflicting priorities during year end closedown added with reduced resources in-year							

		meant not all spreadsheet entries had been completed. A decision on the process for monitoring the Revenue accounts should be made as to whether staying with the present system which results in control weaknesses or to adopt another approach. Although the main control is ensuring at the year-end the accounts are cleared and all variances resolved, this process would be more efficient if regular reconciliations are evidenced at regular intervals to ensure all appropriate actions have been taken.							
Planning, Environment and Economy									
Planning Enforcement 2016/17	1892	Discussions held with Enforcement Officers identified that no specific training is available for staff undertaking enforcement investigations and the	L	30/11/2017	30/04/2019	17		To bring in line with action 1885. Intended that the restructure will be complete by end of November 2017 then time required to complete lean process and set down in procedures for the service to	Newly appointed enforcement officer for the South Team and the North Team leader have been booked onto the Trevor Robert intensive enforcement training course in February 2019. The North Team

Tudalen 150		use of FLARE. Minimal guidance was provided to a seconded employee and further on the job training was required. There are no documented procedures in place for Enforcement Officers. There is a risk that officers would not be working uniformly and actions may be undertaken against legislation and without appropriate knowledge. It also became apparent that there is some reluctance to fully utilise the FLARE system by staff, however these concerns have not been formally raised.						rely on. Restructure completed 1st January 2018. The newly created teams need time to reflect on the processes recorded prior to the restructure and how to change and update these to reflect new and best practice. Following the restructure a Senior Officer has resigned and following interviews the existing Enforcement Officer has been promoted to that role. Further advertisement and interviews took place to appoint a new enforcement officer. This appointment commenced on 30th April 2018. During that time focus has been on dealing with other enforcement actions required.	enforcement officer remains on the waiting list. Formal training notes for the use of FLARE are have not yet been produced as time has instead been directly to the pursuit of the new software system.
Planning Enforcement 2016/17	1885	Audit testing identified a number of concerns regarding the documenting of planning enforcement referrals. • Records can be	H	31/08/2017	30/04/2019	20		The service firstly needs to be restructured and embedded with new policy in use. This may not be completed to late November. Time is then required to review mapping and reflect, plan change to process and implement.	As reflected in the update audit report. The two planning assistant posts are now established and the process of registering, plotting, prioritising and acknowledging complaints is fully underway. Standard correspondence in relation to

Tudalen 151		held in a number of locations (FLARE, enforcement file, shared drives) and no standard procedure existing for correctly documenting a referral. Without clear documented procedures in place it will be problematic to establish the current status of each referral, in particular for new staff. • Information recorded on the FLARE system is not kept up to date with a significant number of actions being recorded retrospectively. This makes the management of referrals difficult and in the event of staff absences the progression of each referral would not be clear. • Evidence from undertaking visits or holding discussions with persons may not always be							warning letters, enforcements notices and appeals have been developed. Unfortunately as there was a delay to securing funding to procure a new software system ML is reluctant to map processes to a defunct current software system. In October 2018 Asset Programme Board agreed the funding to procure a new system. ML has undertaken primary project planning meetings with procurement and IT. The required IT specification for the enforcement process and every other service within development management will be reflected within that IT specification requirement.

Tudalen 152		documented depending what is seen / heard. All actions undertaken in investigating a referral should be recorded to ensure a clear trail exists. • Significant reliance is place on the Enforcement Officers knowledge to establish the status of each referral. All enforcement referrals received have the potential to be challenged in a Court of Law and without a clear trail, robust procedures and documentation in place to support the actions of the Council it could be difficult to defend a decision made.							
Deferred Charges on Properties 2018/19	2459	Houses to Homes Loans There was no formalised and evidenced reconciliation carried out by the Regeneration	M	30/04/2019	-	0	No Update provided		

Tudalen 153		Programme Lead between the Civica System (or equivalent financial system), the Grants & Loans spreadsheet and Land Registry charge extracts to confirm a charge was in place for all relevant properties. Testing was undertaken to ensure that there was a charge in place for all 2018 grants and loans (this was verified via Internal Audit obtaining Land Registry extracts for all the properties detailed on the Grants and Loans spreadsheet. A formalised and evidenced reconciliation against Land Registry extracts would provide assurances that charges are in place against all relevant properties. This service has transferred over to Community and Business Protection (part of the Planning, Environment and							

		Economy Portfolio) on 1st January 2019. Under these new arrangements the operational responsibilities have been assigned to the Health and Safety Team Leader.							

Actions with a Revised Due Date Six Months Beyond Original Due Date (Not Overdue) Appendix F

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Governance									
PCIDSS Compliance (2015/16)	1516	The officer working group should ensure that the self-assessment is completed drawing on the full range of professional expertise and experience of the group.	H	31/12/2016	29/07/2019	08/03/2019	The Council has implemented the necessary changes to ensure compliance with web payments and with payments taken via kiosks in Connects Centres. There is a remaining area of non-compliance with payments taken over the phone that will require new software. The council is looking at how many licences it needs and whether to simply divert some payments from phone to web prior to purchasing and implementing the new software. If/when funding is agreed the council will be able to commission a software supplier and establish a firm date for	A PCIDSS review was undertaken by a specialist QSA provider, ECSC, on 4th October 2017. The review has identified areas of compliance and areas of risk. Overall, the Council is deemed to be 50% compliance to PCIDSS. The findings of the report are now being considered by the Project Group and Chief Officer to identify what measures are required to increase compliance but this will undoubtedly require substantial investments in IT to achieve 100% compliance.	The completed detailed SAQ'S will be completed in Q1 of 2019/20 Revised workforce procedures have now been introduced as part of managing risks associated with PCIDSS (aligned to another audit recommendation) and work to complete the SAQ'S will now commence in January 2018 as part of a join

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
							implementation and thus achieving compliance		
Flintshire Connects (2017/18)	1505	Services accessed by Flintshire Connects cannot always be delivered in full. A fundamental review of all customer facing services will be undertaken to explore the best future method of delivery, including face to face, through Connects centres backed up by feasibility studies for areas where greatest efficiency could be achieved. This review will look in the first instance at service delivery methods across all Portfolios and assess if they are sufficiently lean and a decision made on what services could	M	30/09/2017	31/03/2020	02/05/2019	A fundamental review of all customer facing services has not commenced as the priority for Customer Contact is telephone access to Council services. The Customer Service Strategy is aligned to the Customer Work stream of the Digital Strategy and the current focus is on merging Contact Centre teams and relocating a single team at Ty Dewi Sant, Ewloe. The decision to transform telephone contact superseded the Audit of Flintshire Connects and resources have had to be reprioritised. A review of face to face services is a commitment within the Customer Services Strategy and this acknowledges the work undertaken by Audit. It	The review group have now finished the initial analysis and met with all portfolio's to determine where change is required. The work carried out by the group has identified a number of areas across the council where the digital offer needs to be improved to enable reduction in both telephone calls and face to face provision for a number of services, examples include, logging repairs and Streetscene general report it type functions. It has also identified tasks that could be better delivered by Connects and release back office efficiencies. The work completed has identified that the delivery of the Customer Service Strategy and the	A Programme Manager to lead this transformation project has now been appointed.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		be delivered through Connects without overlap and duplication. Following the review a strategy will be formulated on how services will be delivered in the future.					is important that the face to face services delivered by Flintshire Connects are appropriate in order to support our most vulnerable customers. A new post has been established within Customer Contact and the Customer Contact Manager is expected to be recruited by the end of May 2019. This person will have managerial responsibility for Flintshire Connects and Contact Centre. This role will oversee the successful merger of Contact Centres team and after a period of stability will be able to focus on undertaking a fundamental review of customer facing services as described in the audit recommendations.	Customer Workstream of the Digital Strategy need to be closely aligned and also that the scale of the work that needs to be done to deliver the transformation across the council is beyond what the review group can deliver in the timescales required. It has been agreed that a dedicated resource is required to programme manage this transformational project going forward and work is now underway to recruit to this position so that the work required can be driven forward.	
Flintshire Connects	1514	Services are not always being	M	30/09/2017	31/03/2020	02/05/2019	Following this audit and the revision of the	The review group have now finished the initial	A Programme Manager to lead this

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
(2017/18)		delivered in the most efficient ways. Services delivered through Flintshire Connects Centres will be evaluated for the most appropriate, efficient and effective delivery methods.					Customer Service Strategy a Customer Service Strategy Review Group was formed and tasked to begin reviewing all customer contact across the Council with a focus on how we currently deliver services (face to face, telephone and digital) and looking at the aspirations of how we could deliver differently to ensure we are utilising the most appropriate channels for services/customer contact.	analysis and met with all portfolio's to determine where change is required. The work carried out by the group has identified a number of areas across the council where the digital offer needs to be improved to enable reduction in both telephone calls and face to face provision for a number of services, examples include, logging repairs and Streetscene general report it type functions. It has also identified tasks that could be better delivered by Connects and release back office efficiencies. The work completed has identified that the delivery of the Customer Service Strategy and the Customer Work stream of the Digital Strategy need to be closely aligned and also that the scale of the work that needs to be done to	transformation project has now been appointed. The customer transformation work this post will lead on is a three year project. For this reason the revised implementation date has been amended to 01.09.19 where a more detailed update on both work completed and planned works for future will be available.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
								deliver the transformation across the council is beyond what the review group can deliver in the timescales required. It has been agreed that a dedicated resource is required to programme manage this transformational project going forward and work is now underway to recruit to this position so that the work required can be driven forward.	
Procurement 2016/17	1649	The supplier performance management template is now available in Proactis for completion by contract officers. Contract officers will receive a reminder from Proactis to use the contract management module. All relevant contract officers should receive	M	31/03/2018	31/10/2019	11/03/2019	To promote the current functionality would be counterproductive in light of the need to re-train officers when new product release is launched.	With respect of action 1649, it is still a work in progress, due to awaiting on PROACTIS to develop their product to allow more streamlined functionality to allow performance questionnaires to be undertaken. This has now been done a few weeks ago. We are also seeking clarifications from the Procurement Manager	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		notification so they know the supplier performance management template is available and must be used.						in how she wants to undertake contract / supplier performance management going forward in the light she is revising the CPRs as well.	
Joint Corporate Procurement Unit 2017/18	2253	Our review of Governance arrangements identified; • There is inadequate scrutiny of JCPU objectives and outcomes by Joint Procurement Board (JPB) and by relevant Council committees to address lack of progress with achieving the primary objectives of the JCPU business case around Efficiency, Capacity and	M	31/10/2018	21/12/2019	13/05/2019		CPRs have been re drafted and are being considered by Chief Officer Governance	CPRs have been re-drafted particularly in relation to variations, extensions and exceptions, but the opportunity has been taken to make other changes to the Rules to update them. This has included changes to reflect Brexit and to emphasise the importance of local supplier opportunities (so that for example, the emphasis on using frameworks has been removed). The revised CPRs are being considered by Officers prior to a consultation. In addition, some further changes may be required to reflect procurement

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		Markets (1.1). • Delays in the alignment of procurement strategy and procurement activity across the two Councils. Recent changes, e.g. board membership and corporate priorities, means that the strategy contains out of date information (1.2). • Limited processes in place for measuring and recording efficiency savings achieved through collaborative procurement. There is no evidence that efficiency savings and benefits have been reported to							arrangements post Brexit and also the transitional arrangements.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 162		the JPB (1.3). • Limited evidence of reporting of KPI's to the JPB / no robust targets in place for KPI's (1.4). • Insufficient systems for recording and monitoring the split of procurement staff time across the two Councils (1.5). • Meetings of the JPB not taking place on a regular basis, agendas for the JPB meetings not prepared and circulated in advance of meetings and JPB minutes not available for all meetings / minutes not circulated on a timely basis							

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 163		(1.6). • Limited monitoring and evaluation of expenditure by category and aggregated spend (across services and/or Councils) by the JCPU to ensure opportunities for efficiency savings through collaborative procurement exercises are identified (1.7). • Due to limited availability of data, monitoring of contract end dates by the JCPU cannot take place to ensure opportunities for efficiency savings through collaborative procurement or alternative procurement							

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		models are appropriately explored (1.8).							
Housing & Assets									
Housing Allocations 15/16	1616	The current SARTH policy is under review. Following this, any required changes to procedural notes will be implemented.	M	31/03/2017	28/06/2019	10/05/2019	Comprehensive procedures have been developed and provided to audit. Through November meetings have been held with regional partners to tweak and ensure a consistent approach will be implemented across the partnership. January date is to allow for the development of some user guides to complement the procedures and linked guidance on affordability to be finalised. Staff have been trained and are aware of the new procedures so risks are mitigated whilst final sign off is undertaken.	Feedback from the staff consultation/training sessions held has resulted in some minor tweaks and access issues to be resolved but in the main there have been no major changes to the revised procedures and these will now be progressed for final sign off. Action plan shows that the development of user guides to compliment these procedures will be completed by 25.10.19. It is important that these are in place at the same time as full implementation of new procedures to ensure staff have the correct guidance on how to complete the actions required on the housing	Staff have been made aware of any amendments to the procedures subject to final versions being signed off. This is confirmed within 1:1s and team meetings. Due to unforeseen circumstances there has been an unplanned period of absence from work. The post holder has now returned to work and this is being given priory to be completed. A meeting has been held to determine tasks outstanding to complete this action and both the service and ICT are working to an implementation date of mid-June.

Tudalen 164

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
								system It has therefore been agreed to move to a full implementation date of 01.11.18 to ensure the new procedures are rolled out robustly and correctly.	
SARTH 2017/18	1995	Controls relating to SLA adherence require enhancement. Investigate system developments through the utilisation of new system codes to assist with the automation of cancellations due to non-receipt of evidence. KPIs to be set to measure adherence to process.	L	29/06/2018	28/12/2019	10/05/2019	The majority of the issues identified with the CRM Integration works have now been resolved and seem to be working well. The service is noticing a partial reduction in processing time and as such more focus is now being applied to ensuring other tasks are completed within the SLA guidelines. This will be closely monitored by the Housing Access and SARTH Team Leader. The solution implemented still requires further work and a meeting has been scheduled to scope	Integration work was delayed and went partially live in early February 2019. There are faults with the implementation and these have been reported to ICT and are being worked through with Capita. The solution implemented still requires further work and therefore released the expected capacity to undertake other duties. Without additional resource it is not possible to fully adhere to SLA timescales and maintain this performance level until the integration work is completed and working	Low risk (green)

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 166							these works with Capita. As the solution does not yet meet all the initial requirements it has therefore not fully released the expected capacity to undertake all the other duties. Whilst there will be an improvement in performance against SLA it is not possible to guarantee full adherence to all SLA timescales and maintain this performance level until all the integration work is complete.	correctly.	
DFG 2016/17	2024	The current Private Sector Housing Renewal and Improvement Policy is out of date and was due for review by 30 June 2015. The policy also does not align to current practices in operation within the service. An example of this is the condition of the	M	30/06/2018	31/10/2019	22/05/2019	Due to all DFG activities having to be approved by the DFG oversight board, this action date has been extended to facilitate review of all documentation by the board members. The revised policy has been drafted and will be tabled at Informal Cabinet on Tuesday 30th April 2019. This	The Policy will be drafted once the service has been realigned and will reflect the recommendations from the WG consultation on Housing Adaptations Service Standards. Due to the timetable of Overview and Scrutiny committees, the next Cabinet meeting to receive this policy will be	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		DFG Relocation Grant where the property must be occupied by the applicant as their main residence for a period of 5 years. Currently there is no process to facilitate the measurement or assessment of this condition.					will then be followed by consultation with Community and Enterprise and Health and Social Care Scrutiny committees at the appropriate stage in the scrutiny cycle. The final stage will be to take the policy to Formal Cabinet for adoption and ratification - date not yet known as this will be dependent on the agenda availability of the scrutiny committees. - Action can be set to complete	22 October.	
DFG 2016/17	2058	Not all DFG applications which have been approved are reflected in the DFG spreadsheet which is utilised to track application progress and budget spend. Internal audit were provided with a list of all approved DFGs which was	M	31/05/2018	30/06/2019	30/04/2019	Due to all DFG activities having to be approved by the DFG oversight board, this action date has been extended to facilitate review of all documentation by the board members.	Extensive work has been completed to develop accurate contractor reporting processes and for performance of the service. The new reporting mechanism will be fully implemented ready for the new financial year	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		generated from the FLARE system. This list formed the basis for the sample testing selection.							
DFG 2016/17	2079	Contractors are monitored on a case by case basis, however management information is not maintained to provide oversight of all contractor performance including variation of work and costs, timescales for completion, customer satisfaction survey, etc. Manual spreadsheets have been subsequently developed as the current Flare system does not support reporting capability.	M	31/05/2018	30/06/2019	30/04/2019	Due to all DFG activities having to be approved by the DFG oversight board, this action date has been extended to facilitate review of all documentation by the board members.	All processes have and continue to be reviewed will be fully implemented by the beginning of the new financial year. The final versions will include information regarding expected timescales and budget monitoring and will be in place at the beginning of the new financial year The process for monitoring contractor performance is not effective. More work is required in this area to provide assurance and to ensure underperformance is identified and addressed promptly. Due to the amount of work involved in delivering on this action and extension to the completion date to	The internal KPI's have been agreed on the basis that they are based on the overall Indicator of completion within 247 days. These will be tested and altered as the new processes bed in. There are still some outstanding issues, however, in relation to monitoring of SLAs and audit trails in relation to financial reconciliation which still need to be addressed. A revised completion date of 30th June is suggested to allow for this work to be completed.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
								30th June is suggested.	
People & Resources									
Payroll 2017/18	2218	Data Protection and GDPR Compliance A process to remove leaver information from i-Trent in line with the Retention Policies and GDPR has not been implemented. Management have not been able to provide a detailed plan of what activities have been completed to assist with demonstrating adherence to Data Protection requirements. The consequence to the Council of non-compliance will be greater with the introduction of GDPR in May as the Council may be subject to fines.		30/09/2018	30/06/2019	18/04/2019	The functionality still requires testing, further issues/defects may be found during testing and would need reporting to MHR for their investigation. I have requested 30.04.18 to take into account that possibility.	Conflicting priorities within the team continue to prevent the required further testing of the MHR GDPR software being fully undertaken. Pauline (Connolly) has identified a potential defect and has raised the issue with MHR.	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Planning and Environment									
Section 106 - 15/16	285	The Local Planning Guidance Notes are currently being brought up to date to allow continued use of the Unitary Development Plan (UDP). Whilst the UDP has technically expired, the intention is to keep the plan 'alive' for as long as possible. The bulk of the 'comments' from the LPGN consultation process were reported to the Planning Strategy Group on 25th February 2016. LPGN 22 will be reviewed as required following the adoption of the updated LPGN's. The updated	M	31/07/2016	30/06/2019	18/12/2018	The LPG 22, as overarching guidance, can only be updated once all individual LPGs have been updated, and there is still work to be done to update LPG13 (see below). Lastly, as each individual LPG is up to date (except LPG 13) each can be applied to the consideration of planning applications and any developer obligations that arise. The risk in not updating LPG 22 is therefore very low and can be managed in due course once individual LPGs are updated. This must therefore be a 'green' in terms of risk status.	Follow up audit report 18.5.18: LPGN 22 Planning Obligations (adopted by the Council in February 2007) has not been updated. Discussion with Planning Strategy has suggested that as LPGN 22 acts as a signpost to other planning guidance around developer contributions, it can only be updated once the full suite of planning guidance is in place. LPGN 13, Outdoor Playing Space & New Development, is in the process of being revised. Once the revised planning guidance is adopted LPGN 22 can be updated. Following discussion of the Follow Up audit findings the due date for this Agreed Action has been revised	Monitoring progress with LPG13 via service manager and with reports to S106 working group.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 171		LPGN's (which are still in the consultation period) will be adopted by 30th April 2016. If it is determined that further update to LPGN 22 is required (in particular to take account of the adoption of LPGN 23, Education Contributions - adopted July 2012) then we could expect the adoption of an updated LPGN 22 by 31st July 2016.						to 31/12/18.	
Section 106 15/016	313	Update of SPG 13 Open Space Requirements	M	31/07/2016	28/02/2019	13/03/2019	The revised SPG has not been completed whist work on the production of the LDP is prioritised.		
Greenfield Valley Trust Follow Up 17/18	2195	• 2018-2021 Business Plan to be agreed by the Board of Trustees. • Manageme	M	31/07/2018	30/05/2019	20/05/2019	At their meeting on 07/05/19 Green Valley Trust resolved to agree to sign the new Management Agreement which we have been working on for some		

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		nt Agreement to be completed and to be agreed by the Board of Trustees.					time. This is a significant step forward and cements all of the good work which has gone on in refreshing our approach to this attraction over the past 3-4 years Once we have prepared all the documentation I think we should use the formal signing as a positive publicity opportunity for all parties		
Pollution Control 2017/18	2048	Not all tasks relating to reviewing planning enquiries for potential statutory nuisance are logged or monitored.	L	31/03/2018	31/05/2019	01/06/2018	Computer system will take a length of time to be agreed upon and implemented, and further impacted by move to Ewloe. Smarter apps for efficient working practices are being considered in the meantime.	A revised due date of 31/05/2019 has been made for the new computer system. In the meantime they are pursuing ways of working smarter through the purchasing of apps.	
Section 106 Follow Up 2017/18	2232	The Section 106 working group was tasked with considering; 'Section 106 linkages across the	M	31/10/2018	30/09/2019	13/03/2019		Business case for the new back office has been developed and procurement is underway with a view to implementing in	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		Authority, the information needs of each service area, and the information currently held by service areas to determine where there is scope for efficiencies through the sharing of information (including the scope for sharing information on the Planning DEF database)'. The potential for use of the DEF system to manage s106 balances was considered and subsequently discounted. A piece of work was subsequently undertaken to look at other systems which could be used for the management of s106 balances (together with the management and enforcement of all							September 2020.	

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		legal agreements across the portfolio). A capital bid was submitted for new software in December 2017 but was not successful. In the absence of a central system for the management of s106 balances, suites of spreadsheets are maintained by services impacted by s106 across the Council. Whilst the primary spreadsheet is maintained by Finance, s106 spreadsheets are also maintained by Planning Enforcement and Education (as the data they require differs from the data maintained by Finance). Whilst the use of spreadsheets within								

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		each service ensures appropriate management of s106 balances there is clearly duplication of effort and scope for the achievement of further efficiencies through the streamlining of processes.							
External									
Pensions Administration 2017/18:	2180	The KPIs show poor performance and lack of adherence to legal requirements.		30/06/2018	30/06/2019	06/02/2019	Team leaders will continue to monitor the KPIs and assign work accordingly.	An Action Plan will be devised and implemented when the new Pensions Administration Manager is in position. A revised implementation date has been agreed of 30/06/2019 to allow time for this to be completed. In the meantime the Principal Pensions Officers are reviewing methodology in the department and revising ways of working to	

Tudalen 215

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
								improve the KPIs. The latest stats for Quarter 3 2018 do show encouraging improvement from the ones reviewed at the last audit.	
CPF Investment 2016/17	1943	An Operational Plan will be devised to assign roles and responsibilities for the core functions within the Clwyd Pension Fund team. This will assist with the identification of single points of failure within the team. Individuals to be trained outside of their core role in order to facilitate the delivery of service in the event of long term absence or attrition. Succession planning will also be considered given the relative age of individuals	M	31/12/2017	31/03/2019	01/04/2019	Work is continuing with HR for a revised structure to the section which will accommodate the ongoing needs of the section. The 2018/19 Business Plan includes a structure review of the Finance Team. Work is still on-going with HR to finalise the structure and carry out recruitment. This should be substantially complete in Q1 2018 but full completion may take to Q3 2018.	Work is continuing with HR for a revised structure to the section which will accommodate the ongoing needs of the section. New accountant appointed start date 1st April 2019 Investment trainee post advertised interviews to be held mid-April.	The risks are being managed by outsourcing essential work to third parties.

Tudalen 176

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		completing these functions relative to retirement age.							

Investigation Update

Appendix G

Ref	Date Referred	Investigation Details
1. New Referrals		
No new referrals received since the last audit committee		
2. Reported to Previous Committees and still being Investigated		
2.1	03/01/2019	A whistleblow was received concerning a Council contract. The investigation is ongoing.
2.2	16/10/2018	A complaint was received concerning the awarding of contracts where there is a potential conflict of interest of a member of staff with a contractor. The investigation is ongoing.
2.3	20/08/2018	An allegation was received concerning the awarding of work to a company being run by a former employee of the Authority. The investigation is ongoing.
3. Investigation Completed		
3.1		A referral was received from management relating Houses to Homes Loan. A report has been issued to management which include improvements required to the control environment.
3.2		A complaint was received from a service provider in relation to contract variation and termination. This has been investigated and advice provided to the service.

Internal Audit Performance Indicators

Appendix H

Performance Measure	Qtr 1 19/20 (as at 24/5)	Target	RAG Rating	
Audits completed within planned time	80%	80%	G	→
Average number of days from end of fieldwork to debrief meeting	10	20	G	→
Average number of days from debrief meeting to the issue of draft report	4	5	G	↓
Days for departments to return draft reports	6	7	G	↑
Average number of days from response to issue of final report	3	2	R	↓
Total days from end of fieldwork to issue of final report	22	34	G	↓
Productive audit days	78%	75%	G	↑
Client questionnaires responses as satisfied	100%	95%	G	→
Return of Client Satisfaction Questionnaires	40%	80%	R	→

Key					
R	Target Not Achieved	A	Within 20% of Target	G	Target Achieved
↑	Improving Trend	→	No Change	↓	Worsening Trend

Internal Audit Operational Plan 2018/19 – Carry Forward

Appendix I

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Corporate			
Income from Fees and Charges / Efficiency Savings	H	On Hold	On hold pending the completion of the consultancy work – transferred to 19/20 plan
Budget Planning Challenge	H	Not Started	Defer until 2019/20
Business Planning, Risk and Performance Management	H	Not Started	Defer until 2019/20
North Wales Residual Waste Project (FCC)	H	Complete	Qtr 4
Declaration of Interests	H	In Progress	Interim Report
Collaborative / Partnerships Arrangements (CC - Social Services)	M	Defer	Defer until 2019/20
Education & Youth			
Risk Based Thematic Reviews	H	Complete	
School Funds	H	In Progress	Draft report stage
Governance			
Digital Strategy	Advisory	On going	Combine with Online Transactions DS
Cloud Computing	H	In Progress	
Procurement - Contract Monitoring (Joint Working - Denbighshire)	H	In Progress	
GDPR	Annual	In Progress	Draft report stage
Housing & Assets			
Welsh Housing Quality Standards (WHQS) Investment Plan	H	Complete	
Property Valuations	H	Complete	
Empty Property (Void) Mgt	M	In Progress	
New Homes - Contract Management	M	In Progress	
Property Maintenance	M	In Progress	
Technology Forge (TF)	M	In Progress	Draft report stage
Supporting People	Grant	Complete	
County Hall Campus Working Group	Advice &	Complete	Attendance at Working Group

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
	Consultancy		
Housing Benefits	Annual	Complete	
Main Accounting - Accounts Receivable, including Corporate Debt Management	Annual	In Progress	
People & Resources			
Main Accounting – Accounts Payable (AP) / P2P (2017/18)	Annual	Complete	
Main Accounting - Accounts Payable (AP) and P2P	Annual	In Progress	Fieldwork Complete
Main Accounting - Accounts Receivable (AR), include Debt Management	Annual	In Progress	
Appraisals	H	In Progress	
Exist Packages	New	Complete	
Project Apple	New	Complete	
Pay Deal 2019/20	H	Complete	
Annual Leave	M	Complete	
Occupational Health Unit	M	Complete	
Payroll	Annual	Complete	
Planning, Environment & Economy			
Minerals and Waste	H	Complete	
Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment	H	Complete	
Disabled Facility Grants (DFGs)	Follow Up	Ongoing	Oversight board
Social Services			
Children out of County Care & Education	H	Complete	
Collaborative / Partnerships Arrangements	H	Defer	Defer until 2019/20
Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment	H	Complete	
Safeguarding - Children's	M	In Progress	
Social Services Financial Processes	Follow Up	In Progress	Fieldwork Complete
Streetscene & Transportation			

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Integrated Transport Unit (ITU)	H	Complete	
Fleet Management	M	Draft report with Service	Additional work requested and currently in progress
Highways - Cost Recovery	H	In Progress	
Health & Safety Management – Near Misses, including Plant, Machinery and Work Equipment	H	Complete	
Regional Transport	M	In Progress	
Alltami Stores	Follow Up	In Progress	Draft report issued
External			
Aura	SLA (20 Days)	Complete	

Internal Audit Operational Plan 2019/20

Appendix J

Audit	Priority	Status of Work	Supporting Narrative
Corporate			
Business Planning, Risk & Performance Management	H	Not Started	
Voluntary Sector Grants - Revised Funding Arrangements	H	Not Started	
Integrated Impact Assessments	M	Not Started	
Business Continuity	M	Not Started	
Use of Consultants	Annual	Not Started	
Education & Youth			
Schools Admissions, Allocation, Unfilled Places, Change in Demographics	H	Not Started	
Schools Budgeted Licenced Deficit	H	Not Started	
Early Entitlement	M	Not Started	
Risk Based Thematic Reviews, including CRSA	Annual	Not Started	
Education Grant – Education Improvement Grant (EIG)	Annual	Not Started	
Education Grant – Professional Development Grant (PDG)	Annual	Not Started	
Education Grant – School Uniform Grant	Annual	Not Started	
Governance			
Procurement Hardware and Software	H	Not Started	
Community Benefits (Social Values)	H	Not Started	
Enforcement Agents	M	Not Started	
Digital Strategy	Advisory	On going	
PCIDSS Compliance - Follow Up	Follow Up	Not Started	
Data Protection (GDPR) Compliance	Annual	Not Started	
Council Tax and NNDR (incl. grant)	Annual	Not Started	
Housing & Assets			
Housing Rent & Arrears - (and impact of UIC)	H	Not Started	

Audit	Priority	Status of Work	Supporting Narrative
Land - Ownership, Surplus to Requirements & Disposal	H	In Progress	
Right to Buy (buyback) / Home Loans	M	Not Started	
Housing Benefits (including Subsidy Grant)	Annual	Not Started	
Care and Repair SLA	New	Not Started	
Framework Value for Money	New	Not Started	
Supporting People (grant)	Grant	Completed	
Support People (grant claim assurance)	Grant	Not Started	
SARTH	Follow Up	Not Started	
People & Resources			
Corporate Grants	H	Not Started	
Capital Programme	H	Not Started	
Write Offs	M	Not Started	
Financial Management Accounting within Portfolios	M	Not Started	
Main Accounting - Accounts Payable (AP) and P2P	Annual	Not Started	
Main Accounting - Accounts Receivable (AR), including Corporate Debt Mgt	Annual	Not Started	
Main Accounting - General Ledger (GL)	Annual	Not Started	
Method Statements	Advisory	Not Started	
Budget Planning Challenge	Advisory	Not Started	
Corporate Credit Cards	New	Not Started	
Notification of Leaver to Clwyd Pension Fund	H	Not Started	
Pay Deal 19/20	H	In Progress	
Project Apple	H	Not Started	
Organisational Ethics and Values	M	Not Started	
Payroll	Annual	Not Started	
Planning, Environment & Economy			
Communities4work (grant) & C4W Plus Grant	H	Not Started	
Flood Alleviation Scheme	H	Not Started	

Audit	Priority	Status of Work	Supporting Narrative
Pest Control	H	Not Started	
Climate Change / Carbon Reduction	M	Not Started	
Home Improvement Loans	M	Not Started	
Social Services			
Flying Start - WG Funding	H	Not Started	
Foster Care (Payments to Carers)	H	Not Started	
Sessional work	H	Not Started	
Collaborative Work / Partnerships	M	Not Started	
Client Finance, (Deputyship) Receivership & including Community Living	M	Not Started	
Streetscene & Transportation			
Highways - Condition of infrastructure	H	Not Started	
Concessionary Travel including Bus Services Support (grant)	H	Not Started	
Parc Adfer	H	Not Started	
School Bus Passes	H	Not Started	
O Licence	M	Not Started	
Community Transport	M	Not Started	
Waste Management Service	M	Not Started	
External			
North Wales Residual Waste Project - Contract Management	H	Not Started	
Pensions Administration & Contributions	H	Not Started	
SLA - Aura - 20 days	Annual	Not Started	
SLA - NEWydd - 10 days	Annual	Not Started	
Advisory / Project Groups			
New Flare System Development Group	Ongoing	Not Started	
Corporate Governance Working Group	Ongoing	Ongoing	
Accounts Governance Group	Ongoing	Ongoing	
Financial Procedures Rules	Ongoing	Not Started	

Audit	Priority	Status of Work	Supporting Narrative
E Procurement Working Group	Ongoing	Ongoing	
Programme Coordinating Group	Ongoing	Ongoing	
Corporate Health & Safety Group	Ongoing	Ongoing	
Corporate Data Protection Group	Ongoing	Ongoing	
County Hall Campus Working Group	Ongoing	Not Started	
North Wales Residual Waste Project	Ongoing	Ongoing	
Financial System	Ongoing	Not Started	

Glossary	
Risk Based Audits	Work based on strategic and operational risks identified by the organisation in the Improvement Plan and Service Plans. Risks are linked to the organisation's objectives and represent the possibility that the objectives will not be achieved.
Annual (System Based) Audits	Work in which every aspect and stage of the audited subject is considered, within the agreed scope of the audit. It includes review of both the design and operation of controls.
Advice & Consultancy	Participation in various projects and developments in order to ensure that controls are in place.
VFM (Value For Money)	Audits examining the efficiency, effectiveness and economy of the area under review.
Follow Up	Audits to follow up actions from previous reviews.
New to Plan	Audits added to the plan at the request of management. All new audits to the plan are highlighted in red.
Audits to be Deferred	Medium priority audits deferred. These audits are highlighted in green within the plan.

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday, 5 June 2019
Report Subject	Action Tracking
Report Author	Internal Audit Manager
Category	Advisory

EXECUTIVE SUMMARY

The report shows the action points from previous Audit Committee meetings and the progress made in completing them. The majority of the requested actions have been completed, with some still outstanding. They will be reported back to a future meeting.

RECOMMENDATIONS	
1	The Committee is requested to accept the report.

REPORT DETAILS

1.00	EXPLAINING THE ACTION TRACKING REPORT
1.01	In previous meetings, requests for information, reports or actions have been made. These have been summarised as action points. This paper summarises those points and provides an update on the actions resulting from them. Full action tracking details within Appendix A.

2.00	RESOURCE IMPLICATIONS
2.01	None as a result of this report.

3.00	CONSULTATIONS REQUIRED / CARRIED OUT
3.01	Action owners contacted to provide an update on their actions.

4.00	RISK MANAGEMENT
4.01	None as a result of this report.

5.00	APPENDICES
5.01	Appendix A – Action Points.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None. **Contact Officer:** Lisa Brownbill, Internal Audit Manager **Telephone:** 01352 702231 **E-mail:** lisa.brownbill@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	None.

Appendix A

AUDIT COMMITTEE - ACTION SHEET

Presented Wednesday, 5th June 2019

21st March 2018				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
63	Action Tracking	Report on control issues to be scheduled for a future meeting.	Lisa Brownbill	Analysis of category of actions is included within the Internal Audit Annual Report.

27th March 2019				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
59	WAO Audit Plan 2019	Regulatory reports to be included on the Forward Work Programme when received from WAO.	Lisa Brownbill	The Forward Work Programme will include future regulatory reports from WAO.
61	External Regulations Assurance	To forward to Sally Ellis recent performance reports on DFGS and homelessness.	Karen Armstrong	An update on the performance of DFGs Homelessness has been provided to Sally Ellis.
64	Internal Audit Progress Report	For future reports to include a footnote on Appendix C on which services the Red and Amber/Red assurance reports relate to.	Lisa Brownbill	The Internal Audit Progress Report has been updated to include this information.

65	Composition of Audit Committee	That the Committee wishes to recommend to Council, via the Council's Annual Meeting, that the number of councillors be retained on the Audit Committee and the membership rotated to allow all political groups to participate. Also that an additional lay member be recruited.	Gareth Owens / Lisa Brownbill	The composition of the Audit Committee was discussed at the Council's Annual meeting and approval given for the recruitment of an additional lay member. It is hoped a new lay member will be appointed in time for the July committee meeting.
65	Composition of Audit Committee	To send condolences to Paul Williams, the former lay member, on behalf of the Committee.	Colin Everett	Condolences has been sent to Paul Williams.
67	Forward Work Programme	Corporate Grants and WAO regulatory reports to be scheduled.	Lisa Brownbill	The forward work programme will include Corporate Grants and WAO regulatory reports.

Appendix A

AUDIT COMMITTEE - ACTION SHEET

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AUDIT COMMITTEE

Date of Meeting	Wednesday, 5 June 2019
Report Subject	Forward Work Programme
Report Author	Internal Audit Manager
Category	Advisory

EXECUTIVE SUMMARY

The Audit Committee presents an opportunity for Members to determine the Forward Work Programme of the Committee of which they are Members. By reviewing and prioritising the Forward Work Programme, Members are able to ensure it is Member-led and includes the right issues. A copy of the Forward Work Programme is attached at Appendix A for Members' consideration which has been updated following the last meeting.

The Committee is asked to consider, and amend where necessary, the Forward Work Programme for Audit Committee.

RECOMMENDATION	
1	That the Committee considers the draft Forward Work Programme and approve/amend as necessary.
2	That the Internal Audit Manager, in consultation with the Chair and Vice-Chair of the Committee, be authorised to vary the Forward Work Programme between meetings, as the need arises.

REPORT DETAILS

1.00	EXPLAINING THE FORWARD WORK PROGRAMME
1.01	Items feed into a Committee's Forward Work Programme from a number of sources. Many items are standard every quarter, six months or annually, and Members can also suggest topics for review by the Committee. Items can also be referred by the Cabinet, County Council or Chief Officers.

1.02	In identifying topics for future consideration, it is useful for a 'test of significance' to be applied. This can be achieved by asking a range of questions as follows: 1. Will the review contribute to the Council's priorities and/or objectives? 2. Is it an area of major change or risk? 3. Are there issues of concern in governance, risk management or internal control? 4. Is it relevant to the financial statements or financial affairs of the Council? 5. Is there new government guidance or legislation? 6. Is it prompted by the work carried out by Regulators/Internal Audit?
1.03	At the request of the Committee in March, the Forward Work Programme has been updated to include a report on Corporate Grants in November 2019.
1.04	Following the Committee meeting in March there has been some further movement within the Forward Work Programme needed. This is detailed within 1.05 of the report.

1.05

Report	Reason for Movement	New Report Date
Annual Audit Committee Report	New to the Forward Work Programme.	September 2019
Internal Audit Charter	New to the Forward Work Programme	June 2019
Annual Improvement Report (WAO) (2018/19)	This report will not be available from WAO until July	September 2019
Contract Management	The audit will not be completed in time for June committee.	September 2019

2.00	**RESOURCE IMPLICATIONS**
2.01	None as a result of this report.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	Publication of this report constitutes consultation.

4.00	**RISK MANAGEMENT**
4.01	None as a result of this report.

5.00	**APPENDICES**
5.01	Appendix A - Draft Forward Work Programme.

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	None.

	Contact Officer: Lisa Brownbill Internal Audit Manager **Telephone:** 01352 702231 **E-mail:** lisa.brownbill@flintshire.gov.uk

7.00	**GLOSSARY OF TERMS**
7.01	**WAO, Wales Audit Office** works to support the Auditor General as the public sector watchdog for Wales. They aim to ensure that the people of Wales know whether public money is being managed wisely and that the public bodies in Wales understand how to improve outcomes. **Public Sector Internal Audit Standard (PSIAS)** A set of standards that all Internal Audit teams working in the public sector must comply with.

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APPENDIX A

AUDIT COMMITTEE - FORWARD WORK PROGRAMME 2019/20

Presented to Committee – Wednesday, 5th June 2019

Meeting Date	Agenda Item	Author
5th June 2019	Draft Annual Governance Statement	Karen Armstrong
	Internal Audit Annual Report 2018/19	Lisa Brownbill
	Internal Audit Progress Report 2019/20	Lisa Brownbill
	Audit Charter	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
10th July 2019	Treasury Management 2019/20 Q1 Update and Annual Report 2018/19	Liz Thomas
	Supplementary Financial Information to Draft Statement of Accounts 2018/19	Liz Thomas
	Risk Management update 2019/20	Karen Armstrong
11th September 2019	School Reserves – Annual Report on School Balances	Clare Homard / Lucy Morris

Meeting Date	Agenda Item	Author
	Statement of Accounts 2018/19	Gary Ferguson
	Annual Improvement Report (WAO) (2018/19)	Karen Armstrong
	Audit Committee Annual Report	Lisa Brownbill / Helen Brown
	Contract Management	Gareth Owens
	Internal Audit Progress Report 2019/20	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
20th November 2019	Asset Disposals and Capital Receipts	Neal Cockerton
	Corporate Grants	Gary Ferguson
	Treasury Management 2019/20 – Mid Year Report	Liz Thomas
	Risk Management Update – Mid Year Report	Karen Armstrong
	Financial Procedural Rules (Biennial)	Sara Dulson
	Use of Consultancy Report	Colin Everett
	Internal Audit Progress Report 2019/20	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill

Meeting Date	Agenda Item	Author
29th January 2020	Treasury Management 2019/20 Q3 Update and 2020/21 Strategy	Liz Thomas
	Risk Management Update	Karen Armstrong
	Code of Corporate Governance	Karen Armstrong
	Annual Audit Letter	Gary Ferguson / Paul Vaughan
	Internal Audit Progress Report 2019/20	Lisa Brownbill
	Anti-Fraud & Corruption Strategy and Fraud & Irregularity Response Plan	Lisa Brownbill
	Whistleblowing Policy	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
25th March 2020	Treasury Management 2018/19 Q4 Update	Liz Thomas
	Audit Plan (WAO)	WAO
	Annual Report on External Inspections 2018	Karen Armstrong
	Certification of Grants and Returns Report (WAO)	Gary Ferguson
	Internal Audit Strategic Plan 2019/2022	Lisa Brownbill
	Public Sector Internal Audit Standards Compliance 2018/19	Lisa Brownbill

Meeting Date	Agenda Item	Author
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
	Private Meeting (WAO and Internal Audit)	