Pecyn Dogfen Gyhoeddus

Swyddog Cyswllt:
Sharon Thomas 01352 702324
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At:

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

Aelod Cyfetholedig:
Sally Ellis

29 Mai 2018

Annwyl Gynghorydd

Fe'ch gwahoddir i fynychu cyfarfod Pwyllgor Archwilio a fydd yn cael ei gynnal am 10.00 am Dydd Mercher, 6ed Mehefin, 2018 yn Ystafell Bwyllgor Clwyd, Neuadd y Sir, Yr Wyddgrug CH7 6NA i ystyried yr eitemau canlynol.

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 derbyn unrhyw ymddiheuriadau.
4	**DATGAN CYSYLLTIAD (GAN GYNNWYS DATGANIADAU CHWIPIO)**	
	Pwrpas:	I derbyn unrhyw ddatganiad o gysylltiad a chynghori'r Aelodau yn unol a hynny.
5	**COFNODION** (Tudalennau 5 - 12)	
	Pwrpas:	I gadarnhau, fel cofnod cywir gofnodion y cyfarfod blaenorol 21 Mawrth 2018.

6 **FERSIWN DRAFFT O'R DATGANIAD LLYWODRAETHU BLYNYDDOL** (Tudalennau 13 - 44)

Adroddiad Prif Weithredwr - Aelod Cabinet dros Reolaeth Gorfforaethol ac Asedau

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

7 **CYMERADWYO DATGANIAD CYFRIFON CRONFA BENSIWN CLWYD** (Tudalennau 45 - 48)

Adroddiad Prif Swyddog (Llywodraethu) - Aelod Cabinet dros Reolaeth Gorfforaethol ac Asedau

Pwrpas: I gytuno y bydd Cronfa Bensiynau Clwyd yn cymeradwyo ei Gyfrifon Blynyddol ei hun cyn archwiliad allanol.

8 **ADRODDIAD BLYNYDDOL ARCHWILIO MEWNOL** (Tudalennau 49 - 68)

Adroddiad Rheolwr Archwilio Mewnol - Aelod Cabinet dros Reolaeth Gorfforaethol ac Asedau

Pwrpas: Rhoi gwybod i'r aelodau am ganlyniad yr holl waith archwilio a gynhaliwyd yn ystod 2017/18 a rhoi'r farn Archwilio Mewnol flynyddol ar safon rheolaeth fewnol, rheoli risg a llywodraethu yn y Cyngor.

9 **ADRODDIAD CYNNYDD ARCHWILIO MEWNOL** (Tudalennau 69 - 122)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Cyflwyno Diweddariad i'r Pwyllgor am gynnydd yr Adran Archwilio Mewnol.

10 **ADRODDIAD DILYNOL GORFODAETH GYNLLUNIO** (Tudalennau 123 - 140)

Adroddiad Rheolwr Archwilio Mewnol - Aelod Cabinet dros Reolaeth Gorfforaethol ac Asedau

Pwrpas: Cyflwyno canlyniadau adolygiad dilynol o'r Orfodaeth Gynllunio i'r Pwyllgor.

11 **OLRHAIN CAMAU GWEITHREDU** (Tudalennau 141 - 146)

Adroddiad Rheolwr Archwilio Mewnol -

Pwrpas: Hysbysu'r Pwyllgor o'r camau gweithredu sy'n deillio o bwyntiau a godwyd yng nghyfarfodydd blaenorol y Pwyllgor Archwilio.

12 **RHAGLEN GWAITH I'R DYFODOL** (Tudalennau 147 - 154)

Adroddiad Rheolwr Archwilio Mewnol -

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

Yn gywir

Robert Robins
Rheolwr Gwasanaethau Democrataidd

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE
21 MARCH 2018

Minutes of the meeting of the Audit Committee of Flintshire County Council held in the Clwyd Committee Room, County Hall, Mold on Wednesday, 21 March 2018

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

APOLOGY: Councillor Jean Davies

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

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

Paul Goodlad, Richard Harries and Mike Whiteley of Wales Audit Office

Finance Manager (Technical & Capital) - for minute number 56
Finance Manager (Strategy Accounting & Systems) - minute number 58
Corporate Business & Communications Executive Officer - minute number 59

54. DECLARATIONS OF INTEREST

None were received.

55. MINUTES

The minutes of the meeting held on 24 January 2018 were submitted.

RESOLVED:

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

56. TREASURY MANAGEMENT QUARTERLY UPDATE 2017/18

The Finance Manager (Technical & Capital) presented the quarterly update on matters relating to the Council's Treasury Management Policy, Strategy and Practices 2017/18 to the end of February 2018.

The update reflected the current strategy to maximise short-term borrowing whilst monitoring interest rates; an approach which was supported by the treasury management advisors Arlingclose Ltd. As requested previously, a list was provided of the regulated financial institutions which had approved the Council's application to opt up to 'professional' client status under the Markets in Financial Instruments

Directive (MiFID II). The Finance Manager agreed to follow up Councillor Johnson's query on whether two of the companies were the same.

In response to questions from Councillor Dolphin on the long-term borrowing analysis, it was explained that a number of new loans had been taken out around the same time due to debt restructuring. Explanation was also given on the Public Works Loans Board used by most councils to access long-term borrowing.

Sally Ellis asked if the Wales Audit Office (WAO) representatives had any concerns about risk arising from the change to the Council's policy on Minimum Revenue Provision. Mr. Richard Harries welcomed the Council's engagement with WAO colleagues on the matter and spoke in support of the Council's decision and the level of information which had been shared. He said that the guidance from Welsh Government was awaited and that the WAO sought to work with councils to ensure that their chosen method was prudent.

The Chief Executive provided background to the review of the policy leading to the recommended change which had been formally agreed by full Council earlier in the month. Following advice from the treasury management advisors and WAO colleagues, the change had been recommended on the basis that it was considered to be no less prudent than the previous method (and in the opinion of the Chartered Institute of Public Finance & Accountancy, was suggested to be more prudent).

RESOLVED:

That the Treasury Management 2017/18 quarterly update be noted.

57. WALES AUDIT OFFICE (WAO) PLAN 2018

Mr. Richard Harris presented the Wales Audit Office (WAO) Audit Plan 2018 which set out the arrangements and responsibilities for proposed audit work for the Council and the Clwyd Pension Fund.

In summarising the key points of the Council's Plan, he referred to positive engagement between Council officers and the WAO on the accounts process, including preparations to meet earlier statutory deadlines. The key financial audit risks identified at the planning stage of the audit were mainly generic with only a few specific risks for the Council. Performance audit work incorporated a balance between national work across Wales and local performance work. A slight reduction in the estimated fee for the accounts audit work reflected the level of improvements which had been made to the process. A reduction in the fee for grant certification work was due to streamlined arrangements introduced by Welsh Government which would result in a significant reduction in grant claims to be certified in the traditional way.

The Chief Executive welcomed positive feedback on the financial audit of the accounts for 2016/17 and in particular, recognition of the role of the Accounts Governance Group. He said that changes to the accounting treatment of the North Wales Residual Waste Treatment Project once it became operational in 2019 may result in additional work for an interim period. Whilst the audit opinion on the

robustness of systems had been acknowledged, the sustainability of the budget position was a different matter. Possible changes to the Local Government (Wales) Measure 2009 would require mutual agreement on making best use of any released WAO resources.

On the Plan for the Clwyd Pension Fund, Mr. Harries said that a number of the financial audit risks were not specific to Flintshire, including regulatory changes which meant that Clwyd Pension Fund accounts would no longer be included as part of the Council's Statement of Accounts.

The Chief Executive explained that discussions were underway to agree on the role of the Clwyd Pension Fund Committee in approving its accounts. Whilst the Audit Committee could still have oversight, it would retain responsibility to approve the core accounts.

RESOLVED:

That the Wales Audit Office reports be noted.

58. CERTIFICATION OF GRANTS AND RETURNS 2016/17

The Finance Manager (Corporate Accounting & Systems) presented the Wales Audit Office (WAO) annual report on grant claim certification for the year ending 31 March 2017.

The report had recognised improvements in various areas, particularly in the number of grants submitted within the deadline, noting there was scope for further improvement. The £3,120 net adjustment to claims was a small proportion of the overall grants total of £137m with no financial loss to the Council, and the one significant adjustment of £250,000 on the Local Transport Fund had been due to a timing issue. Work was underway to address the recommendations from WAO and officers involved in the process were being reminded of their specific responsibilities.

In summarising the key points, Mr. Mike Whiteley of WAO spoke about the impact of qualification issues reported in previous financial years and was pleased to note that arrangements put in place by officers should assist the grants process for 2017/18. He provided clarification on the single adjustment of £250,000 which had resulted in an increase of £3,120 in funds payable to the Council, and the reason for the increase in the overall fee for the grants work, as set out in the report. In recognition of current pressures, WAO colleagues were to engage with Council officers on a quarterly basis to help identify further improvements to processes.

The Chief Executive commented on additional work on the certification of the Bus Services Support Grant following the collapse of GHA Coaches. On the adjustment for the Local Transport Fund, he said that the Council's ability to plan was affected by late notification of additional funding and encouraged WAO colleagues to take this up with Welsh Government as a financial planning practice.

RESOLVED:

That the content of the Grant Claim Certification for 2016/17 be noted.

59. RISK MANAGEMENT STRATEGY

The Corporate Business & Communications Executive Officer presented a report on the refresh of the Risk Management Strategy in response to the findings of the recent Internal Audit of risk management of operational risks. Information was also shared on a number of actions being taken to address the areas identified for further improvement.

In order to expand on Section 7 of the Strategy on 'Accountability for Risk', an addendum was circulated setting out the responsibilities of statutory officers to be included as paragraph 7.2 followed by the responsibilities of the Chief Officer Team. The Chief Executive suggested that the section could be further expanded by clarifying the responsibilities of Cabinet Members.

Councillor Woolley raised concerns about references to the 'CAMMS' system within the Internal Audit report. The Executive Officer explained that the system was used where appropriate on strategic/corporate issues and that there were additional mechanisms outside the system to manage risks. The Chief Executive spoke about adopting a shift in culture to escalate risks that were developing within portfolios at an earlier stage.

RESOLVED:

That the refresh of the Risk Management Policy and Strategy for 2018 be endorsed, with the addition of responsibilities of Statutory Officers and Cabinet Members in Section 7 on Accountability for Risk.

60. INTERNAL AUDIT STRATEGIC PLAN 2018/21

The Principal Auditor presented the three year Internal Audit Strategic Plan for 2018/19 to 2020/21. The Plan was subject to variation and review with Chief Officers, with high priority audits and reviews addressing high risk areas given priority in 2018/19.

The Chief Executive welcomed the higher degree of ownership and activities by the Internal Audit team to provide support in consulting work such as on budget modelling and calculations.

Sally Ellis referred to the Committee's role in contributing to risk management and asked how members could seek assurance on management of the Council's strategic risks, for example residential care bed availability. The Principal Auditor explained that this was managed outside the audit process but that areas of risk that were highlighted were incorporated in the Plan. The Chief Executive gave examples where Internal Audit could be involved on corporate issues such as ensuring rigour on forecasting trends and assessing the financial sustainability of the key provider market. The Chief Officer said that the Audit Committee should be assured that

Overview & Scrutiny was fulfilling its role in reporting how risks were being addressed. The Chief Executive suggested that officers consider how best to reflect how this was demonstrated through the work programmes of Overview & Scrutiny to give assurance to the Audit Committee.

The Chief Executive said he believed that Internal Audit resources were sufficient and whilst there were no plans for change, there would be more challenging debate on corporate areas in the new financial year.

The Principal Auditor said that the service was encountering areas where resource limitations were impacting on controls within the Council.

RESOLVED:

(a) That the Flintshire Internal Audit Strategic Plan 2018-2021 be approved; and

(b) That officers discuss how strategic risks are managed through the Overview & Scrutiny process to give assurance to the Audit Committee.

61. PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

The Principal Auditor presented the results of the annual assessment of conformance with the Public Sector Internal Audit Standards. The outcome of the internal self-assessment for 2017/18 and external assessment for 2016/17 indicated general conformance. The only non-conformance was on the need to undertake an assurance mapping exercise, which was scheduled for completion by March 2019. Other actions to address areas of partial conformance were set out in the action plan, including a review of the Anti-Fraud and Corruption Strategy which would be brought to a future meeting of the Committee.

The Chief Officer (Governance) referred to the Committee's self-assessment which was currently being completed. Given the new membership of the Committee, he suggested that a half-day facilitated workshop could help members to complete the questionnaire and also provide an opportunity to review the Forward Work Programme. This was supported by the Committee.

RESOLVED:

That the report be noted.

62. INTERNAL AUDIT PROGRESS REPORT

The Principal Auditor presented the update on progress of the Internal Audit department. Attention was drawn to action tracking where there were several actions with a revised due date six months beyond the original due date which were being addressed.

The Chief Officer (Governance) provided an update on the Payment Card Industry Data Security Standard (PCIDSS) where ICT solutions were being investigated to identify a system to meet requirements. He gave assurance that

progress was being reported to the senior officer team and that risks were being managed.

In response to comments by Councillor Dolphin on Greenfield Valley, the Chief Executive provided a brief update on the conclusion of the review of governance arrangements where all actions had been completed. He agreed to speak with Councillor Dolphin outside the meeting regarding issues outside the remit of the Committee. The Principal Auditor reported that a follow-up audit would be undertaken in the following year to give assurance on actions taken. Councillor Johnson asked that any information provided to Councillor Dolphin also be shared with all local Members for Holywell.

As requested previously, the Chief Officer drew attention to the overview of final reports issued with an amber/red assurance opinion and sought views on how the Committee wished to receive the information. Sally Ellis said it would be helpful to give an indication of associated actions with implementation timescales. She also referred to items deferred from the Plan and questioned how such decisions were made. The Principal Auditor explained that high-risk audits were prioritised and that new requests were discussed with the relevant Chief Officer to establish the level of risk involved.

RESOLVED:

That the report be accepted.

63. ACTION TRACKING

The Principal Auditor presented the progress update report on actions arising from previous meetings. On the action from 15 March 2017 on investigations, it was noted that the Police were not pursuing the matter and that a report on the effectiveness of internal controls would be brought to a future meeting.

RESOLVED:

That the report be accepted.

64. FORWARD WORK PROGRAMME

The Principal Auditor presented the Forward Work Programme for consideration and agreed that the relevant reports would be changed to reflect that Paul Vaughan was the lead officer, in the absence of Liz Thomas.

Sally Ellis requested a future item on delivery of the budget 2018/19 to give assurance on the systems that were in place. The Chief Executive spoke about the collective responsibility of all Council Members in setting the budget following a series of workshops on which Sally was able to attend in future. The Chief Officer (Governance) said that a report to the Council meeting in February would give assurance on the budget processes and management of risks.

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.

65. 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 11.30am

……..
Chair

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday 6th June 2017
Report Subject	Annual Governance Statement 2017/18
Report Author	Chief Executive

EXECUTIVE SUMMARY

For 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 it also meets the requirements of the Accounts and Audit (Wales) Act 2014.

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 so that it can be given due consideration.

RECOMMENDATIONS	
1	For the committee to consider, amend as appropriate and recommend to the Council the Annual Governance Statement 2017/18 to be attached to the Statement of Accounts.

REPORT DETAILS

1.00	EXPLAINING THE ANNUAL GOVERNANCE STATEMENT
1.01	Under the Accounts and Audit (Wales) Regulations 2015 each local authority must ensure it has a sound system of internal control. In addition, 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 changed the format of the report last year to simplify it alongside aligning it 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 The main changes of this newer set of principles were in relation to principles C, D and G which have been expanded upon and made more explicit taking into account national legislation. It is this set of principles which have formed the framework of the assessment questionnaires and the resultant final draft governance statement.
1.05	The corporate governance self assessments have been completed by each Chief Officer. The responses received were analysed by the CGWG and then challenged by the Chief Officer Team to endorse areas of

	strength and those for collective improvement. Areas of strength are highlighted throughout the principles in green text. Areas for improvement are summarised separately and are derived from one of three sources: i) Portfolio self assessment questionnaires ii) Overview and Scrutiny Committee Chairs questionnaires iii) Outstanding 'red' (major) risks contained within the Council Plan 2016/17 end of year report.
1.07	Progress against mitigating actions against governance issues identified in the Annual Governance Statement last year (2016/17) has also been included, with an indication as to if the issues remain 'open' or 'closed'.
1.08	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, 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 2017/18 end of year report. The Statement also describes actions taken against the governance issues reported in last year's Annual Governance Statement (2016/17).

5.00	**APPENDICES**
5.01	Appendix 1: Draft Annual Governance Statement 2017/18

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	Code of Corporate Governance 2017-18 v7FINAL **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.

2017/18

Flintshire County Council – Annual Governance Statement

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:

- is lean, modern, efficient and effective
- is designed, organised and operates to meet the needs of communities and the customer; and
- works 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.

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

- embracing and operating the leanest, least bureaucratic, efficient and effective business systems and processes.

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.

The Council is the Administering Authority for the Clwyd Pension Fund (the Pension Fund). The governance arrangements detailed in this Annual Governance Statement apply equally to the Council's responsibilities to the Pension Fund.
There are further specific requirements for the Pension Fund which are:
• The Statement of Investment Principles;
• Funding Strategy Statement;
• A full Actuarial Valuation to be carried out every third year.

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 ~~the~~ 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;
- 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 2017/18 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 portfolio 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, 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.

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

Demonstrating strong commitment to ethical values

Respecting the rule of law

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

- 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**

- 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.

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)**
  - **Engagement with Trade Unions**

- **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

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

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.**
- Community benefits 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

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

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

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.

- **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 to Care First (independent Counselling support), Management Awareness and Support, internal training and awareness sessions to support stress related absences**

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**
  - Use of the Council's Risk Management system, CAMMS
  - 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**

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.

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

Contributors to an effective Governance Framework

Council	– Approves the Corporate Plan (Improvement 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.
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
- 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 2016/17?

The 2016/17 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 Improvement Plan issues – those that were identified as part of the Improvement Plan for 2016/17 which remain un-mitigated i.e. a 'Red' risk status.
The issues and how they were addressed are below:

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	Development of an integrated impact assessment approach to inform budget decisions and longer term sustainability of services.	Integrated impact assessments (IAA) now developed and used to inform 2018/19 budget. CAMMS system been updated with IAA for all new efficiency projects; process to be operational from April 2018. 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.	Open Until Integrated Impact Assessment fully embedded.
Identifying and managing risks to the achievement of outcomes	• Risks are not mitigated during transitional or implementation phases	Consistent application of the Council's risk management approach across all strategic, operational and partnership	Risks are well managed during transitional and implementation phases. An implementation template has been developed to track implementations and	Open Risks managed well in practice and Policy and Strategy been updated;

Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
	• Outcomes are under-achieved	working.	associated risks. Early indications identify 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.	however, not yet consistently embedded.
Establishing and implementing robust planning and control cycles that cover strategic and operational plans, priorities and targets.	• Misalignment of plans and strategies • Missed opportunities for joint and collaborative working	Refresh of business plan approach across all portfolios including contributions to key corporate strategies.	Council Plan and other related plans and strategies have been mapped to ensure that there are no inconsistencies or duplication.	Closed Council plan, Well-being Plan, Financial Business Plans all in place. Service and portfolio plans in place for operational services.
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 providing the	Open Identified as risk in the 2017/18 AGS questionnaire

Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
			opportunity to a high number of services to benchmark.	
Developing and maintaining an effective workforce plan to enhance strategic allocation of resources.	• Sustainability of service provision • Ineffective allocation of resources	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 Identified as risk in 2017/18 AGS questionnaire
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 are being reviewed as part of the implementation of the General Data Protection Regulation (GDPR) on 2nd May 2018. From this date the financial penalties increase 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 real and significant risk for the Council.	Open Insufficient evidence that all is embedded. Supported by Internal Audit report.
Ensure there is effective	Mis-management of	Financial Procedure Rules (FPR's) and Contract	The management controls in place	Closed

Internal Council Governance issues	Risk	Mitigation	Management Comment	Current Status
internal financial management in place	public funds	Procedure Rules (CPR's) are in place and regularly reviewed. The Council has an internal audit function who periodically test the Councils internal control and provides an annual report on assurance.	from Internal Audit review and the Financial Procedure Rules are still in place and subject to regular review.	Supported by WAO report.

Strategic Issues from the 2016/17 Improvement Plan	Risk	Mitigation	Management Comment	Current Status
Fragility and sustainability of the care home sector	Reduced quality of care, increased difficulties with recruitment and retention of staff and reduced capacity in the care home sector.	Refocus specialisms within in-house provision to fit with changing demands. Continue to monitor capacity in the sector.	Regional work with providers to discuss fragility and the impact of admissions into acute hospitals and early discharge has been undertaken. Work with new providers to support their entry into the Flintshire market is ongoing. The Welsh Government cap on day care has increased from £60 to £70 per week with incremental progression to £100 per week over time to support the sector.	Open Although progress has been made the level of risk remains due to the ongoing fragility of the sector.
Council funding for adaptations and home	Adaptations are a statutory duty for the	Monthly management monitoring of budgets and	New commissioning framework is in place to speed up the allocation	Open The new framework will

Strategic Issues from the 2016/17 Improvement Plan	Risk	Mitigation	Management Comment	Current Status
loans will not be sufficient to meet demand	Council. Demand in excess of current budgets would create a financial pressure on the capital programme	case load. Co-ordination across Council teams to ensure the approach to adaptations makes best use of the available budget.	of work to address the increase in demand for Disabled Facilities Grant (DFG) funding. Further process improvements have been identified.	need to be monitored to ensure value for money. Supported by the Internal Audit report.
Numbers of school places not matching the changing demographics	High teaching ratios, unfilled places and a backlog of maintenance pressures.	Continuation of School Modernisation Programme will reduce unfilled places, reduce backlog maintenance, and remove unwanted fixed costs and infrastructure	Reducing unfilled school placed 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 placed can be realised. This continues to be an ongoing process linked to the School Modernisation Programme. To supplement this Council working closely with schools to consider innovative ways for reduction in capacity on a school by school basis with the objective of meeting national targets of circa 10% unfilled placed in all school sectors.	Open Work is ongoing to meet the national target.
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	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.	Open Capital business cases for improvement and repair and maintenance projects in schools are

Strategic Issues from the 2016/17 Improvement Plan	Risk	Mitigation	Management Comment	Current Status
	places.			considered through the Council's business case process.
Available funding for energy efficient measures may fall short of public demand	• Public frustration and reduced funding may impact upon the Council's reputation • Opportunities to reduce household costs and fuel poverty may not be fully realised	All potential sources of external funding proactively targeted for support. Use made wherever possible of innovative forms of finance. Managing public expectation as far as possible.	There remains more demand for energy efficiency measures than the current level of funding allows.	Open Expectations are being managed as far as possible and other sources of funding are being actively considered.
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'.	Open 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.
The scale of the financial challenge	The Council has insufficient funding to meet its priorities and	The Council's Medium Term Financial Strategy and efficiency programme.	The impact of the final settlement for Flintshire was a 0.2% decrease in funding.	Open The initial forecast for

Strategic Issues from the 2016/17 Improvement Plan	Risk	Mitigation	Management Comment	Current Status
	obligations.	National negotiations on local government funding.	Budget options were considered in two stages with members and agreed in principle by the Council in December 2017. Final budget options were agreed in February 2017.	2019/20 has been considered by Cabinet in April 2018 and will continue to be closely monitored.

What are the significant governance and strategic issues identified during 2017/18?

The review of the effectiveness of the Council's governance framework has identified the following significant issues that will need to be addressed during 2018/19. 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.
ii) Strategic Council Plan issues – those that have been identified as part of the Council Plan for 2017/18 which remain un-mitigated i.e. a 'Red' risk status.

i) Internal Council Governance issues	Risk	Mitigation
Communication and Engagement	• The views and experiences of citizens, service users and organisations of different background including reference to future needs will not be taken into account in decision making and communication of 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	• Embedding of the Integrated Impact Assessment • 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 communication methods
Capacity to provide effective information to support service decisions	• Absence of rounded and robust information to inform decisions	• Review organisational capacity to support information, research and data as a collective
Workforce planning	• Absence of effective workforce planning leads to poor allocation of strategic resources and	• Creation of robust workforce planning tools to promote discussion and further planning

i) Internal Council Governance issues	Risk	Mitigation
	potential loss or under-utilisation of skills and capacity	• Support 'build our own' ethos with appropriate tools
Appropriate induction processes	• Council's ethos, objectives and ways of working will not be provided to new recruits on a timely basis; new recruits will lack the knowledge, ambition and drive that the Council portrays	• Review of both corporate induction and individual service induction approaches
Training and development	• Absence of employee / organisation requirement mapping to optimise individual's skills and ambition with the objectives and capacity of the organisation	• Review to ensure that all individual and organisational requirements are supported with ongoing training and development opportunities
Risk management	• Risks are not clearly escalated within the organisation with a clear allocation of responsibility	• Embedding of new escalation protocol as part of the revised Risk Management Policy and Strategy
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
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 actions plan in place to address the findings, including the establishment of an oversight board.

ii) Strategic Issues from the Council Plan	Risk	Mitigation
Supportive Council: Availability of sufficient funding to resource key priorities – with particular reference to Disabled	• 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

ii) Strategic Issues from the Council Plan	Risk	Mitigation
Facilities Grants (DFGs)		
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
Supportive Council: • Knowledge and awareness of safeguarding not sufficiently developed in all portfolios • Failure to implement safeguarding training may impact on cases not being recognised at an early stage.	• 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 a regular basis • Mentor support provided by senior managers and link officers
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

ii) Strategic Issues from the Council Plan	Risk	Mitigation
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
Learning Council: Limited funding to address the backlog of known repair and maintenance works in Education & Youth assets	• Inefficient school estate • Surplus places • Poor condition and suitability of school estate	• School modernisation programme • Capital business cases submitted through council process
Green Council: Funding will not be secured for priority flood alleviation schemes	• Flood alleviation works will not be implemented effectively with appropriate funding	• Service review to balance ability to secure funding for flood alleviation works alongside statutory duties
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
Service 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.

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. Aaron Shotton – 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

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

AUDIT COMMITTEE

Date of Meeting	Wednesday, 6th June 2018
Report Subject	Approval of Clwyd Pension Fund Statement of Accounts
Report Author	Chief Officer Governance
Type of Report	Strategic

EXECUTIVE SUMMARY

The Clwyd Pension Fund prepares its statement of accounts annually using the same process and timetable as the Council's own statement of accounts. In June the draft accounts are published and are then subject to a period of public consultation, challenge, and external auditing by the Wales Audit Office. The final statement of accounts is then approved by Full Council.

The current approval process for the final statement of accounts is for them to be reported to the Clwyd Pension Fund Committee, then the Audit Committee and finally Full Council. Inevitably this process takes a lot of officer time and co-ordination of meeting dates.

It is desirable/best practice that the statement of accounts is scrutinised by two member bodies to ensure the appropriate degree of accountability and transparency. Originally those two bodies were Audit Committee and Full Council. When the pension fund committee was recently created it was added into the process rather than re-assessing the process as a whole.

Although it is a long standing practice neither legislation nor the Constitution require the final statement of accounts to be approved by Full Council. The Clwyd Pension Fund Committee might be seen as a more appropriate body to undertake that task because it comprises representatives from all relevant stakeholders, i.e. the scheme employers as well as pension fund members.

RECOMMENDATIONS	
1	That Clwyd Pension Fund final statement of accounts is considered by the Audit Committee and approved by the Clwyd Pension Fund Committee.

REPORT DETAILS

1.00	BACKGROUND
1.01	Each year the statement of accounts for the Clwyd Pension Fund is published by the Clwyd Pension Fund Committee in draft. The accounts are considered by the Audit Committee prior to a period of public consultation, challenge and external audit by Wales Audit Office. The final accounts are then considered again by the Clwyd Pension Fund Committee and Audit Committee before final approval at Full Council.
1.02	A two stage scrutiny process for accounts is appropriate to ensure the correct degree of challenge and transparency. For the Council's own statement of accounts that is provided by the Audit Committee and Full Council. This was the case for the pension fund statement of accounts also until the creation of the Clwyd Pension Fund Committee when it was added into the process creating a 3 stage process.
1.03	Neither legislation nor the Constitution require the pension fund statement of accounts to be approved by Full Council. Following consideration by the Audit Committee the accounts could be approved by the Clwyd Pension Fund itself. The Pension Fund Committee might be seen as the more appropriate body because it comprises representatives from all the relevant stakeholders such as scheme employers and pension fund members.

2.00	RESOURCE IMPLICATIONS
2.01	The current three stage process for approval of the pension fund accounts is time consuming and takes a large amount of co-ordination. That process will only become more difficult as the statutory timetable for approval of final accounts is shortened by 1 month.

3.00	CONSULTATIONS REQUIRED / CARRIED OUT
3.01	This will be considered by the Audit Committee and Clwyd Pension Fund Committee before being presented to Full Council

4.00	RISK MANAGEMENT
4.01	As well as scrutiny by councillors the statement of accounts is open to public inspection and challenge and external audit by the Wales Audit Office. The accounts will still be considered twice by two separate member bodies which should be sufficient oversight.

5.00	APPENDICES
5.01	None.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None. **Contact Officer:** Gareth Owens **Telephone:** 01352 702344 **E-mail:** Gareth.legal@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	None

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday, 6th June 2018
Report Subject	Internal Audit Annual Report
Report Author	Internal Audit Manager

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 2018. 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.
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 systems, and to make reports and recommendations to the County 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.
1.04	Information Governance – The IT Service is required to have independent certification to enable Flintshire County Council to connect to the Public Services Network (PSN). External Assurance is provided by PSN on an annual basis through an annual assessment and subsequent issue of a certificate. Ongoing monitoring and testing is also carried out internally on a quarterly basis by IT Services to ensure ongoing compliance with PSN requirements.
1.05	The report gives the level of coverage of the audit team during the year and summarises the work undertaken in 2017/18. 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. Additionally training was delivered by the team to care staff in Social Services on the procedures to be followed should they need to make a whistleblow.
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

2017/18

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 and 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. Due to limited available resources the deadline for completion has been deferred to March 2019. As a consequence the impact of the non-conformance is not considered to be significant and the Internal Audit Service of Flintshire County Council complies with the Standards in all significant areas and operates independently and objectively.

A self-assessment against the Standards has been completed and the results reported to the Audit Committee in March 2018. The Internal Audit Service was self-assessed as being generally conforming. The assessment included a review of the QAIP, actions taken from the previous year and maintained continuous improvement against the QAIP components.

The QAIP reflects the actions following the external assessment and the annual self-assessment. This was presented to audit committee in March 2018 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 of 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 material respects.

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

2 Internal Audit Assurance for 2017/2018

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 2017, the department continued to hold one full time vacant post for a Principal Auditor (the Principal Auditor acted up to Interim Internal Audit Manager). In July 2017, the Principal Auditor was appointed as the Internal Audit Manager and a new Principal Auditor appointed and started in March 2018. During this year, both the Internal Audit Manager and the part time Principal Auditor(by working additional hours), covered the duties of the vacant post over a sixteen month period. This reduction in resources was reflected in the 2017/18 audit plan and this was reported to Audit Committee in March 2017; however, sufficient work was undertaken in order for me to draw a reasonable conclusion on the adequacy and effectiveness of Flintshire County Council's arrangements.

2.3 Internal Audit Opinion

For the year ending 31 March 2018, based on the work we have undertaken, my opinion is that Flintshire County Council has overall an adequate and effective framework of governance, risk management and control.

Three audits were given a 'red' assurance level during the year (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.

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 2018 (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 2017/18, 235 actions were raised and 158 (67%) were implemented to date. The remaining have not reached the due date.

2.5 The Basis of the Opinion

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

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 the annual governance statement 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 Service 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 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 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 issued.

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 2017/18 AIR had not been published; however, verbal feedback from WAO has confirmed that there are no significant issues arising which would raise concern.

The last report was published in July 2016. Overall the Auditor General for Wales has reached a positive conclusion*. "The Council is meeting its statutory requirements in relation to continuous improvement".* No formal recommendations were made during the year. There were four new voluntary proposals for improvement. An executive response to the reviews is set out.

Information Governance – The IT service is required to have independent certification to enable Flintshire County Council to connect to the Public Services Network (PSN). External Assurance is provided by PSN on an annual basis through an annual assessment and subsequent issue of a certificate. Ongoing monitoring and testing is also carried out internally on a quarterly basis by IT Services to ensure ongoing compliance with PSN requirements.

Risk Management

A revised Risk Management Policy and Strategy was issued during 2017/18, with an enhanced risk escalation process included. Quarterly progress reports against the Improvement Plan have been presented to Overview and Scrutiny Committees. In November 2017, Internal Audit issued a report on risk management. This review focused on the identification, management and reporting of operational risks including the process for recording and escalating risks outside of the control of operational managers. The report gave an Amber/Green assurance level – key controls in place but some fine tuning required.

My annual opinion is also informed by the number of risk based audit assignments completed during the year.

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. 70% 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 2017/18, 235 actions were raised to improve the internal control, risk management and governance arrangements across the authority of which 158 actions have been implemented. Implementation of actions continue to show a high degree of compliance with the agreed timescales. Summary results are given in Appendix B, together with definitions of the assurance levels (Appendix A).

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	1		1	1	1		4
Community and Enterprise	3	3	2			1	7
Education and Youth	1	1	4		1		7
Governance	3	2	1	1	1	2	6
Organisational Change 1	1	2		2		2	3
Organisational Change 2	2	3		2	1	3	5
People and Resources	2	2	4	5	4	3	14
Planning and Environment	2	3		1	1	1	6
Social Services	2	2		1		1	4
Streetscene and Transportation	2	4		2	4	3	9
External			1	1			2
Total	**19**	**22**	**13**	**16**	**13**	**16**	**67**
		70					

The original annual plan showed 70 audits / areas of work to be undertaken. The approach to managing the audit plan changed for 2017/18 and this was approved by Audit Committee in March 2017. 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. In total 13 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 2017/18 Audit Plan					
Priority	**Completed**	**In Progress**	**Deferred**	**Ongoing ***	**Total**
High	9	7	3		19
Medium	7	2	13		22
Annual	10	2	-	1	13
Advice & Consultancy	9	-	-	7	16
Position Original Plan	**35**	**11**	**16**	**8**	**70**
New Requests	9		2	2	13

* 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 2017/18, including carry forward work, 60 final reports were brought to the Audit Committee and at the time of this report a further 11 reviews were near completion or draft awaiting finalisation. Overall the 2017/18 plan was substantially completed.

All the deferred audits were considered during the planning meetings for the 2018/19 to 2021/22 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 60 Primary schools and 13 Secondary Schools
Schools Audits	6 school audits
Investigations	See 2.9 below
National Fraud Initiative	63 days on work relating to National Fraud Initiative
Advisory work	124 days on advisory work in the year
Grant audits	1 audit of grants (Education Improvement Grant)

2.9 Investigations

At the start of the year there were four live investigations. During the year ten more were started and ten were completed leaving four ongoing investigations at the end of the year.

Of the ten new investigations three were in Streetscene and Transportation, four related to Community and Enterprise and three to 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 Alternative Delivery models and Community Asset Transfers
- Advice on the Council's approach to method and forecasting statements
- Advice on the security of HRC sites
- Consultancy work on the solar farm

It should be noted that the number of days spent on advisory work (124 days for 2017/18) has increased progressively over the last three years (79 days for 2016/17, 46 days for 2015/16) 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 Fraud Awareness

All fraud related policies; Whistleblowing, Anti-fraud and Corruption Strategy and Fraud Response Plan are published on the Infonet. The policies are reviewed on a regular basis and scheduled for review in 2018/19. At the request of Social Services, the Awareness of Whistleblowing training was provided during 2017.

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. Most targets were met or within 20% of the target as reported in the quarterly performance reports.

Performance has been affected by the temporary loss of staffing resources and reallocation of duties. One of the Principal Auditors has taken flexible retirement and the other full time Principal Auditor acted up, for part of the year, as Internal Audit Manager as this post had not been back filled. This has resulted in Senior Auditors carrying out peer reviews of audit projects reducing time spent on project work and impacting on work performed within planned days.

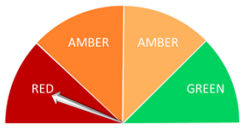
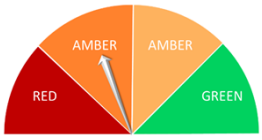
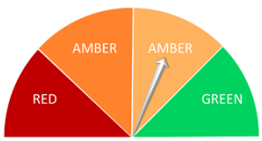
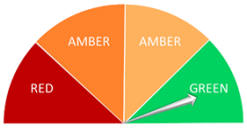
There has been a decline in the time taken for departments to return draft reports. This however is more a reflection of the detailed work undertaken and greater stakeholder involvement and should not be seen negatively.

Internal Audit Performance Indicators

Performance Measure	Q1	Q2	Q3	Q4	17/18 Total	17/18 Target
Reported to Committee	June 17	Sept 17	Jan 18	Mar 18		
Audits completed within planned time	71%	60%	88%	83%	**76%**	80%
Average number of days from end of fieldwork to debrief meeting	17	15	11	9	**13**	20
Average number of days from debrief meeting to the issue of draft report	5	14	2	3	**6**	5
Days for departments to return draft reports	10	11	7	7	**9**	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	39	34	27	27	**32**	34
Productive audit days	79%	74%	82%	78%	**78%**	75%
Client questionnaires responses as satisfied	100%	100%	100%	100%	**100%**	95%
Return of client satisfaction questionnaires	66%	75%	75%	57%	**68%**	70%

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 2017/18

Appendix B

Auditable Area	Number of Reports & Audit Opinions						Priority & Number of Agreed Actions			
	Red	Amber -	Amber +	Green	Advisory - No Opinion Given	In Total	High	Medium	Low	In Total
Community & Enterprise	2	1	0	2	2	7	4	18	11	33
Corporate	0	0	3	0	1	4	0	8	8	16
Education & Youth	0	1	8	2	2	13	1	32	33	66
Governance	0	1	2	0	0	3	0	11	0	11
Organisational Change 1 & 2	0	0	2	0	2	4	0	1	5	6
People & Resources	0	3	3	0	2	8	0	12	10	22
Planning & Environment	1	2	2	1	1	7	4	13	15	32
Social Services	0	0	1	1	3	5	0	2	5	7
Streetscene & Transportation	0	1	2	0	4	7	1	13	5	19
External	0	0	1	0	1	2	0	4	4	8
Total	**3**	**9**	**24**	**6**	**18**	**60**	**10**	**114**	**96**	**220**

PSIAS –Quality Assurance Improvement Programme (QAIP)

Appendix C

Actions from External Assessment March 2017 and self-assessment February 2017– questions not scored as conforming

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
1100 (EA)	The Service does not currently stipulate that "advice / recommendations are provided without prejudice to the right of Internal Audit to review and make further recommendations at a later date" after providing a consultation service in an area that may be later audited.	Suggestion	The Service could consider using the suggested statement in reports. This would clarify to clients that request a consultation service that the assurance provided is not absolute and it does not exempt them from a future audit in the same area of work. (*1100)*	LB	**Implemented**	This statement is now included in any consultancy report issued.
1310 (EA)	Does the QAIP include both internal and external assessment?	Partial	Continue internal assessments, external assessment to be completed by 2017/18. *(1310)*	LB	**Implemented**	External Assessment completed in March 2017. Internal assessment continues to be undertaken. The results from both assessment are included within the QAIP.
1320 (EA)	Quality Assurance and Improvement Programme- The annual internal self-assessment and resulting improvement plan are currently reported to the Audit Committee together, although the PSIAS state that the results of the QAIP and progress against any improvement plans must be reported in the "annual report".	Suggestion	Although it is acknowledged that it may cause duplication of work, the Section should consider including the self-assessment improvement plan in its Annual Report along with the other performance targets and measures that are currently in place to monitor Internal Audit's activities to give a full picture of its QAIP. *(1320)*	LB	**Implemented**	Whilst it is felt this is a duplication since the Quality Assurance Improvement Plan (QAIP) is reported to AC each year in March, reference was made to the QAIP in Internal Audit Annual Report in June 2017 and will continue each year.
2120	Has the internal audit activity evaluated the potential for fraud	Partial	Improve awareness of fraud. Collect data on fraud	LB	**Implemented**	Fraud risk analysis is undertaken as part of each audit review.

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
	and also how the organisation itself manages fraud risk?		risk.*(2120)*		**Implemented** March 2019 March 2019	Whistleblowing training has been delivered to Social Services. Anti-Fraud and Corruption Strategy and Fraud Response Plan is due for review during 2018/19. Once reviewed, this will be launched on Council's Infonet. Develop an online reporting solution which would support digital and customer strategies during 2018/19.
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 is being undertaken to assess the effectiveness of all PIs. The committee will be updated 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	March 19	Not achieved. This was originally planned for March 2018; however, due to the change in Management and a vacancy for a Principal Auditor for the last 16 months, this will be deferred until March 2019.
1000 (EA) (SA)	The internal audit charter does not define the term 'senior management', for the purposes of the internal audit activity. (EA)	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-	LB	July 18	The Charter will be reviewed 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
	The Audit Charter does not make reference to auditing a third party. (SA)		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)*			
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	Implemented	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 was picked up for the Internal Audit Managers appraisals (May 2018). In relation to the appointment of the Internal Audit Manager, the Chair of the

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
						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 2018/19 audit plan.
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	Ongoing	Whilst the Audit Charter will be updated to address this point (July 2018), 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 IT assurance is referenced within the Internal Audit Annual Report for 2017/18.

Ref	Conformance with the Standard	Compliance	Planned Actions	Responsible Officer	Timescale	Comment
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	July 18	The document retention policy is currently under review to ensure compliance with GDPR. The Audit Manual will be updated to include the retention policy as an appendix.

AUDIT COMMITTEE

Date of Meeting	Wednesday, 6 June 2018
Report Subject	Internal Audit Progress Report
Report Author	Internal Audit Manager

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 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. Since March 2018, one 'Red' or 'Limited' assurance opinion has been issued for Disabled Facility Grants (DFG). Details of this review is noted within Appendix C. Copies of all final reports are available for members if they wish to see them.
1.03	At the request of the committee Appendix D provides an overview of those

	audits reports issued with an Amber Red assurance opinion.
1.04	The automatic tracking of actions continues using 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. E-mails are also sent to them and copied to Chief Officers if actions are not completed on time. Monthly reports are also sent to Chief Officers informing them of outstanding actions for their teams. The system was rolled out from the 4th January 2016, including requiring all managers and Chief Officers to register. It included all actions from reports issued since April 2015, along with outstanding actions previously tracked. Appendix E shows the current situation. Of 732 actions entered into the system 653 have been cleared and 80 remain live. There are no overdue actions to be reported. Appendix F 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.
1.05	Appendix G shows the status of current investigations into alleged fraud or irregularities. The table includes the start dates of the investigations.
1.06	Appendix H shows the range of performance indicators for the department. Performance continues to meet the current targets set however there has been a slight reduction in 'Average number of days from response to issue of Final Report' and in the number of Client Questionnaires returned and this is reflected in the stats. This will continue to be monitored.
1.07	Appendix I shows the current position of work being finalised from the 2017/18 plan.
1.08	Appendix J shows the current position with regards to the 2018/19 plan.
1.09	On a quarterly basis the 2018/19 plan will be reviewed and reprioritised to accommodate new requests for work or to respond to emerging issues. Since April 2018 we have had one new request for work.
1.10	Review of the annual plan (since it was submitted for approval in March 2018) has identified a formula error in the calculation of available days which will require the number of days in the plan to be reduced. Due to the change in the operating model, the plan is due to be reviewed with the Chief Officers in light of their new areas of responsibility. Any reduction to the plan will be made to the medium priority audits. High priority audit will not be affected. Any changes will be reported back to the next Audit Committee.

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 2018 Appendix C – Red / Limited Assurance Reports Issued Appendix D – Amber Red Assurance Reports Issued Appendix E – Action Tracking – Portfolio Statistics Appendix F – Actions with Revised Due Date Six Months Beyond Original Due Date Appendix G – Investigation Update Appendix H – Performance Indicators Appendix I – Operational Plan 2017/18 (Carry Forward) Appendix J – Operational Plan 2018/19

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	**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. **Wales Chief Auditors Group:** An informal meeting group of Chief Auditors to discuss items of mutual interest. **Operational Plan:** the annual plan of work for the Internal Audit team.

Flintshire Internal Audit

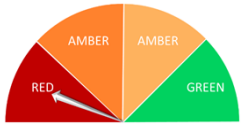
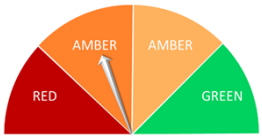
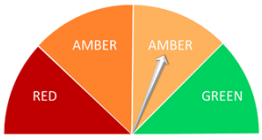
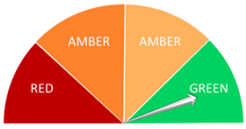
Progress Report

June

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
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: 51-85% 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: 85%+ 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.

Final Reports Issued Since March 2018

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.

Project Reference	Project Description	Audit Type	Level of Assurance	Actions		
				High	Med	Low
16-2017/18	Disabled Facilities Grants	Risk	Red	2	8	2
5-2017/18	Working Time Regulations	Risk	Amber Red	0	4	2
21-2017/18	Housing Rent Arrears	Risk	Amber Red	0	3	0
10-2017/18	IR35 Compliance	Risk	Amber Red	0	3	1
30-2017/18	Main Accounting – Accounts Receivable (AR) including Debt Management	Risk	Amber Green	0	2	2
23-2017/18	Main Accounting General Ledger (Cash Receipting)	Risk	Amber Green	0	2	3
12-2017/18	IT Procurement in Schools	Risk	Amber Green	0	3	0
44-2017/18	Greenfield Valley Heritage Park Follow Up	Follow Up	Amber Green	0	1	2
45-2017/18	S106 Follow Up	Follow Up	Amber Green	0	1	2
47-2017/18	Planning Enforcement (including Building Control) Follow Up	Follow Up	Amber Green	0	3	2
22-2017/18	Treasury Management	Risk	Amber Green	0	1	2
26-2017/18	Housing Benefits	Risk	Green	0	1	1
31-2017/18	Council Tax and NDR	Risk	Green	0	0	2
AC15 – 2017/18	Aura Leisure & Libraries Ltd	External	n/a	n/a	n/a	n/a

Reports Issued 'Red / Limited' Assurance

Appendix C

Disabled Facilities Grant (DFG)

Background

An audit of the Disabled Facilities Grant (DFG) was undertaken as part of the approved Internal Audit Annual Plan. The audit reviewed and considered:

- Compliance with relevant policies, procedures and regulations;
- Administration of DFG scheme;
- Third parties service level agreements and protocols; and
- Performance monitoring.

A DFG is a mandatory grant to help individuals living with a disability with the cost of adapting their homes to enable them to continue living at their residence with the maximum amount of independence. The administration of the DFG is performed by the Council's Regeneration team following a referral from an Occupational Therapist. The amount of grant will depend on the cost of the approved works and where applicable an applicant's financial circumstances. A means test will be carried out on applications with the exception of child applicants and where the adult applicant is in receipt of Council Tax Reduction and/or Housing Benefit. Depending on the outcome of this assessment the amount of grant payable offered may vary from zero to 100 per cent of the cost. The maximum grant payable in Wales is £36,000.

A Disabled Facilities Discretionary Top up loan will be considered in exceptional circumstances where the required works for the adaptations exceed the statutory limit of £36k. This loan is only provided to owner occupiers and the loan amount is registered as a financial charge against the property at the Land Registry. Additionally, where the adaptations required are unsuitable at the applicant's current residence, a Disabled Facilities Relocation Grant is available to cover the expenses of a disabled persons' move to a more appropriate property. This grant covers expenses such as removal costs and connection of services as well as bridging the affordability gap between the value of the applicant's existing home and the property to be purchased.

At the time of the audit the 2017/18 DFG budget was £1 million, however due to the rising cost of adaptations relating to inflationary increases in construction costs and the increase in complex referrals for adaptation work, a budget pressure was submitted by the service. In response to this a decision was later made to postpone non-emergency applications. Any emergency adaptation work would be considered via the Capital Asset

programme board. Enhancements are to be made to improve budget tracking to ensure the service is not underfunded and the Council meets its statutory duty.

Overall yearly performance data for 2016/17 showed the service performance had improved over the previous year as reflected by the National Performance Indicator for DFG however quarterly performance for 2016/17 was volatile. Currently this is the only performance indicator utilised by the service to monitor DFG performance and it is not effective to support management of service delivery and overall customer satisfaction.

The service has also identified that the nature of the DFG works required are increasingly more complex and thus impacting delivery timescales. The Welsh Government is in the process of consulting on the adequacy of this performance indicator and the Council have requested clarity and guidance on the DFG national PI measurement to ensure performance data comparison with other councils' is fair and accurate.

The review has highlighted a number of opportunities for control improvements relating to the holistic review of service and contract performance in order to reduce delivery timescales and deliver value for money. The DFG Adaptation Framework was devised and due to be implemented in February 2017. This framework set out the procedure for ordering works, the main terms and conditions for the provision of the Works and the obligations of the Supplier. A total of nine contractors form part of this framework. The service was unable to roll out the aforementioned framework due to two related investigations. In both instances the investigations were conducted internally with the first receiving external independent examination. In both instances, the outcome of the review was there was no case to answer however some opportunities to improve working practices were identified and these have been included within this report. During this interim period the service is currently inviting these contractors to tender for the various DFG work.

The service is in the process of fully implementing the adaptation work framework as this will address the tendering issue relating to the process for work allocation identified in the review. Those DFG cases deferred during 2017/18 will be considered in quarters 1 and 2 of 2018/19 under the new framework agreement.

There have been a number of changes to the management structure within the service over the last year and this combined with a number of open positions within the adaptation team has led to some areas for improvement identified throughout the review and mentioned above. It should be acknowledged that some of the DFG processes are currently under review since the audit commenced by the Regeneration Programme Lead who was recently appointed in July 2017. Due to his time in role, his knowledge of the systems and processes were still developing at the time of the audit.

Overall Conclusion:

The review confirmed adaptation referral forms submitted by Occupational Health were available for all approved DFG applications, there was evidence to support the approval of the DFG applications based on the current financial criteria and means test and the Housing and Regenerations Programme Board met as per the agreed frequency to provide oversight over the DFG delivery. However there were inadequate

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.

Work has commenced by the service to address the findings within the report. To provide additional assurance a professional oversight board will be established comprising of the chief Executive, Chief Officer, Service Manager, Internal Audit and a Service Manager independent of the portfolio. The purpose of the board will be to provide corporate oversight and challenge of the recovery plan, to sign off the implementation actions and monitor performance for a period of time.

A verbal update will be provided to Audit Committee and it has been agreed that as part of the Strategic Audit Plan for 2018/19 a follow up review will be undertaken of DFGs.

Disabled Facilities Grant: Action Plan

No.	Findings and Implications	Agreed Action	Who	When	Current Status
1 (R)	Since 2016/17, the staffing costs within the adaptations team has a reduction of £95k. Consequently there are key officers within the team whom are responsible for the majority of stages involved in an adaptation process. Although the review has not identified inappropriate practice, management oversight is not undertaken of the work completed by staff relating to the end to end grant allocation process. Where monitoring in place to track the rotation of contractors invited to tender as part of the current process, this was found to be incomplete and had not been adhered to since 2015. It is	Instigate documented review process of individual cases to monitor system compliance and progress. Full implementation of the new DFG Framework and continuous monitoring to demonstrate procedural adherence whilst monitoring budget spend and value for money. URN 02075	Regeneration Programme Lead	31 May 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	recognised the latter will be addressed with the implementation of the new DFG framework as long as the process is being adhered to and compliance monitoring is reintroduced. In January 2017 the Regeneration Manager left the Council and the role remains vacant. A Regeneration Programme Lead was assigned to post six months after the departure of the Regeneration Manager. This contributed to both of these issues and prevented the facilitation of a handover between managers to ensure controls operated effectively. This poses a risk that the Council does not obtain value for money by utilising the DFG Adaptation framework and through the rotation or selection of contractors.				
2 (R)	Land charges are not always being placed against the property at the time of work completion as stipulated in the conditions for the Disabled Facilities Grant and DFG Top Up Loan. One of the conditions of the DFG grant is the repayment of grant if the applicant chooses to move within 10 years of the	Controls to be introduced to verify the conditions stipulated for the Disabled Facilities Grant, Disabled Facilities Relocation Grant and the Disabled Facilities Discretionary Top Up Loan in line with policy review. A review to be completed of all DFGs and	Service Manager – Enterprise and Regeneration Regeneration	30 July 2018 30 June 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	completion date for any grant above £5,000, up to a maximum repayment of £10,000. The DFG Top Up Loan amount is also registered as a financial charge against the property at the land registry to ensure the Top Up Loan is repaid in the event of a sale or property transfer. From a sample of 5 applications, it was identified in all cases land changes had not been placed against the respective properties totalling £107K. Additionally, there are limited controls to ensure all Disabled Facility Grant, Disabled Facilities Relocation Grant and Disabled Facilities Discretionary Top up Loan conditions are met. Testing has identified limited controls are in place to meet the following conditions: • Relocation Grant - a condition of the grant is that the purchased property must have no category 1 hazards present. Testing has identified that there is no evidence on file to demonstrate this is being checked this is largely due to the grant being award prior to the purchase of the property. It is acknowledged the	DFG Top Up Loan which have been completed to ensure land charges have been placed against the relevant properties, where required. Check list for all DFGs to be put in place to ensure all process controls used and recorded on FLARE. URN 02066	Programme Lead Regeneration Programme Lead	31 May 2018	

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	volume of relocation grants is minimal (only 3 have ever been awarded). • Discretionary top up loan - one of the loan conditions is that the property must be covered by buildings insurance until the loan is repaid. A process is not in place to check this information. Whilst these grant conditions need to be verified, the grant application form does not stipulate these requirements and the applicant's responsibility to adhere to these terms and conditions. As a consequence it may be difficult to enforce compliance or seek reimbursement.				
3 (A)	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 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	The policy context remains unchanged. However, the details of each programme of work changes frequently as funding programmes change. A simple programme summary with eligibility criteria will be created and approved to replace this section of the policy. URN 02024	Service Manager – Enterprise and Regeneration	30 June 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	assessment of this condition.				
4 (A)	A process has not been defined to deal with clients where the value of the eligible work exceeds the DFG amount and is below the Disabled Facilities Discretionary Top Up Loan value. Although these cases are reviewed on a case by case basis, this may lead to an inconsistent approach to clients' needs and a potential reputation impact for the Council should it be challenged.	A process to be defined on how to deal with client cases which exceed the DFG grant (36K) amount but are below the Disabled Facilities Discretionary Top Up Loan (Minimum loan amount of £3K). Officers will have discretion to manage these cases within new guidelines. URN 02028	Service Manager – Enterprise and Regeneration	30 June 2018	In Progress
5 (A)	The income eligibility amount for child tax credit and working tax credit within the DFG application form is out of date. Specifically, the eligibility amount is understated by £1055 and used to determine eligibility. This poses a risk that applicants may be declined due to the incorrect criteria. Additionally, the privacy notice on the Disabled Facilities Grant application is not compliant with current Data Protection Act and future GDPR. Specifically it does not advise the applicant on why and how the Council will be processing their information, the legal basis for processing the information, the retention period for the	A review to be completed of the application form to ensure it is in line with all current regulatory and legal requirements. URN 02055	Regeneration Programme Lead	31 May 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	personal information, and whether the provision of personal data is part of a statutory or contractual requirement. 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.				
6 (A)	There are currently 24 stages within the current DFG process. Documented procedures are not in place to provide guidance on the various DFG processes such as tendering, means test documentation, variation of orders, payments, etc. This has led to inconsistencies in approach and documentation retained for the various DFG applications processed.	A process review should be completed to identify areas where improvements can be made or the process could be streamlined. Documented procedures (desk instructions) for all DFG processes to be drafted. URN 02078	Regeneration Programme Lead	31 May 2018	In Progress
7 (A)	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. Control improvements would assist in identifying poor contractor performance,	Management information to be developed to report on contractor performance. Management to investigate system requirements to eliminate the need for manual spreadsheets and the potential to use Proactis, the Councils' contracts management system. URN 02079	Regeneration Programme Lead	31 May 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	emerging trends in variation costs and evaluating whether value for money is achieved and service delivery improved.				
8 (A)	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 generated from the FLARE system. This list formed the basis for the sample testing selection. Sample testing identified that some applications which had been approved had not been reflected in the DFG spreadsheet. This spreadsheet was recently introduced by the Regeneration Programme Lead as the current Flare system are not adequate to track application progress. This spreadsheet is populated with data extracted from 2 main sources: P2P and FLARE. There are currently 24 steps within the current process to deliver a DFG. Reporting is not available to demonstrate the volume of applications at each stage of the process. The current national performance indicator	Monthly reconciliation to be completed between DFG spreadsheet with the information provided by finance to ensure budget spend is accurately reported and managed as well as providing an accurate overview of all grants in process. Following the review of the current process in an attempt to streamline, target dates to be assigned to all process steps. Monthly reporting to be generated to review progress of delivery against agreed SLAs. Review of cases where SLAs have not been achieved to understand reasons for delay and opportunities for process improvements. Internal KPIs to be established to monitor DFG delivery. URN 02058	Regeneration Programme Lead Regeneration Programme Lead Regeneration Programme Lead Regeneration Programme Lead Regeneration Programme Lead	31 May 2018 31 May 2018 31 May 2018 31 May 2018 31 May 2018	In Progress

No.	Findings and Implications	Agreed Action	Who	When	Current Status
	utilised by the service to monitor performance of DFG delivery is not sufficient and there are no internal indicators to assist with the identification of issues leading to delay in service delivery and contributing to customer dissatisfaction. Additionally, agreed time frames have not been defined for each step of the delivery process for which delivery can then be measured against. The service is missing an opportunity to measure service performance, manage budget spend and identify service process improvements.				

Reports Issued 'Amber Red / Some' Assurance

Appendix D

Working Time Regulations:

Areas Managed Well	Areas Identified for Further Improvement
• The review of individual contracts in place identified no contracts with hours over the maximum limits set.	• Employees were identified with cumulative contracts exceeding maximum working hours in line with regulations. To address this the contractual position of the two identified employees has been reviewed and remedied. The new starter checklist will also be amended to prompt the Employment Services team to check the number of contracted hours if already employed by the Council or associated companies (AURA and NEWydd) and any issues will be reported to the Business Partner team and this work will be completed by 30 May 2018. • Employees were identified working on average over the maximum hours as defined within the regulations and there was no defined process for the monitoring of employees working hours. To monitor this a report is to be produced on a quarterly basis for each Portfolio to identify all employees who have worked on average in excess of 48 hours over the defined period. This information will be shared with each Chief Officer for review and action and concerns will be escalated as required to the Senior Manager HR & OD and Head of Paid Service and this process will be place by 31 July 2018. • Whilst there is a Corporate Working Time document available, it doesn't clearly cover all employees in line with the regulations. A new Working Time Policy was formally approved in April 2018 with an effective date of May 2018. It will be circulated to managers and published on the Infonet. This will be implemented by 30 May 2018. • The review identified a manual processing error and a number of duplicate records were identified. Employment Services are responsible for replacing / deleting bank details when notified rather than adding an additional bank account. To address this the Employee Services Manager will raise the issue at the next team meeting and an exercise will be undertaken to correct the records of the employees identified. The review confirmed there was no evidence duplicate payments had been made. This action will be implemented by 30 May 2018.

IR35 Compliance:

Areas Managed Well	Areas Identified for Further Improvement
• Our Managed Agency Staff Solution - Matrix has undertaken a review, prior to April 2017, of all agencies and individuals they work with to ensure their IR35 status is known. • Our off-payroll school worker provider New Directions has provided assurance all their workers are paid via their payroll. • Payroll have set up a process for the correct payment of IR35 status for off-payroll workers. • AP are providing some control through a review of invoices for potential off-payroll workers. • P2P staff assess all new vendors for whether an IR35 check is required to be completed by the engaging manager before the vendor is added to the system. • Procurement have included provision for IR35 status checks when setting up contracts. • The Theatre is raising awareness of IR35 rules amongst their engaging managers and carrying out checks prior to engagement of workers.	• The IR35 Compliance – Guidance for Managers is in draft and although on the infonet; has yet to be publicised across the Council Workforce. To address this the guidance will be reviewed and publicised as part of the confirmation of the new Matrix contract by 30 June 2018. • The current guidance does not include advice on dealing with IR35 status disputes and does not fully reflect the specialist circumstances found in the Theatre. The guidance does not define the process by which process for Council wide compliance will be measured. Documented procedures specific to the needs of the Theatre will be produced by 30 August 2018. • Engaging managers are not routinely carrying out IR35 checks prior to engaging off-payroll workers due to a lack of awareness of the process. Reminders will be issued across the Council that agency workers must be obtained via Matrix by 30 September 2018. • Agencies outside Matrix are not being contacted to establish if their agency workers provided are paid via their payroll. HR will contact service areas who are going outside of Matrix and remind them of their requirements to establish PAYE status of any agency worker they use by 30 September 2018. • Expenditure (£113,801) is being miscoded to the agency workers GL code. To address this agency codes will be a standard agenda item on practitioners meetings, monitored by Financial Systems to ensure accuracy of use and the development of more appropriate codes for the contracts and suppliers found miscoded will be undertaken by 30 September 2018.

Housing Rent Arrears:

Areas Managed Well	Areas Identified for Further Improvement
• Introductory and Secure Tenancy arrears are identified and managed correctly according to their requirements. • Income Team deliver their service in accordance with the Corporate Debt Recovery Policy and their rent recovery procedures from first contact to dealing with Court appearances. • Income team deliver their service is compliance with the Housing Act (Wales) 2014	• The level of rent arrears has shown a recent increase as a result of various factors including the introduction of universal credit and pre tenancy checks. There is a need for change to the collection processes. To influence and manage this transition a workforce task group constituting of the Chief Officer, Housing & Assets, Revenues Manager, Customer Support Manager & Accommodation Support Services Manager will be formed. The task group will develop a planned programme and monitored its progress. Tangible signs of improvement are likely to be at least June 2019. • Evidence was found that there are a group of tenants who are in persistent arrears. The authority is looking to change this culture however this is a complex area of work requiring interventions at a number of levels and within a number of services. In order to influence positively the service needs to transition from a Housing First approach to a Rent First approach, this will take time. A number of pieces of work are being piloted and initial results have been positive, further work however, is necessary in order to change the customer mind-set to acknowledge that paying rent is equally as important as paying their rates. To influence and manage this transition a workforce task group constituting of the Chief Officer, Housing & Assets, Revenues Manager, Customer Support Manager & Accommodation Support Services Manager will be formed. The task group will develop a planned programme and monitored its progress. Tangible signs of improvement are likely to be at least June 2019. • A comparison was made with other Housing Authorities to compare the process followed for the collection of rent arrears, good practice was identified which has indicated that the Council should consider a radical change to their rent arrears process to develop a 'Rent First' culture in Flintshire. A ‘proof of concept’ will be undertaken to adopt a more commercial approach to rent collection, with targeted out-bound telephone calls, doorstep visits using debt recovery techniques and staff from the Councils debt collection/in-house enforcement service. The ‘proof of concept’ will ensure court action is taken quickly in those cases that fail to engage or co-operate with the Council, in a similar way to how Magenta Living recover un-paid rent from tenants. It is intended to complete this piece of work by March 2019.

Action Tracking – Portfolio Performance Statistics

Appendix E

Portfolio	May 2017 Statistics: Number of Actions Raised Since January 2016	May 2017 Statistics: Actions Implemented since Jan 2016 *(including Actions No Longer Valid)*	May 2017 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 E	
Chief Executives *	31	30	89%	1	0	**1**	**0**	**0**
Education & Youth	57	45		12	0	**3**	**1**	**0**
Governance *	83	69		14	0	**10**	**2**	**5**
Housing & Assets *	105	94		11	0	**3**	**1**	**1**
People & Resources	122	111		11	0	**6**	**2**	**0**
Planning, Environment & Economy *	38	30		9	0	**10**	**1**	**5**
Social Services	88	82		6	0	**5**	**4**	**0**
Strategic Programmes*	39	32		7	0	**1**	**0**	**0**
Streetscene & Transportation	75	75		0	0	**0**	**0**	**0**
External	22	20		2	0	**2**	**0**	**0**
Individual Schools	72	65		7	0	**6**	**6**	**0**
Total	**732**	**653**		**80**	**0**	**47**	**17**	**11**

*** 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 with a Revised Due Date Six Months Beyond Original Due Date

Appendix F

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Education & Youth								
Schools Risk Based Thematic Review	1855	There is not a single system for purchase orders for schools using manual processes A spreadsheet will be developed and issue to schools with guidance on how to record and authorise purchase orders. Schools Financial Procedures will be updated.	L	30-Se-17	31-May-18	The new business manager of Holywell High School has come from a Denbighshire school where she already had P2P. She has requested her school is an early adopter, she has also offered to be available for support and encouragement for other schools transitioning to P2P. The move to roll out P2P to all schools is in progress however there are serious concerns about school budgets across the county and in all schools, dealing with this is the priority.	The roll out of P2P is currently in progress for a number of schools.	Schools continue to use various methods of purchase orders, this is not a high risk and will be resolved by all schools adopting the P2P system which is the aim for this year.
Governance								
Data Protection - 15/16	1406	A new workflow process will be implemented to include subject access requests. This will also	M	31-Mar-17	31-May-18	Service to confirm This forms part of the wider Information System which is being	This is currently under development as part of the GDPR project.	A spreadsheet is being maintained of current requests, this will be replaced by the new

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		raise awareness, heighten the profile and educate staff within Portfolios of the existence of SAR's and the correct steps and guidelines to be used when dealing with them.				developed. We have started with FOI as there are higher risks in this area.		workflow system.
Data Protection 15/16	1414	The introduction of a workflow process for SAR's will ensure a central control over the process and ensure the process is fully complete.	M	31-Mar-17	31-May-18	Service to confirm The Information System forms part of a wider project. The project has started with FOI as there are higher risk issues in this area.	This is currently under development as part of the GDPR project.	A spreadsheet is being maintained of current requests, this will be replaced by the new workflow system.
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-Dec-16	31-Aug-18	Revised due date to tie in with the external assessment with QSA support	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 implementation and thus achieving compliance	The council has implemented the necessary changes to ensure compliance with web payments and with payments taken via kiosks in Connects Centres.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
PCIDSS Compliance 2015/16	1523	Working group to establish an action plan and carry out checks each year end to ensure guidance is up to date.	L	31-Dec-16	30-Jun-18	Work is ongoing to update and re-issue guidance and procedures for the workforce responsible for taking payments. This guidance will be issued by 31st March 2018.	The findings of the external PCIDSS audit are currently still being considered and two payment channels are already fully PCIDSS compliant (web payments and ATP payments - automated telephone payments). Relevant SAQ'S are being drafted for these payment channels. New technologies and investments are being assessed to establish whether full compliance can be realistically achieved within budget provision through the development of a mid-call solution. Alternatively, through service planning and a strategic move away from telephone payments and channel shift towards to web payments or ATP payments, we need to determine whether residual risks would warrant the major investments to achieve full compliance.	In the meantime guidance will be updated and re-circulated to the workforce responsible for taking payments.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
PCIDSS: Non-compliance with PCI DSS or DP Act.	1572	Working group to ensure systems comply with PCIDSS and Data Protection requirements.	H	31/12/2016	31/03/2019	PCIDSS Accredited External Assessors have been appointed to conduct an initial review of systems and architecture leading to the identification of processes which are likely to already meet the requirements of PCIDSS and those processes where there is scope to improve. The external assessment is due to take place on-site from 2/10/17 to 04/10/17. Following the review the SAQ will be completed and based on the findings of the external risk assessment.	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 with 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	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 with 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
Flintshire Connects	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	M	30-Sep-17	1-Sep18	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	TBC	TBC

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		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 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.				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 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.		
Flintshire Connects	1514	Services are not always being delivered in the most efficient ways. Services delivered through Flintshire Connects Centres will be evaluated for the most appropriate, efficient and effective delivery methods.		30-Sep-17	1-Sep18	Following this audit and the revision of the 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	TBC	TBC

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 96						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. 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		

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 97						delivered by Connects and release back office efficiencies. The work completed has identified that the delivery of the Customer Service Strategy and the 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.		
Housing & Assets								
Housing Allocations 15/16	1616	The current SARTH policy is under review. Following this, any required changes	M	31-Mar-17	30-Jun-18	The date has been amended to coincide with the most recent	The policy review was completed and agreed by the SARTH Regional Steering	Staff have been made aware of any amendments to the

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		to procedural notes will be implemented.				audit recommendations. The SARTH policy is a regional policy and the revised date reflects the date the regional panel will be signing off the revised policy and procedures.	Group in September 2017. The final draft of the policy document is now with partners to agree prior to publication. The SARTH Regional Operational Group have now commenced work on revision of the procedures and this work is aimed to be completed in June 2018.	procedures subject to final versions being signed off. This is confirmed within 1:1s and team meetings.
Community Asset Transfers 2016/17	1606	A paragraph statement will be included in the CAT process to sign post fraud risk through the Policy, Guidance document, and through to the Legal document. The monitoring arrangements will include an expectation to witness financial records within the Annual report.	L	30-Jun-17	08-Jun-18	Reviewing how this may best be incorporated within the CAT Guidance document to reflect the action.	Proposed wording has been determined and will be inserted into CAT guidance, which will then need translation and uploading back onto the Web site.	Fraud or the potential for fraud would be discussed on a cases by case basis in the interim period with groups seeking to progress a CAT.
People & Resources								
Payroll 2016/17-	1902	Payroll Key Performance Indicators are not in place. Performance Indicators will be devised and reported on to measure productivity, effectiveness of processes, compliance with regulatory requirements and SLAs, etc. Key performance	L	30-Sep-17	31-Jul-18	This action was previously allocated to the Team Leader - HR, resource to address this has not been available. However work is in progress, for example, data relating to under & over payments has been issued earlier this year.	Performance indicators within the recruitment process by will be developed by the service.	The PI need to be developed to monitored performance.

Tudalen 98

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		indicators to consider should be overpayments, underpayments, % of payslips manually recalculated, processing of requests in line with SLAs for new starters, change in role, leavers, system access, etc.						
Compulsory and Voluntary Redundancies 2016/17	1925	The Databases will be reviewed and improved to ensure all appropriate information is captured. Regular reviews will be undertaken to ensure all relevant fields are completed and due process is being adhered to.	M	31-Jul-17	01-Jul-18	Service to confirm Awaiting for IT to make necessary changes to system as per follow on notes	After a recent iTrent update the database was no longer accessible. It has been agreed as there is a new database which will be released in 6 weeks IT won't spend time trying to make the soon to be obsolete database work.	The service are keeping paper records whilst awaiting the new database.
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	M	31-Jul-16	31-Dec-18	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	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.	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	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 100		'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 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.				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.	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 to 31/12/18.	
Section 106 - 15/16	313	Leisure to discuss the inclusion of an upfront specification for play equipment in the LPGN with the Planning Policy team. This would allow specifications to be built into the planning application (as such any	M	31-Jul-16	31-Oct-18	Specification is still awaited from Leisure and will be included as part of updating LPG 13 (see below). Revised due date set was unrealistic and unachievable given circumstances reported	Follow up report 18.5.18: SPGN 13, Outdoor Playing Space & New Development, is in the process of being 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	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		changes to specification would require an amended planning application).				below for LPG 13 update.		
Section 106 - 15/16	314	Planning recognise that they need to educate Members in respect of the options available to them when considering Planning Applications with management companies / residents associations proposed for the ongoing maintenance of open spaces, and their influence in planning terms. Consideration will be given to ways in which we can use the Planning Guidance to mitigate risks around management of on-site play facilities and open spaces by resident Management Companies (e.g. requirement for developers to provide a bond; one off costs could be added to the purchase price of new homes (with lower annual contributions from home owners), etc.).	L	31-Jul-16	31-Oct-18	Will be considered as part of updating LPG 13 (see below). Revised due date set was unrealistic and unachievable given circumstances reported below for LPG 13 update. Given the extent to which we can't prevent developers proposing a management company this is a low risk.	Follow up report 18.5.18: SPGN 13, Outdoor Playing Space & New Development, is in the process of being revised.	Monitoring progress with LPG13 via service manager and with reports to S106 working group.
Section 106 -	320	A cross directorate	L	30-Jun-16	30-Jun-18	Now part of wider review	Follow up report 18.5.18:	The in house monitoring

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
15/16		working group will be established to address the issues identified in the audit report. The working group will be chaired by the Chief Officer (Planning and Environment) and is likely to include representation from Planning, Education, Leisure, Finance, Legal and other services areas as appropriate. The working group will be time limited, and will consider; Section 106 linkages across the 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 adequacy of the processes in place for				of Development Management back office system and potential procurement of IDOX system to replace current Civica system. Capital bid submitted December 2017 and if successful procurement in Spring 2018.	There has been no formal reporting around s106 developer contributions to date, but a report is due to go to the Planning, Environment & Economy Programme Board in May 2018.	system (S106 spreadsheet) is still maintained pending further consideration by the cross portfolio working group around process and flow of information.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 103		effectively managing those balances which must be spent within certain time frames or returned to the developer. The scope for utilising contributions held to ensure we maximise the benefit to the Authority (specifically Education contributions which cannot currently be spent under the terms of existing s106 agreements). The requirement for corporate oversight of the s106 processes and the robustness of the reporting structures to ensure appropriate overall control of s106 monies.						
Section 106 - 15/16	1435	Leisure Services to liaise with Planning to determine whether there is scope for further amendment to the revised Planning Guidance for Open Spaces to update the amount per dwelling requested from developers, and to amend	M	30-Jun-16	31-Oct-18	Revised date set in line with the meeting of the Planning Strategy group which will sign off the revised Planning Guidance note on 29th June	Follow up report 18.5.18: SPGN 13, Outdoor Playing Space & New Development, is in the process of being revised. Discussion with Planning and the Play Unit has suggested the new planning guidance will include updated thresholds for on-site play provision; changes to the	Existence of the current Planning Guidance ensures that risks are managed in the meantime.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		the thresholds within the Planning Guidance.					amounts payable per dwelling, and minimum specifications for play equipment, play areas, sports pitches and open spaces.	
Planning Enforcement 2016-17 -	1889	A revised Enforcement Policy will be produced and presented to the Environment Overview and Scrutiny Committee in September 2017.		30-Sep-17	31-Jul-18	The policy is due to be approved (July 2018) and will be published accordingly.	The revised Planning Enforcement policy has yet to be published. The policy was presented to the Environment Overview and Scrutiny Committee in September 2017 and then to Cabinet in January 2018. A period of public consultation (6 weeks) is now underway which will end on 12 June 2018 when the policy can be finalised and published. An approved policy will formalise the remit of the service and this will help ensure resource is focussed on activity for which the team is responsible.	The policy is due to be approved (July 2018) and will be published accordingly.
Social Services								
Flying Start Childcare Placements 2015/16	1608	Management have agreed the following actions: (a) To review the sessional rate offered to existing providers considering pricing across Wales and what elements the fee	M	30-Jun-17	01-Apr-19	As advised by Procurement - In agreement with Flying Start Welsh Government Account Manager.	(a) Actioned. A review has been completed of the sessional rates across North Wales. A phased reduction was introduced June 2017 in alignment with the childcare offer too. (b) Actioned. Work is in	The Flintshire model is considered to be exampler, as Flintshire Flying Start only pay for places booked. There are no block booking for FS childcare places, unlike many other Authorities.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 105		will cover. (b) To contact Corporate Procurement to discuss the undertaking of a tender exercise to include support for smaller organisations (c) To review similar processes and paperwork undertaken by other local authorities in Wales and the viability for using best practice examples in Flintshire. (d) To ensure any tendering exercise is aligned with the Welsh Government 3-4 year old pilot for funded childcare to ensure consistency of rates, and sustainability for childcare settings. (e) Undertake tender exercise for the procurement of childcare placements, to include a briefing and support session with Settings. (f) Notify successful/					progress with Procurement. A tender document has been produced. (c) Actioned. A review has been undertaken through the Flying Start Network and best practice examples and lessons learnt are being applied in preparation for procurement. (d) Revised due date. Due to the implementation of the Childcare Offer and ensuring stability in the Sector and sufficiency of places for Early Entitlement, Childcare and Flying Start placements the procurement exercise is being delayed until the early implementation childcare offer is completed. (e) Part-actioned. The briefing and support session material is prepared in readiness for a procurement exercise. (f) Successful and unsuccessful settings will be notified within	Attendance is closely monitored, alongside quality and staff qualification level. This is undertaken by specialist advisory teachers. The monthly payments to Settings is also closely monitored with the necessary audit trail. All Flying Start settings are approved by WG.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		unsuccessful settings					timescale.	
Care Leavers 2016/17:	1783	Pathway plans do not clearly state the future needs that the Young Person requires to have prior to leaving care and living independently. The process involved in the completion of the pathway plans requires reviewing. The Pathway Plan should be re-designed to ensure it captures the actions which will be necessary from the local authority, the young person's carer, young person, parent and other identified parties to assist the young person to make a successful transition from care. It should be clear and concise for the YP to understand. It should be clear and straightforward for employees to work with and populate. A set of guidelines for the	H	30 Sep 17	30 June 18	Production of new regional plan The 6 North Wales authorities worked collaboratively to develop a set of regional assessment and planning documents. This included a revised pathway plan for North Wales. The documentation was updated to reflect new legislative changes (Social Services Well-Being Act). The new pathway plan incorporates both the future needs of the young person and the expected outcomes. The document was agreed in November 2017. The new pathway plan template was launched locally in February 2018 following staff training and guidance.	The new pathway plan template is live and being used by Practitioners. The form is scanned into our PARIS IT system as part of the young person's electronic social care record. The form will be built into the workflow of the PARIS system to avoid the need for scanning.	Case file audits assess the effectiveness of the new form in supporting quality assessments and planning. This is supported by management supervision and oversight of cases. Collectively this action is enabling us to manage the risks identified in the audit

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 107		practitioners to follow and ensure compliance with the well-being act and the strategy should also be created and used as an everyday work tool, to ensure employees in an ever changing workforce are working towards the same aims and objectives. This should include the process for completing a pathway plan to reviewing the pathway plan. This will ensure consistency when completing and reviewing pathway plans across the team. The Pathway plan should ensure each individual need is identified, details will then include how the need will be met, where and when. Once reviewed or the outcome is achieved full recording should take place with the progress to date or that the planned outcome has been reached. It would be good practice for all 7 areas of the plan						

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Tudalen 108		to be completed by the SW and where needs are not required within all the areas then the SW can at least state that no need has been identified. This will then ensure that if a need is to be stated then the SW will not miss the opportunity to clearly state it. In addition to the basic training, all employees within PACT should receive the extended enhanced PARIS training and refresher training. This should be recorded and Managed by the Team Manager and full records should be maintained to show evidence of when employees have attended the training.						
Care Leavers 2016/17:	1785	The Participation group requires a review and the aims and objectives should be clearly stated. Review of the Participation Group, with clearly set aims and objectives of the	L	31 Oct 17	29 Sept 18	Vacant Post The post was vacant for 8 months. The post holder commenced in March 2018 and has built up a relationship with the young people to	Post holder has worked with young people to take forward this action. The group has been rebranded as Young Voices Out Loud with new members joining and a logo developed to reflect the focus	Progress and issues from the Young Voices Out Loud Group are reported to the Children's Services Forum

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
		group/s.				begin the review process.	of the Group. The Group will present their aims and objectives to the Children's Services Forum after the summer break in September 18.	
Care Leavers 2016/17:	1791	Lack of a clear and concise strategy for the Council to act as a Corporate Parent. A Corporate Parenting Strategy should be developed and introduced as soon as possible.	M	31 Oct 17	31 May 18	The Strategy was developed concurrently with a national review of review of best practice in Corporate Parenting. A set of statements/ Corporate Parenting commitments were developed and presented to Health and Social Services Overview Scrutiny Committee on 5 October 2017. Following consultation and involvement from young people a draft Corporate Parenting Strategy was presented to the Children's Services Forum on 17 January 2018. It was agreed that the Strategy should be presented to the annual joint Social Services and Education Scrutiny	The strategy is tabled for approval at the joint Social Services and Education Scrutiny Committee on 24 May 2018.	An update on progress, including a set of statements to form the basis of the Strategy was presented to Health and Social Services Overview Scrutiny Committee on 5 October 2017. A final draft document for comment was presented to the Children's Services Forum on 17 January 2018. This has enabled sustained oversight and focus.

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
						Committee.		
Individual Schools								
Hawarden High Risk Based Thematic Review	1795	FOI Policy - The Freedom of Information Policy to distinguish between a Freedom of Information Request and a Subject Access Request.	M	31-Oct-17	25-May-18	Policy awaiting confirmation of content and compliance from DPO Mr. Bridge once received and approved by Governors will be uploaded.	Policy awaiting DPO (David Bridge) to ratify contents to ensure fully complies with the new GDPR regulations - David Bridge has informed that a new policy is currently being drafted for schools and Governors will adopt this version when it is available which we are being told will be prior to the 25th May which is the implementation date for GDPR	The risk is being managed by using the policy in it's draft form as even though not approved by GB it has been provided by our DP provider.
Flint High Risk Based Thematic Review	1820	Consideration to be given to revising the Charging and Remissions Policy and expanding it to include a procedure for the recovery of unpaid invoices or writing off bad debt.	L	01-Sep-17	24-May-18	Policy is due for review in November and Business Manager is to make recommendations ready for forthcoming Finance & Premises Committee Meeting.	Finance Meeting to take place on Feb 7th 2018. CS currently in discussion with County regarding bad debt procedures. Policy will be updated for the 7th Feb. Policy still under revision. Finance Meeting has not taken place due to pending budget information from County	Risk management; Policy will be in updated as from 19th March following Governors Finance Committee meeting on 14th March
Flint High Risk Based Thematic Review 2016/17	1824	As soon as practically possible the handwritten classroom furniture inventory needs to be computerised	L	01-Sep-17	25-May-18	Completion of task has been delegated by Craig Stedman to an admin officer. This process is ongoing but a completion	Computerised version partially complete. Due to current workload issues and re-prioritisation of tasks the due date has been	Risk is currently being managed as a paper copy is available and this is kept safe until the full update is

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
						deadline set for 23rd march.	revised.	complete.
Flint High Risk Based Thematic Review 2016/17	1830	Relevant officers and Governors at the school to receive Data Protection training with the following details recorded in a Training Register: name of the officer/governor, date of training, refresher training date and level of training received.	M	01-Sep-17	28-May-18	Business Manager is to receive training "Information Law for Administrators" end Oct/early Nov. Working with David Bridge to identify suitable training for staff / Governors.	Have discussed training requirements and looking at how to proceed - adding staff raining into a twilight session and Governors into a full Governing Body meeting Training schedule has commenced with the first Support Staff training session taking place 26/02/18. This training is to be rolled out further. Full Governing Body meeting / training forthcoming	Risk management; a training schedule is being put in place to ensure the majority of staff have received basic training by the 26th May.
Flint High Risk Based Thematic Review 2016/17	1834	Next Full Governing Body meeting March 2018. Craig Stedman is project Managing the GDPR. Flint High School has signed up to the services of David Bridge as the appointed Data Protection Officer	M	01-Sep-17	25-May-18	Fair Processing Notice included on new forms - to be checked by David Bridge for suitability within forthcoming site audit Site audit has not yet taken place; Craig Stedman in process of arranging.	Site audit took place on Monday 26/02/18 and Privacy Notices will be updated again in line with David Bridges' recommendation on Privacy Notices and Fair Processing Notice. Discussed with David a 'suite' of model documents that schools will be able to adopt for compliance purposes.	Risk management; this will be in place with GDPR introduction date due to signing up with David Bridge
Flint High Risk Based Thematic	1836	Consideration to be given to setting staff attendance targets in the School	M	01-Sep-17	25-May-18	To be given further consideration by Committee; meeting date	Committee has not yet had an opportunity to discuss. CS to add as agenda item May 16th	Risk Management: Standard sickness absence monitoring

Audit	Ref:	Action	Priority	Original Action Due Date	Revised Due Date	Reason for Revised Due Date	Current Status	How Risk is Being Managed
Review 2016/17		Development Plan.				31/01/18.	2018 meeting	procedures continue to be utilised as per policy.

1. Investigation Update

Appendix G

Ref	Date Referred	Investigation Details
1. New Referrals		
1.1	21/05/2018	A review is being carried out of invoices submitted by a former Council contractor to ensure they are legitimate.
2. Reported to Previous Committees and still being Investigated		
2.1	30/10/2017	A referral was received concerning potential misuse of a grant scheme by a former member of staff. An investigation is ongoing.
2.2	02/02/2018	A referral was made concerning the use of a Direct Payment. An investigation has been completed and a report is being prepared.
3. Investigation has been Completed		
3.1	04/04/2018	A complaint was received concerning the recruitment process followed for a recent appointment. A review of the process followed has been completed and found the appointment to be sound. Some control improvements have been recommended.

Internal Audit Performance Indicators

Appendix H

Performance Measure	Qtr 1 17/18	Qtr 2 17/18	Qtr 3 17/18	Qtr 4 17/18	Qtr 1 18/19 (as at 21/5)	Target	RAG Rating	
Audits completed within planned time	71%	60%	88%	83%	87%	80%	G	↑
Average number of days from end of fieldwork to debrief meeting	17	15	11	9	7	20	G	↑
Average number of days from debrief meeting to the issue of draft report	5	14	2	3	1	5*	G	↑
Days for departments to return draft reports	10	11	7	7	3	7*	G	↑
Average number of days from response to issue of final report	1	2	2	2	3	2	R	↓
Total days from end of fieldwork to issue of final report	39	34	27	27	19	34	G	↑
Productive audit days	79%	74%	82%	78%	80%	75%	G	↑
Client questionnaires responses as satisfied	100%	100%	100%	100%	100%	95%	G	→
Return of Client Satisfaction Questionnaires	66%	75%	75%	57%	40%	80%	R	↓

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

* Changes to Performance Indicators

Following a review of the Internal Audit PI's at the end of the 16/17 financial year, two target PI's have been changed to accurately reflect the time taken to complete key aspects of the audit process. There are:

PI : Average number of days from debrief meeting to the issue of draft report.

This target has been increased from 3 working days to 5 working days. This is to take into account the part time working arrangements in place within the Internal Audit Service

PI : Days for departments to return draft reports

This target has been increased from 3 working days to 7 working days. This increase in target is more a reflection of the detailed work undertaken and greater stakeholder involvement and should not be seen negatively.

Internal Audit Operational Plan 2017/18 (Carry Forward)

Appendix I

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Corporate			
Income from Fees and Charges / Efficiency Savings	H		Start date June to determine the effectiveness of the new policy recently released.
Community & Enterprise			
Strategic Housing and Regeneration Project (SHARP)	H	In Progress	
Housing Rent Arrears	M	Complete	
Disabled Facilities Grant	M	Complete	
Council Tax & NNDR	Annual	Complete	
Housing Benefit	Annual	Complete	
Education & Youth			
IT Procurement in schools	M	Complete	
Risk based thematic reviews across all schools including central controls	Annual	Draft Report stage	
Governance			
Joint Central Procurement Arrangement (Joint Review)	H	Draft report stage	This review will include aggregated spend
Procurement - Aggregated Spend (Joint Review)	H	Draft report stage	Combined within the above review
GDPR	H	Draft report stage	
Legal Case Management	M	In Progress	
Information Security Policies	Advice & Consultancy	Complete	New to Plan - request for IA involvement
Organisational Change 1			
Post Transfer - Leisure, Libraries & Museum Services	H	Complete	
Organisational Change 2			
Post ADM Transfer - Facilities Services	H	In Progress	
County Hall Campus Working Group	Advice & Consultancy	On going	Attendance at
People & Resources			

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Working Time Regulations	H	Complete	
IR35 Compliance	H	Complete	
Payroll	Annual	Draft report stage	
Treasury Management	M	Complete	
Main Accounting – Accounts Payable (AP) / P2P	Annual	In Progress	
Main Accounting – Accounts Receivable (AR)	Annual	Complete	
Main Accounting – General Ledger (GL)	Annual	Complete	
Planning & Environment			
Greenfield Valley Heritage Park	H	Complete	
Section 106 Agreements – Follow Up	M	Complete	
Social Services			
Safeguarding - Adults at Risk	H	In Progress	
Streetscene & Transportation			
Bereavement Services	H	Complete	
Integrated Transport Unit (ITU)	H	In Progress	
Fleet Management	M	In Progress	At the request of the service department this review has been carried forward into 17/18
External			
Pensions Administration	Annual	Draft report stage	

Internal Audit Operational Plan 2018/19

Appendix J

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Corporate			
Budget Planning Challenge	H	Not Started	
Business Planning, Risk and Performance Management	H	Not Started	
North Wales Residual Waste Project (FCC)	H	Not Started	
North Wales Residual Waste Project (Lead)	H	Not Started	
Declaration of Interests	H	In Progress	
Collaborative / Partnerships Arrangements (CC - Social Services)	M	Not Started	
Integrated Impact Assessments	M	Not Started	
National Grant Funded Schemes	M	Not Started	
Use of Consultants	Annual	Not Started	
NWRW - Validation of Local Labour Figures	Advice & Consultancy	In Progress	Request to review CNIMs local labour figures
Education & Youth			
Risk Based Thematic Reviews	H	Not Started	
School Funds	H	Not Started	
School Funding Formula (CC - People & Resources)	M	In Progress	
Pupil Stats - Cross Cutting	M	Not Started	
Early Entitlement	M	Not Started	
Education Grants - Including Education Improvement Grant (EIG) & Pupil Development Grant (PDG)	Annual	Not Started	
Governance			
Digital Strategy	H	Not Started	
Cloud Computing	H	Not Started	
Procurement - Contract Monitoring (Joint Working - Denbighshire)	H	Not Started	
Deferred Charges on Properties (CC - Social Services & Planning, Environment & Economy)	H	In Progress	

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Online Transactions (Digital Strategy) (CC – Strategic Programmes)	H	Not Started	
Members Allowances	M	Not Started	
Procurement of Hardware & Software	M	Not Started	
GDPR	Annual	Not Started	
Housing & Assets			
Welsh Housing Quality Standards (WHQS) Investment Plan	H	Not Started	Waiting for the WAO report
CAT - New	H	Not Started	
Property Valuations	H	Not Started	
Right to Buy (buyback) / Home Loans	M	Not Started	
Empty Property (Void) Mgt	M	Not Started	
Travellers	M	Not Started	
New Homes - Contract Management	M	Not Started	
Property Maintenance	M	Not Started	
Technology Forge (TF)	M	Not Started	
Supporting People	Annual	Not Started	
Council Tax and NNDR	Annual	Not Started	
Housing Benefits	Annual	Not Started	
Main Accounting - Accounts Receivable, including Corporate Debt Management (CC - People & Finance)	Annual	Not Started	
Homelessness	Follow Up	In Progress	
SARTH	Follow Up	Not Started	
Strategic Programmes			
ADM - New	H	Not Started	
Clwyd Theatre Cymru (CTC)	H	In Progress	
Online Transactions (Digital Strategy) (CC - Governance)	H	Not Started	
Bailey Hill	M	Not Started	

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
People & Resources			
Financial Model, incorporating Collaborative Planning	H	Not Started	
P2P – Transfer of Process	H	In Progress	
School Funding Formula (CC - Education & Youth)	M	In Progress	
Corporate Grants	M	Not Started	
Main Accounting - Accounts Payable (AP) and P2P	Annual	Not Started	
Main Accounting - Accounts Receivable (AR), include Debt Management (Cross cutting with Community & Enterprise)	Annual	Not Started	
Main Accounting - General Ledger (GL)	Annual	Not Started	
Appraisals	H	Not Started	
Pay Deal 2019/20	H	Not Started	
Notification of Start, Leavers and Changes to Clwyd Pension Fund	M	Not Started	
Annual Leave	M	In Progress	
Occupational Health Unit	M	Not Started	
Payroll	Annual	Not Started	
Planning, Environment & Economy			
Minerals and Waste	H	Not Started	
Corporate Health & Safety – Near Misses, including Plant, Machinery and Work Equipment (CC - Social Services & Streetscene & Transportation)	H	Not Started	
Deferred Charges on Properties (CC - Governance & Social Services)	H	In Progress	
Community Safety Partnership	M	Not Started	
Planning & Enforcement	Follow Up	Complete	
Disabled Facility Grants (DFGs)	Follow Up	Not Started	
Social Services			
Children out of County Care & Education	H	Not Started	
Collaborative / Partnerships Arrangements (CC - Corporate)	H	Not Started	
Deferred Charges on Properties	H	In Progress	

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
(CC - Governance & Community & Enterprise)			
Corporate Health & Safety – Near Misses, including Plant, Machinery and Work Equipment (CC – Planning, Environment & Economy & Streetscene & Transportation)	H	Not Started	
Direct Payments	M	In Progress	
Flying Start - WG Funding	M	Not Started	
Safeguarding - Children's	M	Not Started	
Social Services Financial Processes	Follow Up	Not Started	
Streetscene & Transportation			
Highways - Cost Recovery	H	Not Started	
Service Efficiency and Income Targets	H	Not Started	
Corporate Health & Safety – Near Misses, including Plant, Machinery and Work Equipment (CC - Planning, Environment & Economy & Social Services)	H	Not Started	
Regional Transport	M	Not Started	
Alltami Stores	Follow Up	Not Started	
External			
Aura	SLA (20 Days)	Not Started	
NEWydd	SLA (10 Days)	Not Started	
Advisory / Project Groups			
Corporate Governance Working Group	Advice & Consultancy	Ongoing	
Accounts Governance Group	Advice & Consultancy	Ongoing	
Annual Governance Statement	Advice & Consultancy	Ongoing	
Council's Constitution	Advice & Consultancy	Ongoing	
North Wales Residual Waste Project	Advice & Consultancy	Ongoing	
E Procurement Working Group	Advice & Consultancy	Ongoing	
GDPR Working Group	Advice & Consultancy	Ongoing	
County Hall Campus / Relocation/ Working Group	Advice & Consultancy	Ongoing	
Programme Coordinating Group	Advice & Consultancy	Ongoing	
Financial System	Advice & Consultancy	Ongoing	

Audit	Internal Audit Priority Rating	Status of Work	Supporting Narrative
Anti-Fraud and Corruption			
National Fraud Initiative (NFI)	Proactive Fraud	Ongoing	
Review and Update the Counter Fraud Policies and Plans	Proactive Fraud	Ongoing	
Develop On-line Fraud Reporting Solution	Proactive Fraud	Ongoing	
Annual CIPFA Fraud & Corruption Survey	Proactive Fraud	Ongoing	
Fraud Risk Awareness	Proactive Fraud	Ongoing	
Audit Developments			
Continue to develop the use of Computer Assisted Audit Tools and Techniques	Development	Ongoing	
Continue to develop and refine the use of Control Risk Self-Assessments	Development	Ongoing	
Develop the use of Root Cause Analysis	Development	Ongoing	
Assurance Mapping Exercise	Development	Ongoing	

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 in substitute for new higher priority reviews / advice. These audits are highlighted in green within the plan.

AUDIT COMMITTEE

Date of Meeting	Wednesday, 6 June 2018
Report Subject	Planning Enforcement Follow Up
Report Author	Internal Audit Manager

EXECUTIVE SUMMARY

In September 2017, a Red assurance report on Planning Enforcement was presented to Audit committee. The report identified concerns regarding the lack of evidencing for work undertaken, referrals not being formally prioritised and inaccurate statistical information being provided to Welsh Government.

As requested by Audit Committee a follow up review of the Planning Enforcement Services has now been completed, showing reasonable progress has been made in implementing the recommendations.

RECOMMENDATIONS	
1	That Members note the progress made in implementing the actions from the original report.

REPORT DETAILS

1.00	EXPLAINING THE INTERNAL AUDIT PROGRESS REPORT
1.01	The Internal Audit Planning Enforcement follow up review has been completed. The final report is attached as Appendix A. The follow-up review included interviewing management, examining supporting documentation and undertaking audit testing to determine progress made against management's eleven agreed actions. Since the original audit, the Planning Enforcement team has been through a restructure and new procedures have been introduced to manage the workload. There has been a significant amount of work undertaken since the last audit review and improvements have been identified across the workforce including the use of FLARE, responding to referrals, evidencing records and

	providing a clear audit trail for each referral. Overall, of the eleven actions, six actions have been implemented, four are in progress and one has not been implemented. The outstanding action relates to staff training which has been delayed due to the restructure of the team.

2.00	**RESOURCE IMPLICATIONS**
2.01	None other than officer time and associated costs to implement the recommendations.

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

4.00	**RISK MANAGEMENT**
4.01	The main risks were in not implementing the recommendations, leading to continuing weaknesses in control. These risks have been mitigated by the actions taken.

5.00	**APPENDICES**
5.01	Appendix A – Follow Up Report Planning Enforcement

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	**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. **Wales Chief Auditors Group:** An informal meeting group of Chief Auditors to discuss items of mutual interest. **Operational Plan:** the annual plan of work for the Internal Audit team.

Mae'r dudalen hon yn wag yn bwrpasol

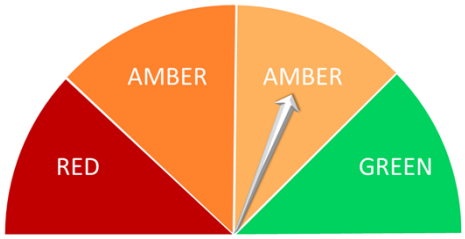
Flintshire Internal Audit

Follow Up Audit Report

Title:	Planning Enforcement (including Building Control) - Follow Up Review
Portfolio:	Planning & Environment
Issued Dated:	May 2018
Report No:	47-2017/18
Report Status:	Final

Internal Audit engagements are conducted in conformance with the Public Sector Internal Audit Standards.

Audit Opinion



1. Executive Summary:

Introduction and Scope:

We completed an audit of Planning Enforcement (including Building Control) in July 2017, audit report reference 11-2016/17.

Our overall opinion for Planning Enforcement was that the controls environment in operations at the time provided **limited assurance** that key risks were not being managed and controlled effectively. The original audit report we issued contained 4 high / 3 medium agreed actions for management. For Building Control, **substantial assurance** was provided and the risks are being managed effectively.

The scope of this follow-up is to assess how effectively the outstanding actions identified in the original audit report have been addressed.

Our approach in this follow-up audit includes interviewing management, review of supporting documentations and carry out audit testing to identify the progress made against management's agreed action.

The Planning Enforcement team has since been through a restructure and new procedures have been introduced to manage the workload. There has been a significant amount of work undertaken since the last audit review and improvements have been identified across the workforce including the use of FLARE, responding to referrals, evidencing records and providing a clear audit trail for each referral.

The actions carried forward from this review should further assist the team moving forward.

Audit Opinion:

Taking account of the issues identified in the remainder of the report and in line with our definitions set out below, in our opinion Management has demonstrated **Reasonable** progress in implementing agreed actions.

Definition:

Overall number of agreed actions fully implemented	85%+	51-84%	31-50%	>30%
Opinion	**Substantial**	**Reasonable**	**Some**	**Limited**

The audit opinion is assessed following the completion of the audit by qualified staff. Audits resulting in **Some** or **Limited** assurance will be reported to Audit Committee and progress monitored over the implementation of agreed actions.

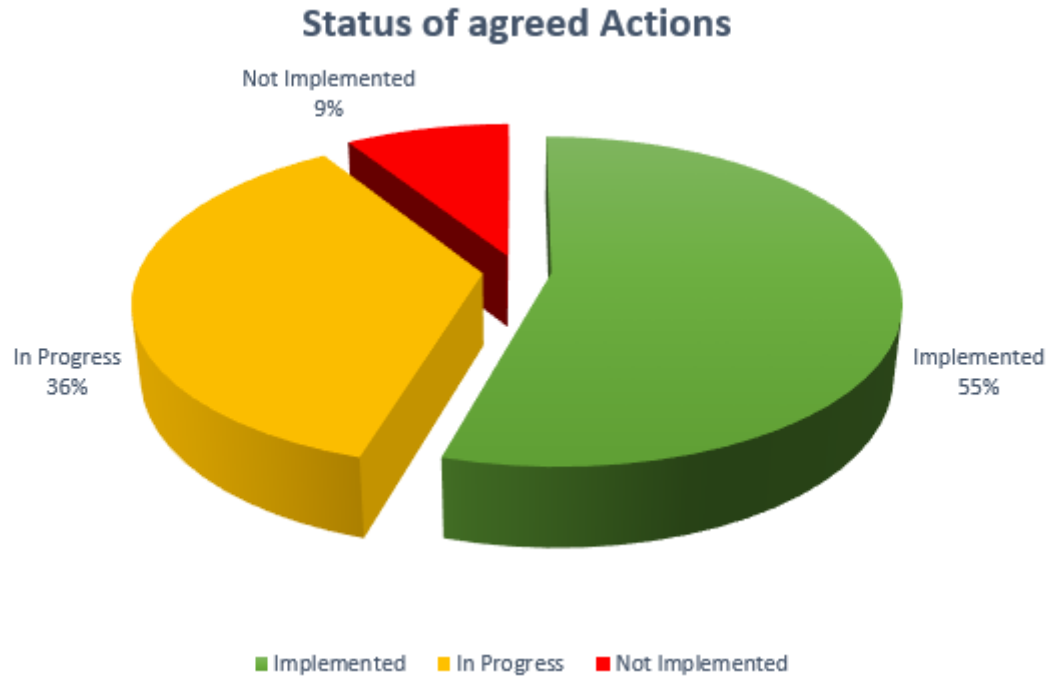
Summary of Actions carried forward:

The table below highlights the number and priority of carried forward agreed actions to be implemented.

Priority	High	Medium	Low	Total
No.	0	3	2	5

2. Data to Support our Opinion:

Status of Agreed Actions							
	(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(1+4)*	*(2+3+5)*
Total No. of Agreed Actions	**Implemented**	**In Progress**	**Not Implemented**	**No Longer Valid**	**Not due for Implementation**	**Agreed Actions confirmed as completed or no longer valid**	**Agreed Actions carried forward for follow up at next review**
11	6	4	1	0	0	6	5
100%	**55%**	**36%**	**9%**	**0%**	**0%**	**55%**	**45%**



3. Action Plan – Actions carried forward:

Priority	Description
High (R)	Issues are fundamental and material to the system of internal control for the area under review.
Medium (A)	Issues where improvements in control are needed to reduce the risk of loss, error, irregularity, or inefficiency.
Low (G)	Matters that merit attention and would improve overall control or efficiency.

No.	Findings and Implications	Agreed Action	Who	When
1 (A)	A review of all current cases (181) identified improvement in how the service manages its workload, however, our testing identified the following findings: • 28 referrals are allocated to Officers who have left the team. 12 referrals have not been allocated. • 80 referrals have not been assessed with a priority level meaning target dates for first response and completion are unclear. • 40 referrals have not been updated within the last 12 months. • 3 cases were considered within the remit of the service when they should have been referred elsewhere. • 1 case was identified as a duplicate record. Good quality management information would enable Team Leaders to monitor the current caseload and ensure that the progress achieved thus far continues to improve. (Original action 01895)	We will review the current caseload and take action to address the highlighted issues including: • reallocate cases to active officers • ensure all cases are allocated the correct priority • ensure all referrals have a recent update • reinforce the policy to the team (covering remit and responsibilities of the service)	Development Manager	30/09/2018

No.	Findings and Implications	Agreed Action	Who	When
2 (A)	We identified variances in the data submitted to the Planning Directorate for Welsh Government over the last 3 quarters of 2017/18. It is important that data supplied to the Welsh Government is accurate. Flintshire Council were provided with a report template from Civica to populate this data from the FLARE system and all evidence is now retained of data submissions to Welsh Government. However, inaccuracies have been identified in the data produced and full reliance is currently placed on this information. Variances are not investigated and there is no management oversight prior to submission. (Original action 01886)	We will investigate the Civica report to identify reasons for variances. We will ensure that Q1 18/19 return is produced and reviewed prior to submission.	Development Manager	30/09/2018
3 (A)	Whilst the structure of the teams and the overall process has been reviewed and changes made, documented procedures have yet to be produced for the team. A process mapping exercise is planned which will further assist Officers in how this work is to be undertaken. Up to date procedures will help ensure compliance and consistency across the service. Our testing identified an increased use of FLARE and a clear audit trail for more recent caseloads. (Original action 01885)	Draft process maps will be produced.	Development Manager	30/09/2018

No.	Findings and Implications	Agreed Action	Who	When
4 (G)	The revised Planning Enforcement policy has yet to be published. The policy was presented to the Environment Overview and Scrutiny Committee in September 2017 and then to Cabinet in January 2018. A period of public consultation (6 weeks) is now underway which will end on 12 June 2018 when the policy can be finalised and published. An approved policy will formalise the remit of the service and this will help ensure resource is focussed on activity for which the team is responsible. (Original action 01889)	The policy is due to be approved (July 2018) and will be published accordingly.	Development Manager	31/07/2018
5 (G)	A training programme has not been produced for Enforcement Officers to assist with undertaking enforcement referrals and the use of the FLARE system. (Original action 01892)	Officers have been booked onto the waiting list for the Trevor Roberts Association Enforcement residential course since September 2017. The budget for this training is in place, and we are hoping to be advised of our attendance dates soon. Training will continue to be provided to Officers as required.	Development Manager	30/09/2018

4. Findings:

Each recommendation followed up has been categorised in line with the following definition:

Implemented	The entire recommendation has been fully implemented
In Progress	The recommendation has been partly though not yet fully implemented
Not Implemented	The recommendation has not been implemented
No Longer Valid	The recommendation has been superseded and is no longer applicable
Not Due for Implementation	The agreed date for implementing the recommendation has not yet been reached

PLANNING ENFORCEMENT

No.	Agreed Action	Original Priority	Implementation Date	Responsible Officer	Outcome / Findings
1	A review of all pending enforcement referrals was required to ensure that investigations could be completed and the workload could be managed effectively. There was a significant risk that referrals received were not being investigated within the defined timescales which could have a detrimental impact on both the area in question and the reputation of the Council. A review of all cases commenced in April 2017 and was expected to be completed by September 2017.	High	September 2017	Development Manager URN 01895	**In Progress:** A review of all current cases (181) identified some improvement in managing the workload and the current caseload has reduced since the previous audit review (228). However, further work is still required to manage the current caseload and the following concerns were identified: • 28 referrals (15%) are still allocated to Officers who have left the team. 12 referrals (7%) have not been allocated. • 80 referrals (44%) have not been assessed with a priority level. • 40 referrals (22%) have not been updated within the last 12 months. This information has been shared with the Team and actions are being taken to resolve these issues.

2	The documenting of planning enforcement referrals was incomplete with: • Records being held in a number of locations and no standard procedure existing for correctly documenting a referral. • Enforcement investigations not being kept up to date with a significant number of actions being recorded retrospectively. • Evidence from undertaking visits or holding discussions with persons not always be documented. • Significant reliance was place on the Enforcement Officers knowledge to establish the status of each referral. The service was reviewing how enforcement referrals were investigated through process mapping and ensuring that consistency exists within the team.	High	August 2017	Development Manager URN 01885	**In Progress** It was identified that improvements have been made within the service in how enforcement referrals are documented and investigated. The use of FLARE has been improved and it is encouraging that evidence is retained within the system. However, documented procedures have yet to be produced for the team. A process mapping exercise is planned which will further assist Officers in how work is to be undertaken. A sample of 10 current referrals identified improvements for maintaining an up to date record of an investigation. However, older referrals are still problematic and didn't contain a sufficient level of detail and this will need to be addressed.
3	Enforcement referrals were not being appropriately prioritised and it was the responsibility of each investigating officer to prioritise their own workload. Training was to be provided to all officers on how to use priorities and how to report from the current FLARE system to assist their workload management.	High	July 2017	Development Manager URN 01893	**Implemented:** There has been a significant improvement in Enforcement referrals being prioritised since August 2017 with 81 out of 93 (87%) referrals being prioritised. The prioritising of referrals now forms part of the procedures for receiving and allocating a referral. However, our testing identified a number (80) of active cases on the FLARE system without a priority level being recorded and this issue has been identified within Action 1.

<table>
<tr>
<td>4</td>
<td>Each Council is required to report to Welsh Government on the number of enforcement referrals investigated and resolved within a defined time-frame and this information is requested on a quarterly basis.

The audit review identified significant variances in the data submissions for 2016/17 due to the FLARE system not being kept up to date.

Technical meetings with systems and enforcement officers were planned in June / July 2017 as part of training to implement priorities to ensure we are collecting correct data for Welsh Government returns.

Work has also commenced to improve reporting from FLARE through a software update.</td>
<td>High</td>
<td>July 2017</td>
<td>Development Manager

URN 01886</td>
<td>In Progress:
A review of the three previous submissions for 2017/18 identified significant discrepancies in the data being submitted.

<table>
<tr><td>2017/18</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>Referrals completed within 84 days</td><td>14</td><td>445</td><td>4</td></tr>
<tr><td>Referrals completed over 84 days</td><td>52</td><td>21</td><td>11</td></tr>
</table>

<table>
<tr><td>2017/18</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>Referrals completed within 84 days</td><td>3</td><td>4</td><td>4</td></tr>
<tr><td>Referrals completed over 84 days</td><td>25</td><td>8</td><td>11</td></tr>
</table>

The same reports were re-produced

A report template was provided by Civica for the FLARE system to produce these statistics for Welsh Government. Full reliance is placed on these reports and no verification exercise is undertaken. In particular, the data submitted for Q3 (445) was not possible as this figure was higher than the overall caseload.

The data provided to Welsh Government is inaccurate in its current form and the report template will need to be investigated and corrected.</td>
</tr>
</table>

					It was also identified that a number (40) of referrals had not been updated over the previous 12 months and therefore active referrals could exist which could be closed and assist in providing a truer picture of the services performance.
5	A review of the Enforcement Policy was required as it had not been updated since 2005. A revised draft Planning Enforcement Policy was to be presented to the Environment Overview and Scrutiny Committee for approval.	Medium	September 2017	Development Manager URN 01889	**In Progress:** The revised Planning Enforcement policy was presented to the Environment Overview and Scrutiny Committee in September 2017 and then to Cabinet in January 2018. A period of public consultation (6 weeks) is now underway which will end on 12 June 2018 when the policy can be finalised and published.
6	The review of the process for investigating an enforcement referral identified evidence of duplication which was not necessary. Duplication existed with recording referrals received, information obtained from site visits / interviews and the storage of electronic evidence. The service reviewed how investigations are documented through process mapping which should assist in avoiding duplication.	Medium	August 2017	Development Manager URN 01894	**Implemented:** Assistant Planners now have responsibility for receiving and recording all enforcement referrals. Checks are now undertaken to ensure duplicate referrals don't exist. The record of complaint form and standard letters are now produced electronically from the system removing further duplication. The increased use of FLARE for documenting updates and attaching evidence files also reduces the level of duplication. Manual records are still duplicated when undertaking site visits or interviews, however, until a fully automated system is in place ie tablets used to record such information then this method of work will continue.

7	A review of the types of enforcement investigations being responded to was required. Process mapping was to commence in July 2017 to assist with streamlining the process and avoid taking on work which was not part of the remit of the service.	Medium	August 2017	Development Manager URN 01890	**Implemented:** All staff have been reminded on what the teams remit is for investigating referrals and this will be further supported by the publication of the revised Enforcement Policy. A review of all current referrals was undertaken and 9 referrals were identified which indicated possible work outside of the teams remit. These findings were discussed with a Team Leader and it was established that 3 referrals could have been allocated outside of the team (Highways, Environmental Health). This issue should also be addressed by Action 1 in section 3.
8	No specific training is available for staff undertaking enforcement investigations and the use of FLARE. There was no documented procedures for Enforcement Officers and there was a risk that officers would not be working uniformly and actions may be undertaken against legislation and without appropriate knowledge. Process mapping was to commence in July 2017 to form the basis of training notes in order for any officer to be able to use the FLARE enforcement system.	Low	November 2017	Development Manager URN 01892	**Not Implemented:** The service has been going through a restructure since the previous audit review and process mapping for the operation of the Planning Enforcement Team has yet to start. A training programme will be produced following the completion of this work.
9	Benchmarking against other authorities was not undertaken across Councils regarding managing referrals. A North Wales Annual Enforcement Forum is available for	Low	August 2017	Development Manager URN 01896	**Implemented:** Managers and Officers have been attending the forums and best practice is shared with other Councils.

	Officers and Management. With the significant workload the Enforcement Team was undertaking, it would have been useful to share best practice with other Councils in an attempt to streamline their own work and operate more efficiently. The Development Services Manager was due to attend the following DC managers meeting and Officers where due to attend the next Enforcement forum and raise issues of benchmarking.				The issues of benchmarking has been overtaken by proposals to amend how enforcement performance is measured. This is an ongoing process and actions will be taken once decisions have been made. It is useful that we now have representation in these forums moving forward.
10	Welsh Government obtains statistical data from all local authorities on planning information including enforcement. The Council is required to report on the number of enforcement cases investigated and resolved within a defined time-frame and this information is required on a quarterly basis. It was identified that when the data has been collated for each submission, evidence of the figures reported has not been retained. A technical meeting was due to be held in June / July 2017 and all officers will be trained in how to enter the data required in order to meet the required returns.	Low	July 2017	Development Manager URN 01887	**Implemented:** Statistics are required to be produced to the Planning Directorate for Welsh Government on a quarterly basis. The 3 previous submissions for 2017/18 were obtained and it was identified that evidence is now retained for each submission. A new reporting template has been provided for the FLARE system to produce these statistics and evidence is retained to support the data. These previous submissions were also submitted within their deadlines. Issues have been identified regarding the statistics produced for Welsh Government and actions have been raised within Action 4 in Section 3.

BUILDING CONTROL					
No.	**Agreed Action**	**Original Priority**	**Implementation Date**	**Responsible Officer**	**Outcome / Findings**
11	A test was carried out on 15 building control cases to establish that all payments had been received before the case is closed as completed and certificate issued. Whilst all had been correctly paid for, it was not easy for Building Control to confirm this. Building Control are sent monthly spreadsheet reports from Masterpiece showing income and expenditure but as these do not include the unique reference number given to each case by Building Control, it is a time consuming process to match income to completed cases. A meeting will be arranged to meet with AP/AR team leader to establish process for including Building Control's unique reference case numbers on invoices and Masterpiece	Low	September 2017	Building Control Team Leader URN 01888	**Implemented:** The AP/AR Manager has advised staff to include Building Control reference numbers to allow for ease of reference. A sample report was produced and all income records and case references included.

5. Distribution List:

Title		
Development Manager	Accountable Officer for the Implementation of Agreed Actions	

Development Manager	
Chief Officer, Planning and Environment	
Building Control Team Leader	

AUDIT COMMITTEE	
Date of Meeting	Wednesday, 6 June 2018
Report Subject	Action Tracking
Report Author	Internal Audit Manager

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, 6th June 2018

15th March 2017				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
56	IA Progress Report	To provide an update to audit committee once the police investigation has reached a conclusion.	Lisa Brownbill	A verbal update was provided at audit committee in March 2018.

22nd November 2017				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
34	Use of Consultancy	That the £25K threshold for Chief Executive approval of consultants is reviewed on an annual basis.	Colin Everett / Gareth Owens	This will be reviewed on an annual basis.
34	Use of Consultancy	Future annual reports to include whether the list of consultants used for the period were local or national.	Colin Everett / Jo Pierce	This will be included as part of the annual report to committee in November 2018.
36	Joint Protocol between Internal Audit and WAO	Assurance mapping to give assurance of working arrangements between departments and other bodies.	Lisa Brownbill	This will be picked up as part of the assurance mapping exercise to be undertaken.

24th January 2018				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
46	Mid-Year Risk Report	That the Risk Management Policy and Strategy be brought to the next meeting to give assurance that this has been fully updated.	Karen Armstrong	Update report to be presented to March Audit Committee.
47	Code of Corporate Governance	To consider how best to present the draft AGS to the new membership of the Audit Committee.	Colin Everett / Gareth Owens / Karen Armstrong	Deliver a presentation to Audit Committee on the AGS, background, purpose and comparison to previous year.
50	IA Progress Report	That the report of the follow-up review of SARTH include details of any delays to ICT changes.	Lisa Brownbill	Included within the Internal Audit Strategic Plan.

21st March 2018				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
56	Treasury Management Quarterly Update 2017/18	To follow up Councillor Johnson's query on whether two of the companies listed in para 1.08 (ICAP plc and Tullet Prebon (UK) Ltd) were the same company named TP ICAP.	Paul Vaughan	Email response provided to Cllr Johnson on 13th April 2018.
60	IA Progress Report	That officers discuss how strategic risks are managed through the Overview & Scrutiny process to give assurance to Audit Committee.	Lisa Brownbill / Robert Robins	In progress. Update to be provided at September committee.

21st March 2018				
Agenda Item No.	**Report**	**Action Required**	**Responsible Officer**	**Action Taken**
61	PSIAS	To schedule the updated Anti-Fraud & Corruption Strategy to a future meeting.	Lisa Brownbill	Anti-Fraud and Corruption Strategy to be reviewed and presented at a future meeting.
61	PSIAS	To arrange for a half-day workshop to assist the Committee in the completion of self-assessment questionnaires and to review the Forward Work Programme.	Lisa Brownbill	To be arranged prior to September 2018.
62	IA Progress Report	To include on Appendix C, actions and timescales for amber red assurance reports.	Lisa Brownbill	Actions and timescales now included within the Progress Report for amber red assurance reports.
62	IA Progress Report	To ensure that any information on Greenfield Valley given to Cllr Dolphin also be shared with other local Members for Holywell.	Colin Everett / Lisa Brownbill / Sim Joh l/ Ian Bancroft	Exploratory meeting has taken place between the three parties (the Council, Town Council and Greenfield Valley). The Town Council has requested the Chief Officer for Strategic Performance meet individually with the three parties as a next step.
63	Action Tracking	Report on control issues to be scheduled for a future meeting.	Lisa Brownbill	A report to be presented at a future meeting.
64	Forward Work Programme	To change the report author for Liz Thomas' reports to Paul Vaughan.	Lisa Brownbill	Forward Work Programme has been amended.

Mae'r dudalen hon yn wag yn bwrpasol

AUDIT COMMITTEE

Date of Meeting	Wednesday, 6 June 2018
Report Subject	Forward Work Programme
Report Author	Internal Audit Manager

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 consider 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	Following consultation with the Chair and Vice Chair of the Committee, there has been some movement within the Forward Work Programme for June 2018. This is detailed within 1.04 of the report.

1.04

Report	Reason for Movement	New Report Date
Annual Improvement Report (WAO)	This report will not be ready for the June meeting.	September 2018
Annual Report on External Inspections	This report is produced on the back of the Annual Improvement Report.	September 2018
Risk Management Update	An update on risk management was not due in June.	September 2018
Asset Disposals and Capital Receipts	Requested to move to September due to work on closure of accounts.	September 2018
School Reserves – Annual Report on School Balances	The school balances for 2017-18 is to be presented to Overview & Scrutiny in September. The service has asked for this report to be presented to AC in November.	November 2018

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
	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. **PSIAS, Public Sector Internal Audit Requirements** A set of standards that all Internal Audit teams working in the public sector must comply with.

Mae'r dudalen hon yn wag yn bwrpasol

APPENDIX A

AUDIT COMMITTEE - FORWARD WORK PROGRAMME 2018/19

Presented to Committee - Wednesday, 6th June 2018

Meeting Date	Agenda Item	Author
6th June 2018	Draft Annual Governance Statement	Karen Armstrong
	Internal Audit Annual Report	Lisa Brownbill
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Follow Up Report Planning Enforcement	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
11th July 2018	Treasury Management 2018/19 Q1 Update and Annual Report 2017/18	Paul Vaughan
	Supplementary Financial Information to Draft Statement of Accounts 2017/18	Paul Vaughan
12th September 2018	Asset Disposals and Capital Receipts	Neal Cockerton
	School Reserves – Annual Report on School Balances	Clare Homard / Lucy Morris

Meeting Date	Agenda Item	Author
	Statement of Accounts 2017/18	Gary Ferguson
	Corporate Governance Report	Karen Armstrong
	Annual Improvement Report (WAO)	Karen Armstrong
	Annual Report on External Inspections	Karen Armstrong
	Audit Committee Self-Assessment	Lisa Brownbill
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
21st November 2018	Treasury Management 2018/19 – Mid Year Report	Paul Vaughan
	Use of Consultancy Report	Colin Everett
	Financial Procedure Rule	Sara Dulson
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
30th January 2019	Treasury Management 2018/19 Q3 Update and 2019/20 Strategy	Paul Vaughan

Meeting Date	Agenda Item	Author
	Risk Management update	Karen Armstrong
	Corporate Governance Report	Karen Armstrong
	Contract Management	Gareth Owens
	Annual Audit Letter	Gary Ferguson / Paul Vaughan
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill
27th March 2019	Treasury Management 2018/19 Q4 Update	Paul Vaughan
	Audit Plan (WAO)	WAO
	Certification of Grants and Returns Report (WAO)	Gary Ferguson
	Risk Management Strategy	Karen Armstrong
	Internal Audit Strategic Plan 2019/2022	Lisa Brownbill
	Public Sector Internal Audit Standards Compliance	Lisa Brownbill
	Internal Audit Progress Report 2018/19	Lisa Brownbill
	Audit Committee Action Tracking	Lisa Brownbill
	Forward Work Programme	Lisa Brownbill

Meeting Date	Agenda Item	Author
	Private Meeting (WAO and Internal Audit)	