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Argyll and Bute Council
Comhairle Earra Ghaidheal agus Bhoid

Customer Services
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18 September 2014

NOTICE OF MEETING

A meeting of the **AUDIT COMMITTEE** will be held in the **COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD** on **FRIDAY, 26 SEPTEMBER 2014** at **11:15 AM**, which you are requested to attend.

Douglas Hendry
Executive Director - Customer Services

BUSINESS

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST**

3. **MINUTES**
   Audit Committee 27 June 2014 (Pages 1 - 8)

4. **PERFORMANCE MANAGEMENT REPORTING - UPDATE**
   Report by Head of Improvement and HR (Pages 9 - 10)

5. **EXTERNAL AUDIT REPORT ON FINANCIAL STATEMENTS - ISA 260**
   Report by Audit Scotland, External Auditors (to follow)

6. **TREASURY MANAGEMENT ASSURANCE REPORT**
   Report by Head of Strategic Finance (Pages 11 - 16)

7. **ANNUAL RISK ASSURANCE REPORT**
   Report by Chief Internal Auditor (Pages 17 - 22)

8. **INTERNAL AUDIT UPDATE SUMMARY**
   Report by Head of Strategic Finance (Pages 23 - 28)

9. **INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE**
   Report by Chief Internal Auditor (Pages 29 - 130)

10. **EXTERNAL AUDIT - PROGRESS REPORT ON EXTERNAL AUDIT PLAN**
Report by Audit Scotland, External Auditors (Pages 131 - 140)

11. **EXTERNAL AUDIT REPORT - REVIEW OF INTERNAL CONTROLS 2013-14**
Report by Audit Scotland, External Auditors (Pages 141 - 146)

12. **EXTERNAL AUDIT REPORT - REVIEW OF HELENSBURGH CHORD**
Report by Audit Scotland, External Auditors (to follow)

13. **EXTERNAL AUDIT REPORT - REVIEW OF SCOTTISH SUBMARINE MUSEUM**
Report by Audit Scotland, External Auditors (to follow)

14. **EXTERNAL AND INTERNAL AUDIT REPORT FOLLOW UP 2014-2015**
Report by Chief Internal Auditor (Pages 147 - 158)

15. **AUDIT COMMITTEE DEVELOPMENT DAY ACTION PLAN**
Report by Chief Internal Auditor (Pages 159 - 162)

16. **DEVELOPMENT OF ASSURANCE MAPPING EXERCISE**
Report by Grant Thornton (Pages 163 - 166)

17. **AUDIT COMMITTEE EFFECTIVENESS: PRACTICAL GUIDANCE**
Report by Chief Internal Auditor (Pages 167 - 178)

AUDIT COMMITTEE

Martin Caldwell (Chair)
Councillor Michael Breslin
Councillor Iain MacDonald
Sheila Hill
Councillor Gordon Blair
Councillor Maurice Corry
Councillor Richard Trail

Contact: Fiona McCallum Tel. No. 01546 604392

Agenda Item 3

MINUTES of MEETING of AUDIT COMMITTEE held in the COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD on FRIDAY, 27 JUNE 2014

Present: Martin Caldwell (Chair)

Councillor Gordon Blair
Councillor Michael Breslin
Councillor Maurice Corry
Councillor Iain MacDonald
Councillor Richard Trail
Sheila Hill

Attending: Sally Loudon, Chief Executive
Bruce West, Head of Strategic Finance
Iain Jackson, Governance and Risk Manager
Kevin Anderson, Chief Internal Auditor
Russell Smith, Audit Scotland
Grace Scanlon, Grant Thornton

The Chair welcomed the two new Members of the Audit Committee and the new Chief Internal Auditor to their first meeting of the Audit Committee.

The Chair ruled and the Committee agreed to vary the order of business and consider the report on the Review of Code of Corporate Governance before the report on the 2013/ 2014 Unaudited Financial Statements to allow the Chief Executive to make comment on this report before she left the meeting.

1. APOLOGIES FOR ABSENCE

There were no apologies for absence.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES

The Minutes of the Audit Committee of 14 March 2014 were approved as a correct record.

4. UPDATE ON AUDIT SCOTLAND REPORTS - COMMUNITY PLANNING AND HEALTH INEQUALITIES

Consideration was given to a report which provided an update on progress of the Community Planning Partnership in relation to two Audit Scotland National Reports on Improving Community Planning and Health Inequalities in Scotland.

Decision

1. Noted and agreed that the update of progress detailed at paragraph 4.2 of the report satisfied the requirements of the Action Plan following the national reports and quality assurance process; and

2. Noted that the Council approved the Single Outcome Agreement Development Plan on 26 June 2014.

(Reference: Report by Executive Director – Community Services dated 28 May 2014, submitted)

5. RISK MANAGEMENT AND AUDIT

A report setting out a summary of the key issues/developments in relation to risk management and related activities around internal and external audit was considered. The report set out how the Chief Executive has oversight of these areas and also set down some of the important developments over the last year.

Decision

Noted the terms of the report and the update provided by the Chief Executive.

(Reference: Report by Chief Executive dated 15 June 2014, submitted)

6. STRATEGIC RISK REGISTER UPDATE

Consideration was given to a report which had also been submitted to the Performance Review and Scrutiny Committee and which updated Members in relation to progress in developing the Council's Strategic Risk Register. The Strategic Risk Register is updated on a live basis and will be formally reviewed twice yearly, in August (post year end) and in February as part of the budget setting process. This report gave a progress update together with outline detail of amendments made including scoring, narrative, ordering and formatting and it also showed Risks added to and deleted from the Strategic Risk Register.

Decision

Noted the contents of the report.

(Reference: Report by Head of Strategic Finance dated 19 May 2014, submitted)

7. REVIEW OF CODE OF CORPORATE GOVERNANCE

A report detailing the process by which the Council reviews the content of the local Code of Corporate Governance to ensure that it remains fit for purpose and the content reflects the current position within the Council was considered.

Decision

1. Noted the content of the report;

2. Approved the revised Code of Corporate Governance for 2013/14;

3. Approved the Action Plan for 2014/15;

4. Approved the draft statement of Governance and Internal Control for 2013/14; and

5. Noted that at the next review of the Code the Governance and Risk Manager would advise the Governance Group of the Committee's request that consideration be given to amending the third core principle to include a reference to high ethical standards.

(Reference: Joint report by Chief Executive and Executive Director – Customer Services dated 18 June 2014, submitted)

8. 2013 - 2014 UNAUDITED FINANCIAL STATEMENTS

A report giving an overview of the financial statements for 2013-14 and a summary of the significant movements from 2012-13 along with information on the revenue outturn for 2013-14 was considered.

Decision

1. Noted the unaudited accounts for 2013-14 which were presented to the Council on 26 June 2014; and

2. Noted that the Head of Strategic Finance would advise the Head of Customer and Support Services of Councillor Corry's request for clarification on the Council policy on Non Domestic Rates refunds.

(Reference: Report by Head of Strategic Finance dated 18 June 2014, submitted)

9. EMPLOYMENT TAX RISK REVIEW

The Council asked tax consultants KPMG to carry out an Employment Tax Risk Review to identify any areas of potential risk in the Council's Employment Tax accounting processes. A report outlining any issues identified by KPMG and the procedures that have been put in place, or are in the process of being put in place, in order to reduce the level of risk was considered.

Decision

1. Noted the contents of the report and that further updates will be provided once all action points were complete;

2. Noted that KPMG have been asked to bring forward options for the Council to consider in respect of Members travel between home and HQ; and

3. Noted that further detail would be included within the action plan and would be circulated to the Audit Committee by the Head of Strategic Finance.

(Reference: Report by Head of Strategic Finance dated 18 June 2014, submitted)

10. VAT RISK REVIEW

The Council asked tax consultants KPMG to carry out an VAT Risk Review to identify any areas of potential risk in the Council's VAT accounting processes. A report outlining any issues identified by KPMG and the procedures that have been put in place, or are in the process of being put in place, in order to reduce the level of risk was considered.

Decision

Noted the contents of the report and that further updates will be provided once all action points were complete.

(Reference: Report by Head of Strategic Finance dated 18 June 2014, submitted)

11. AUDIT SCOTLAND NATIONAL REPORTS

In compliance with the CIPFA Code of Practice for Internal Audit, the Audit Committee receives Audit Scotland reports pertaining to Local Government. A report providing a summary of six recently issued reports and checklists was considered. These reports were issued in the last six months and covered:- Scotland's Public Finances; Procurement in Councils; Overview of Local Government; How Council's Work – Options Appraisal; Reshaping Care for Older People; and Scotland's Public Sector Workforce.

Decision

1. Noted the contents of the report;

2. Noted that the Head of Strategic Finance would take forward to the Chair of the Performance Review and Scrutiny Committee the Audit Committee's proposal that consideration should be given to these reports being submitted initially to the Performance Review and Scrutiny Committee given the emphasis on them on performance rather than audit issues;

3. Agreed that a half day's joint seminar be organised for the Audit and PRS Committee in order to improve knowledge of the remit of each Committee and to consider future planning of workload and activity including consideration of Audit Scotland National reports.

(Reference: Report by Head of Strategic Finance dated 18 June 2014, submitted)

12. INTERNAL AUDIT ANNUAL REPORT 2013 - 2014

Internal Audit provides the Audit Committee with an Annual Report commenting on the duties and audits undertaken by the section throughout the financial year. The Annual Internal Audit report and the allocation of audit days for 2013 – 2014 was before the Committee for consideration.

Decision

Noted the Internal Audit Annual Report for 2013 – 2014.

(Reference: Report by Chief Internal Auditor dated 29 May 2014, submitted)

13. ANNUAL REPORT BY AUDIT COMMITTEE

In compliance with the CIPFA Code of Practice for Internal Audit in Local Government a draft annual Audit Committee report has been prepared by the Chair and Vice Chair which summaries the work of the Audit Committee during the year and outlines its view of the Council's internal control framework, risk and governance arrangements. The draft annual report attached in Appendix 1 to the report was before the Committee for consideration.

Decision

Agreed to approve the contents of the report and appendix on an interim basis and to review this once the external auditors report on financial statements (ISA 260 report) is received.

(Reference: Report by Chief Internal Auditor and draft Audit Committee Annual Report 2013 – 14, submitted)

14. PROGRESS REPORT ON INTERNAL AUDIT PLAN 2014 - 2015

A report covering the audit work performed by Internal Audit as at 2 June 2014 was considered.

Decision

Noted the progress made with the Annual Audit Plan for 2014 – 2015.

(Reference: Report by Chief Internal Auditor dated June 2014, submitted)

15. INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE

In compliance with good practice set out in the CIPFA Code of Practice for Internal Audit in Local Government, final report summaries and action plans from recent internal audits were before the Committee to review.

Decision

1. Noted the contents of the reports in respect of the following audits:-

   (a) Review of Carefirst

   (b) Review of Customer Service Centre

   (c) Review of Universal Credit

   (d) Review of Budget Preparation and Control

   (e) Review of Additional Special Needs

   (f) Review of Leisure

   (g) Review of Business Continuity

   (h) Review of Statutory Performance Indicators 2012/13

   (i) Review of Treasury Management

   (j) Review of Procurement

   (k) Review of Creditors – Purchase Cards

   (l) Review of Stocktaking

2. Noted the concerns raised by Councillor Breslin in respect of the Review of Additional Support Needs and agreed that this concern would be discussed further at the joint seminar to be arranged with the PRS Committee;

3. In respect of the Review of Procurement noted Councillor Corry's request for an update on staffing within the Procurement Team which the Head of Strategic Finance would arrange for the Head of Customer and Support Services to provide; and

4. Noted the response to Councillor Corry's request for clarification on reporting of procurement savings and non-financial benefits.

(Reference: Report by Chief Internal Auditor dated 29 May 2014, submitted)

16. EXTERNAL AUDIT PROGRESS REPORT

Audit Scotland's Annual Audit Plan for the 2013/14 audit was presented to the Audit Committee on 14 March 2014. The audit plan set out what Audit Scotland perceived to be the key financial statement risks facing Argyll and Bute Council. A report providing progress against the 2013/4 Annual Audit Plan was considered.

Decision

Noted the contents of the report.

(Reference: Report by Audit Scotland dated June 2014, submitted)

17. EXTERNAL AND INTERNAL AUDIT REPORT FOLLOW UP

Internal Audit document the progress made by departmental management in implementing the recommendations made by both External Audit and Internal Audit. A report detailing the results from a review performed by Internal Audit for recommendations due to be implemented by 30 April 2014 was considered.

Decision

Noted and approved the contents of the report.

(Reference: Report by Chief Internal Auditor dated 21 May 2014, submitted)

18. UPDATE ON INTERNAL AUDIT DEVELOPMENT PLAN

A report highlighting further progress made against the improvements identified as a result of the Internal Audit Review against the Public Sector Internal Audit Standards was considered.

Decision

Noted progress to date in completion of the development plan.

(Reference: Report by Head of Strategic Finance dated 27 June 2014, submitted)

19. ANNUAL AUDIT PLAN 2014/15

A report introducing the Annual Audit Plan for 2014/15 was before the Committee for consideration.

Decision

Agreed and approved amendments to the Annual Audit Plan 2014/15 which were taken on board by Officers.

(Reference: Report by Chief Internal Auditor dated 4 June 2014, submitted)

20. AUDIT COMMITTEE DEVELOPMENT DAY DRAFT ACTION PLAN

A report introducing the draft Audit Committee Development Day Action Plan for 2014/15 was considered.

Decision

1. Noted the contents of the report; and

2. Agreed that any amendments Members of the Committee wished to make to the Action Plan should be forwarded to Internal Audit within the next 7 days.

(Reference: Report by Chief Internal Auditor dated 4 June 2014, submitted)

21. PROPOSALS FOR ASSURANCE MAPPING EXERCISE

A report outlining the process that Grant Thornton and the Internal Audit Team will adopt to map the Council's key risks and the source and level of assurance that the Council receives on those risks was considered.

Decision

1. Noted the proposed scope of the exercise; and

2. Noted that a report will be submitted in September with the results of the this exercise which will highlight any gaps and allow the Audit Committee to feed into preparations for the draft 2015/16 internal audit plan due in December 2014.

(Reference: Report by Head of Strategic Finance dated 26 June 2014, submitted)

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

CUSTOMER SERVICE **26 SEPTEMBER 2014**

PERFORMANCE MANAGEMENT REPORTING - UPDATE

1 INTRODUCTION

1.1 This report updates the Audit Committee on progress against the process for scrutiny of the council's performance management processes and procedures that was agreed by the Audit Committee in June 2013. The Audit Committee's role is to ensure that there are appropriate management systems in place. The council's Performance Review and Scrutiny Committee has a different role as set out in its Terms of Reference.

2 RECOMMENDATION

2.1 1 That the Audit Committee notes progress against the agreed scrutiny process for the council's performance management system and procedures.

3 DETAIL

3.1 In June 2013, the Audit Committee agreed a series of actions to ensure that due process is followed in relation to scrutinising the process of performance management, its systems and procedures. This is distinct from the role of the Performance Review and Scrutiny Committee.

3.2 Although the PRS will consider scrutiny of the council's performance, the Audit Committee retains a responsibility to ensure that appropriate management systems are in place across the council.

3.3 In June 2013, the Audit Committee agreed that the following actions would be put in place to meet this responsibility and ensure that management systems are in place. Updates on these actions are presented to the Audit Committee for information and comment.

3.4 Annual Audit Plan
The Annual Audit Plan includes audit of the performance management system which is reported to the Audit Committee as a matter of course. This audit is scheduled for Quarter 3 14/15 and will be reported to the Audit Committee December.

3.5 **Annual Report**
An Annual Report on performance management processes and procedures will be developed as part of the review of the Planning and Performance Management Framework. This was identified as a new and additional piece of work. The review of the Planning and Performance Management

Framework will be presented to the Performance Review and Scrutiny Committee in November. This will then be brought to the December Audit Committee for information.

3.6 **Performance Risk Based Assessment of Audit**
An additional criterion will be added to the Audit Plan Risk Assessment process based on a scoring of the section/team/service's performance management processes. This will ensure that higher risk sections were highlighted for additional support and if required additional scrutiny. It is proposed that this will be introduced to the audit plan preparation process for 15/16.

3.7 **Internal Audit Findings**
Internal audit findings will, where relevant, give consideration to effectiveness of a section/department/team's performance management system and where appropriate, cross reference to performance scorecard information to ensure consistency of reporting and improvement of performance scrutiny.

4 CONCLUSION

4.1 The Audit Committee agreed a series of actions in June 2013 to ensure that there continues to be an assessment of the performance management system that is in place in the council. This report provides an update on progress against these actions.

5 IMPLICATIONS

Policy	None
Financial	None
HR	None
Legal	None
Equal Opportunities	None
Risk	Effective management of performance reduces risk across the council.
Customer Service	None

Douglas Hendry – Executive Director Customer Services

For further information contact:
Jane Fowler, Head of Improvement and HR, Tel 01546 604466

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **26 SEPTEMBER 2014**

TREASURY MANAGEMENT ASSURANCE REPORT

1. INTRODUCTION

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

2. RECOMMENDATIONS

2.1 The treasury management assurance report is noted.

3. DETAIL

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

3.2 Treasury management is defined as:

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

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

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

control those activities.

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

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

d) The Council nominates the Performance Review and Scrutiny Committee to be responsible for ensuring effective scrutiny of the treasury management strategy and policies.

e) The Council nominates the Policy Lead for Strategic Finance as the member responsible for ensuring effective scrutiny of the treasury management strategy and policies.

Management Arrangements

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

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

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

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

3.7 Reporting: The Council meets and exceeds the requirement for reporting on treasury management by

- Preparing an annual treasury and investment strategy (submitted to

Council 20 March 2014)
- Submitting an annual report on treasury and investment activities (submitted to Council on 26 June 2014)
- Submitting a quarterly report on treasury activities to the Council as at end of June, September and December. These will be submitted 2 monthly to Policy and Resource Committee and quarterly to PRS Committee going forward.

3.8 Member Involvement: The Council Leader and Policy Lead for Strategic Finance is the nominated lead member for treasury management and receives copies of all reports on treasury management for scrutiny.

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

3.10 Internal Audit: Treasury activities are subject to regular review by internal and external audit. During 2013-14 an internal audit of 10 days was undertaken and there were two recommendations. One of these have been addressed. One is due to be completed by 30 September 2014. A copy of the action plan is attached as Appendix 1.

3.11 External Audit: The external audit carried out a preliminary systems review of treasury management during 2013-14 to confirm that the stated controls were in place. There were no recommendations from the review.

3.12 Advisory Support: The Council is supported by Capita Asset Services as its Treasury Advisors. Capita Asset Services are part of the Capita group of companies. It is the largest provider of treasury advice to Councils in the UK. The Council reappointed Capita Asset Services in March 2012 for a period of 3 years following a tendering exercise.

3.13 A Compliance Evidence Delivery Review (CEDR) has been carried out internally based on a model developed by Capita Asset Services to identify areas for improvement. An action plan to address the areas for improvement will have been prepared by the date of the Audit Committee.

Key Risks

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

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

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

3.17 Interest Rate Risk: Interest rate and market data is monitored daily and

assessed in terms of any action the Council needs to consider or take. Triggers are set to prompt formal consideration of when to drawdown borrowing or reschedule debt etc.

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

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

4. CONCLUSION

4.1 The report outlines the management arrangements and audit activities in place relating to the Councils treasury function to provide assurance to the Audit Committee that the risks and controls related to the Council's treasury activities are properly managed.

5. IMPLICATIONS

5.1	Policy –	None.
5.2	Financial -	None
5.3	Legal -	None.
5.4	HR -	None.
5.5	Equalities -	None.
5.6	Risk -	None.
5.7	Customer Service -	None.

Bruce West, Head of Strategic Finance

For further information please contact Bruce West, Head of Strategic Finance 01546-604151.

Appendix 1 – Audit Report Action Plan

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Treasury Management Practices 2013/14 document		**High/ Medium or Low**		
The Treasury Management Practices 2013/14 document would benefit from some adjustment to layout as it is disjointed and in places difficult to read due to formatting issues.	Detail may be missed by the reader due to poor presentation.	Low	**Review the presentation of the Treasury Management Practices taking into account the template provided by the treasury management advisors and the ease of updating following any changes.**	**Finance Manager – Corporate Support 30 September 2014** **Can we make sure this is complete by the date of Audit Committee 26 September.**
2. Prudential Indicator Calculations		**High/ Medium or Low**		
The indicator calculations for different reports were calculated at different times using figures available at that time, leading to slightly different actual figures within different reports. Thereby the actual figures for set years can differ in reports.	Confusion as to the accuracy of figures if they differ from one report to the next.	Low	**References to the sources of the figures will be provided and where appropriate copies of the source documents will be retained to allow the numbers to be verified.**	**Finance Manager – Corporate Support 30 June 2014** **This has been completed**

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE SMT**

STRATEGIC FINANCE **26 September 2014**

ANNUAL RISK ASSURANCE REPORT

1.0 EXECUTIVE SUMMARY

The report provides an update on risk management activity. It provides assurance the risk management is a live process within the organisation and continues to develop and mature.

1.2 The Council participates in CIPFA /ALARM risk management benchmarking club. Results of this exercise are due to be published shortly however draft reports suggest a further year on year improvement moving from a "working" classification to "Embedded and Integrated".

1.3 Risk registers are held for both strategic risks and operational risks. Both areas have been subject to considerable review during the year. The Council has recently agreed an updated strategic risk register in June 2014. Operational risk registers were integrated into the 14/15 service planning exercise and there is an evidenced link of risk being considered at planning stage.

1.4 Annual Risk Assurance statements are completed by each Head of Service. Each service has confirmed that risk management is an active process within their service area. Testing is carried out to ensure supporting evidence is in place to support statements made.

1.5 Grant Thornton undertook an internal audit of risk management and reported a substantial level of assurance with our processes being assessed as "risk managed".

1.6 There are number of areas for development during 14/15. These include additional work around:

- Risk culture and risk appetite
- Further embedding risk management within service management teams
- Reviewing both SRR's and ORR's to ensure partnership and shared risk is defined.
- Assess risk opportunity where appropriate
- Reviewing risk reduction measures in terms of insurable risk.

1.7 There are no financial implication associated with this report which is for noting only.

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **26 SEPTEMBER 2014**

ANNUAL RISK ASSURANCE REPORT

2.0 INTRODUCTION

2.1 The report provides an update on risk management activity. It provides assurance the risk management is a live process within the organisation and continues to grow in profile.

3.0 RECOMMENDATIONS

3.1 Audit Committee note the content of the report.

4.0 DETAIL

4.1 Argyll and Bute Council is part of the ALARM CIPFA risk management benchmarking club and takes part in an annual exercise which is designed as a performance tool to assist in raising the standards of risk management within organisations. The survey is based on ALARM's National Performance Model for Risk Management in Public Services.
The survey breaks downs risk management activity into seven strands:

- Leadership and management
- Strategy and policy
- People
- Partnership, shared risks and resources
- Processes and tools
- Risk Handling and assurance
- Outcomes and delivery

4.2 Under each strand, a series of questions have been developed. Responses to these questions are weighted to reflect their relative impact on performance and collated into a final "score" for each section. This identifies the level of maturity the organisation has reached.

4.3 Results and action points from the output of this exercise are due to be published shortly however draft reports suggest a further year on year improvement moving from a "working" classification to "Embedded and Integrated". Action points are in relation to risk culture and appetite, shared risk arrangements and risk reduction measures. (Insurable risk)

4.4 Operational risk registers are reviewed on an updated on a live basis and formally reported each quarter. All services have a register in place. 14/15 service planning protocols were revised to include a specific template

detailing operational risks. The Council continues to use a Demand and Supply approach when preparing risk registers. This provides a useful framework and consistency of approach. This approach also allows for a clear link of risk to service outcomes.

4.5 The Council agreed its strategic risk register in June 2014. The preparation process included input from members, senior management team, chief officers group and the strategic risk group. A number of seminars and training events also took place during the year to discuss the draft strategic risk register and raise general awareness of risk management.

4.6 Annual risk assurance statements are prepared as part of our risk management protocols. The risk assurance statements are been based on the following statements:

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

4.7 Heads of Service are requested to indicate which level of compliance is appropriate to their service being, non –compliance, partial compliance or full compliance for each of the statements. Heads of Service were further requested to evidence their selection and where appropriate give further detail of actions to be taken.

4.8 Results are consistent with previous year submissions. There were no instances of non-compliance. Submissions are subject to a random evidence testing exercise undertaken by Internal Audit . Evidence obtained supports assurance statements that risk management is being regularly discussed by departmental management teams and by service management teams. Risk registers are being reviewed and updated where appropriate and consideration is given to mitigating plans and actions.

. 4.9 Our internal audit partners undertook a review of our risk management activity and provided a substantial level of assurance and assessed our activity as Risk Managed. The review considered the way in which risk is managed within the Council, drawing on a risk maturity assessment tool. The review also included a desktop exercise which reviewed terms of reference, the risk management policy and guidance, committee reports on the strategic risk register and the operational risk registers prepared by a sample of departments. We also reviewed the risk monitoring facilities on the Council's performance monitoring system, Pyramid. Interviews were also undertaken with key contacts, including the Head of Strategic

Finance and risk officer.

4.10 There a number of actions arising from the CIPFA benchmarking exercise, annual risk assurance exercise and the Grant Thornton review. There is a consistency of finding relating to risk appetite and risk culture, risk opportunity and risk reduction measures (relating to insurable risk). Upon formal publication of all findings, a risk management action plan (RMAP) will be prepared addressing all of the issues raised. Some of this work is already in progress as the strategic risk group has requested options for developing a risk appetite framework and the Audit committee is currently exploring a risk assurance mapping exercise.

5.0 CONCLUSION

5.1 Risk Management activity continues to improve and mature and assurance can be taken from in year assessment of “Risk Managed” and “Embedded and Integrated”. The RMAP for 14/15 will target further developments to our processes.

6.0 IMPLICATIONS

6.1 Policy

6.2 Financial: None directly from this report but effective risk management assists with effective governance and stewardship of council resources

6.3 Legal

6.4 HR

6.5 Equalities

6.6 Risk – effective risk management assists with effective governance.

6.7 Customer Service

Kevin Anderson
26 September 2014

For further information contact: Kevin Anderson, Chief Internal Auditor

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ARGYLL AND BUTE COUNCIL **Audit Committee**

STRATEGIC FINANCE **26 September 2014**

INTERNAL AUDIT UPDATE SUMMARY

1.0 EXECUTIVE SUMMARY

This report details the Internal Audit activity undertaken June to September 2014. The objective of the report is to provide an update with regards progress during Quarter 2 against a number of areas.

Good progress continues to be made. There is clear evidence of improved interaction and engagement between Internal Audit and Service Management.

- **14/15 Audit Plan progress**: Audit plan is currently on track.

- **Individual Audits undertaken**: 10 individual audits have been completed during the period. Of these ten audits, 1 has a high level of assurance, 7 are rated substantial and 2 are rated limited.

- **Continuous Monitoring Programme Testing**: A number of auditable units are subject to continuous testing. Reporting is by exception. Issues arising during the quarter requiring management action are in relation to weaknesses in cash control procedures which were evident during spot checking exercises.

- **National Fraud Initiative**: Data mismatches in relation to Council Tax records have been identified and work has commenced in relation to reviewing each case.

- **Development Plan**: Good progress continues to be made against development plan action points. All items are on track.

- **Performance indicators**: Revised indicators are in place and current status is on track / green.

ARGYLL AND BUTE COUNCIL **Audit Committee**

STRATEGIC FINANCE **26 September 2014**

INTERNAL AUDIT UPDATE SUMMARY

2.0 INTRODUCTION

2.1 This report details the Internal Audit activity undertaken June to September 2014. The objective of the report is to provide an update with regards progress during Quarter 2 against a number of areas;

- 14/15 Audit Plan progress,
- Individual Audits undertaken
- Continuous Monitoring Programme Testing
- National Fraud Initiative
- Development Plan
- Performance indicators

.

3.0 RECOMMENDATIONS

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

4.0 DETAIL

4.1 The Audit Plan is currently on track. Ten audits have been completed as detailed at 4.2. In addition a number of audits are also in progress and are at various stages of completion. These are scheduled for submission at December committee.

4.2 Audits completed June 2014 to September 2014 are detailed in Table 1.

Table 1: Summary of Audits performed in Quarter 2, 2014/15:

Audit Name	Level of Assurance	No. of recommendations	High Recommendations
NPDO Arrangements	High	1	0
Marine Services	Limited	7	2
Capital Contracts and Operating Leases	Limited	3	1
Sickness Absence	Substantial	5	1
Crematoriums	Substantial	14	1
Section 75 Planning	Substantial	3	3
Insurance arrangements	Substantial	6	0
LGBF Indicators	Substantial	2	0
Risk Management	Substantial	2	0
Procurement -Utilities	Substantial	0	0

4.3 Audits planned for the remainder of the financial year.

Quarter 3	Quarter 4
Land and Asset Disposal	Central Governance
Children and Families	Homecare Services
Customer Service Centre	Business Support
Pyramid	Revenue and Benefits
Income Maximisation	Chord
Information Security	Employment and Training
Winter Maintenance	ICT
Flood Control	Adult Learning & Community Development
Airports	

4.4 A number of areas which were previously subject to individual audits now form part of our continuous monitoring programme. These areas are tested on a regular basis and detailed reporting will be by exception to Audit Committee. Standard audit tests are applied relevant to each auditable unit. Clients are notified by memo of any concerns and a follow up process is in place to ensure active management /rectification of issues raised. Table 2 below summarises activity to date outlining issues arising and provides a level of assurance.

Table 2: Continuous monitoring programme results:

Audit Unit	Areas Tested	Issues Arising	Assurance Level	Follow up
Payroll and Overtime	• Excessive & Regular Overtime • Ghost Employees • Starters and Leavers	None	Substantial	Memo sent to dept with minor queries.
Debtors	• Segregation of duties	None	Substantial	n/a
Creditors	• Payments exceeding 10k. Authorisations	None	Substantial	n/a
General Ledger Controls	• Posting Authorisations	None	Substantial	n/a
Cash Spot Checks 6 Locations in Helensburgh area: • Leisure • Libraries • Social Services • Catering and Cleaning	• Cash Reconciliation's • Authorisations • Procedures • Roles ,responsibilities and remits	Cash did not reconcile in 3 premises. Reconciliations not carried out regularly. Documentation Incomplete. Staff unaware of responsibilities	Limited	Action Memo issued
School Fund checks	• Not scheduled	n/a	n/a	n/a

4.5 The Audit Commission's NFI team carries out matching work on behalf of Audit Scotland. The Flexible Matching Service (FMS) web application is used for uploading data for Argyll and Bute Council and allows for data matching in a number of areas. Council Tax data in relation to Council Tax Reduction Scheme has returned a number of matches and these are currently being reviewed as per the table below.

Council Tax to Electoral register is a comparison of Council Tax records to Electoral Register records. Matches will trigger where more than one person is registered at an address which is currently in receipt of a discount.

Council Tax rising 18's is in relation to matches where households have occupants who are turning 18 years old thus potentially impacting on Council Tax discount eligibility.

Table 3: National Fraud Initiative Matches:

Datasets	Total Matches	Status of Sample Match Testing	Responsible Officer
Council Tax to Electoral Register	694	Started	Revenues Supervisor
Council Tax rising 18's	147	Started	Revenues Supervisor
Total	**841**		

4.6 This section highlights further progress made against the actions points on our 14/15 Internal Audit development plan. These include improvements identified as a result of our review against the Public Sector Internal Audit Standards.

Table 4: Internal Audit Development plan Key Actions:

Area For Improvement	Agreed Action	Progress Update	Timescale
• Training and CPD	• Formalise our plans for internal audit training, including continuing professional development (CPD) requirements.	• On Track: • Senior Accounting Assistants are signed up to complete IIA Diploma qualification.	• Ongoing
• Induction Programme	• Development of Induction process for new members of staff joining the team.	• On Track: • Audit Manual is being updated to include induction section	• 31/12/2014
• Performance Indicators	• Revision of IA's Performance indicators per AC's approval in June 14.	• Complete: • Survey question were reviewed and benchmarking	• 31/08/2014

	• To be updated in Pyramid system.	undertaken with other LA's with a view to ensuring consistency of approach.	
• Audit Plan Preparation	• 2015/16 Plan to be submitted to December committee for comment and feedback	• On Track: • Plan will continue to be risk based. Work has commenced on our audit universe and risk evaluation. Preparation process is being reviewed to include complaints and where appropriate inclusion of topical (national and local) Issues.	• 30/11/2014
• Audit manual	• Development Audit Manual	• On Track: • Work has commenced on Audit Manual	• 31/03/2015
• SharePoint site	• Creation of Audit share point site to co-ordinate documentation and version control. Track stage progress and publish reports.	• On Track: • 2 members of staff trained on use. On-going weekly discussion session as to items for inclusion. Protocols being developed	• 31/03/2015 • Basic site up operational by 31/03/2015 then continuous development.

4.7 Internal Audit scorecard data is available on pyramid. The indicators are currently showing green and or /on track. The undernoted table is an extract of the key information.

Internal Audit Team Scorecard 2014 – 15 FQ 1 14/15			
TEAM RESOURCES People			
PRDs IA Team	Target	Percentage of PRDs complete	
	100%	100%	
	Number of eligible employees FTE	Number of PRDs complete FTE	
	4	4	
Financial			
Revenue Finance	ACTUAL	BUDGET	G
Year to date	£41,809	£48,409	
Year end	£221,753	£221,753	
NEW INTERNAL AUDIT MEASURES			
% of risks within the SRR	Actual	30%	G

audited in reporting period	Target	30%	
	Benchmark		
Quarterly meetings held with Chair of Audit Committee	Actual	Yes	G
	Target	Yes	
	Benchmark		
% satisfaction rates from post audit surveys	Actual	100%	G
	Target	80%	
	Benchmark	80%	
% Recommendations followed up	Actual	100%	G
	Target	100%	
	Benchmark		
% customer satisfaction with audit reports	Actual	100%	G
	Target	80%	
	Benchmark	80%	
Percentage qualified staff	Actual	60%	G
	Target	60%	
	Benchmark	60%	
Training hours per year per auditor (	Actual	237hrs	G
	Target	250hrs	
	Benchmark	0	

5.0 CONCLUSION

5.1 This report highlights good progress is being made across a range of areas. The audit plan is on track and there are currently no material issues impacting on Internal Audit activity. A programme of on-going review and continuous improvement is in place.

6.0 IMPLICATIONS

6.1 Policy - None

6.2 Financial -None

6.3 Legal -None

6.4 HR -None

6.5 Equalities - None

6.6 Risk – Internal Audit continue with a risk based approach to its activity.

6.7 Customer Service - None

Kevin Anderson, Chief Internal Auditor

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

ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **26 September 2014**

INTERNAL AUDIT REPORTS TO AUDIT COMMITTEE 2014 - 2015

1.0 EXECUTIVE SUMMARY

1.1 There are 10 audits being reported to the Audit Committee. One audit has a high level of assurance, 7 have a substantial level of assurance with the remaining 2 being rated as limited Assurance.

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

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

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

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

- **Sickness and Absence**: This audit has provided a substantial level of assurance with the exception of production of statistics which requires improvement. There are sound policies and procedures in place. The report highlights areas for improvement relating to double keying and labour intensive working methods.

- **Marine Services**: This audit reviewed the Councils Ferry services and has a limited level of assurance. The report highlighted a number of weaknesses in relation to adherence to Health and Safety requirements, berthing practices and ticketing protocols.

- **Capital Contracts and Operating Leases**: This audit provided a limited level of assurance. Weaknesses were identified in relation to adherence to prescribed guidance and in some instances records were incomplete. Procedures for collation and recording of lease information were also weak with the potential for mis-reporting.

- **Risk Management**: This audit was undertaken by our partners Grant Thornton and provided a substantial level of assurance. Risk management procedures were assessed as Risk Managed being well developed and communicated. Action points are in relation to risk appetite and risk opportunity.

- **Local Government Benchmarking Framework Indicators**: The processes and procedures used by Argyll & Bute Council services for the collation of statistical information required for reporting LGBF indicators was reviewed in order to provide substantial assurance that there was robust back up evidence to support the submission. Procedures and processes in place for all 11 indicators were verified.

- **NPDO** : This audit provided a high level of assurance. Robust contract and financial monitoring arrangement are in place. Processes and procedures are well documented with appropriate reference to relevant performance criteria.

- **Insurance**: This audit provided a substantial level of assurance. Observations included some minor issues in relation to tender and claim documentation. There is also scope for improvement in relation to risk reduction measures and protocols where roles and responsibilities require to be clarified.

- **S75 Planning**: This audit provided a substantial level assurance. Issues arising relate to formalising and documenting procedures which in some cases were outdated. Reporting and monitoring protocols require to be reviewed to ensure S75 agreements are fully progressed and all relevant actions completed.

- **Crematoriums**: This audit provided a substantial level of assurance. The audit specifically looked at recovery of ashes protocols in light of national interest and refers to Lord Bonomy's national findings which are cross referenced to Internal Audit findings. Argyll and Bute operates to a policy whereby an attempt to recover ashes from the cremation process in made

in all cases. In the very few instances where no ashes were available, bereaved families had been advised of the likelihood and documentation had been signed acknowledging this. The audit provided a number of other recommendations in relation to administrative protocols. It also highlights potential concern in relation to planned legislative changes relating to the removal of a medical referee stage from the authorisation process.

- **Procurement of Utilities**: This audit provided a substantial level of assurance. Purchasing is via a national framework. Appropriate monitoring arrangements for both usage and cost levels are in place.

2.0 Recommendations

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

3.0 CONCLUSION

5.1 Management has accepted each of the reports submitted and has agreed responses and timescales in the respective action plans. The total number of recommendations made within the 10 audits is as undernoted:

- High – 8
- Medium – 18
- Low – 18

6.0 IMPLICATIONS

6.1 Policy - None

6.2 Financial - None

6.3 Legal - None

6.4 HR - None

6.5 Equalities - None

6.6 Risk - None

6.7 Customer Service – None

Kevin Anderson, Chief Internal Auditor

26 September 2014
For further information contact: Kevin Anderson, Chief Internal Auditor
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ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	CUSTOMER SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	SICKNESS AND ABSENCE
AUDIT DATE	JUNE 2014

2014/2015

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Sickness and Absence within Improvement and HR as part of the 2014/15 Internal Audit programme.

The current Maximising Attendance at Work Policy was developed in 2012 this policy and the associated procedures are being monitored and reviewed to ensure that they continue to meet the Council's aims and principles. With over 36,800 work days lost due to sickness absence and sick pay costing £3.4 million in 2012/2013, the Council are keen to review options with a view to putting in place measures that will improve attendance. The Council has developed a range of initiatives to support employees and aid prevention and reduction of sickness absence. The figures for the period April 2013 – March 2014 are 36,033 work days lost due to sickness absence and sick pay costing £3.1 million, showing a small improvement during the year.

The Council has developed a range of initiatives designed to support employees and prevent and reduce sickness absence levels including Occupational Health, Counselling Service, health improvement policies, flexible and home working arrangements and additional training for managers. They are also developing management information systems which will enable managers to receive detailed reports on the causes of absence and identify any trends that may be evident as well as the concentration of absence at a particular location.

2. AUDIT OBJECTIVES

The Objectives of the Audit are as follows:

- To ensure that the Council's Sickness and Absence Policies and Procedures are up to date.
- To ensure that roles and responsibilities for Sickness Absence management are clearly defined and managed in a consistent manner across the council and employees are aware of their individual responsibilities.
- To ensure that periods of sickness absence are properly recorded and supported by appropriate documentation.
- To ensure that reports on Sickness Absence are received and reviewed regularly, the information is reported accurately and any follow up actions identified are actioned.

3. RISKS IDENTIFIED

IHR04 - Failure to deliver high quality, continually improving, efficient and responsive services:

- Service review changes are not embraced by service users resulting in additional unnecessary demands.
- Insufficient or inaccurate information leads to inefficiencies, duplication and errors.
- Systems and Process do not support Corporate / Departmental requirements.
- Failure to implement Employment Law, Statutory regulations and HMRC guidance in a timely manner.

Audit risk:

- The council does not maintain appropriate sickness and absence policies and procedures resulting in a failure to provide quality services efficiently and effectively.
- Responsibility for Sickness Absence management is not clearly defined and employees are not aware of their individual responsibilities.
- Periods of sickness absence are not properly recorded and not supported by appropriate documentation.
- Sickness Absence is not managed in a consistent manner across the council.
- Reports on Sickness Absence are inaccurate, not received and reviewed regularly and no follow up action is taken.

4. AUDIT OPINION

The level of assurance given for this report is Substantial with the exception of production of statistics which requires improvement.

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

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

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

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

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

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

5. FINDINGS

The following findings were generated by the audit:

- A review of the Maximising Attendance Policy showed that the roles and responsibilities of management and employees are clearly set out within the Policy. The policy is live and continuously updated HR are currently conducting a quick review.

- Live testing with new employees confirmed that they were referred to the Absence Line Reporting Procedure documents, either on the HUB or by provision of paper copies on their first day at work as part of the induction process, this is in line with the Induction Policy.

- The System used to monitor and process sickness and absence is Resource Link with Civica as the document management system. Security measures such as password protection and mandatory fields were evidenced as functioning.

- During testing it was noted that the Council operates an absence line for the reporting of absence. It was noted that data collection for this process is labour intensive and a number of operations are keyed and rekeyed into the system.

- Six instances of short term absence were followed from the initial calls to the absence line, to the inputting of information into Resource Link, then on to the return to work calls and confirmation of receipt of all relevant paperwork. All procedures and guidelines were followed. Return to work interviews took place on the return date for 5 out of the 6, with the last one being completed within the maximum guideline of 5 days. All relevant paperwork was completed and recorded within the system. The performance statistics for 2013-14 showed that of the 4,648 instances of absence from work during the year, 68% received a return to work interview.

- It was noted that the recording of long term absence is labour intensive and requires manual monitoring and inputting of data.

- Documentation required for all types of absence was reviewed and found to be complete and stored within the document management system.

- Figures and statistics for reports are produced via the Cognos report writing tool for Resource Link. The reports are generated using defined parameters and based on returns /data received to date. There is a reporting risk of information not fully reflecting activity /position due to timing issues, information keying delays and in transit delays.

- Production of the data for performance statistics used for written reports to committees and Council regarding sickness figures was found to be labour intensive, involving data extraction, manual analysis and rekeying.

- Reports on sickness absence are received and reviewed regularly. Evidence of follow up actions leading from reports was noted in departmental team meeting minutes.

6. GOOD PRACTICE

A rolling programme of procedural reminders has been implemented by some departments, during their weekly team meetings a procedure or policy is chosen and a brief reminder of the contents is covered.

7. CONCLUSION

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

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Production of Statistics		**High/ Medium or Low**		
A review of the production of data for performance statistics and reports to committees and Council regarding sickness figures, found the process to be labour intensive. A number of manual operations take place when extracting data, some data is rekeyed, manually analysed and then entered into another system.	Incorrect figures being reported leading to follow up actions which may be unnecessary. Inefficient use of resource.	High	A review of the current manual provision of statistical information will be undertaken with consideration given to amending production of data via excel and pivot tables to ensure accuracy. This interim process will be in put place until implementation of Leave Management within Resourcelink Phase 4 Project which is due for completion March 2016	**Head of Improvement & HR** **31/12/14 (1st Action interim)** **31/03/16 (2nd Action)**

2. Double Keying		**High/ Medium or Low**		
Data collection for the absence line is labour intensive and a number of operations are keyed and rekeyed into the system.	Increased risk of input error. Inefficient use of resource	Medium	This will continue on an Interim basis until implementation of Leave Management within Resourcelink Phase 4 Project which is due for completion March 2016.	**Head of Improvement & HR** **31/03/16**
3. Manual Recording				**High/ Medium or Low**
It was found that the recording of long term absence is labour intensive and requires manual monitoring and inputting.	Manual recording is open to human error, omissions and is labour intensive.	Medium	This will continue on an Interim basis until implementation of Leave Management within Resourcelink Phase 4 Project which is due for completion March 2016.	**Head of Improvement & HR** **31/03/16**
4. Production of Reports				**High/ Medium or Low**
The reports are generated within defined parameters and based on returns /data received to date.	Risk of information not fully reflecting activity /position due to timing issues, information keying delays and in transit delays.	Medium	Information generated is for a defined period of time. Future reports to highlight that "**the information reported is for returns/data received to specified date". "May include % error due to timing".**	**Head of Improvement & HR** **31/08/14**

APPENDIX 2 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Good Practise		**High/ Medium or Low**		
A rolling programme of procedural reminders has been implemented by some departments, during their weekly team meetings a procedure or policy is chosen and a brief reminder of the contents is covered.	Good Practise is not rolled out across all areas of the Council.	Low	**To be agreed following discussions with regard corporate policy on good practise.**	**To be agreed**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	DEVELPOMENT AND INFRASTRUCTURE SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	MARINE SERVICES
AUDIT DATE	JUNE 2014

2014/2015

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Marine Services within Economic Development as part of the 2014/15 Internal Audit programme.

Marine Services has two main functions.

- The ownership and maintenance of Harbours and Piers. An objective of the service is to maximise income generation of the harbours and piers including their operational function and safeguard their future potential in relation to economic development and in particular renewable energy.
- The operation of four life line ferry services to Jura, Luing, Lismore and Easdale.

2. AUDIT SCOPE AND OBJECTIVES

The audit scope and objectives are to ensure Ferry services are operated in accordance with regulatory guidance including;

- Adherence to appropriate Maritime regulations and inspection /maintenance regimes;
- Adherence to Health and Safety directives;
- Appropriate controls are in place for collection and recovery of any income due, Ferry Fares and Berthing dues.

3. RISKS IDENTIFIED

- ORR: Failure to ensure local authority marine services meet the needs of communities.
- ORR: Adequate response to regulatory authority inspections e.g., Maritime & Coastguard Agency (MCA).
- ORR: Assets maintained to meet customer and community needs and regulatory body requirements.
- Audit: Increasing Maintenance Costs / Age of vessels.
- Audit: Failure to collect income due.

4. AUDIT OPINION

The level of assurance given for this report is Limited.

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

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

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

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

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

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

5. FINDINGS

Health and Safety

- Observations of ferry operations showed that not all ferry operatives were wearing the appropriate Health and Safety statutory Personal Protective Equipment (PPE).
- Safety and Emergency instructions for passengers, Life jacket and muster stations were all in evidence on board the ferries.
- On entering and exiting the ferries the ropes were either not attached to the slip (held) or attached loosely over a hoop fixed to the slipway.

Maritime regulations and inspection /maintenance regimes

- ASP Ship Management Ltd, operators of the Islay to Jura Ferry route and designated person ashore for the other routes, were asked by Marine Services to provide documentation for review. The information provided was found to be clear and complete. Documentation included:
    - Health, Safety, Security and Environment Policy;
    - Induction Record Safety Familiarisation sheet, and;
    - Staff manual (which includes a Schedule for Safety Surveys and checklists).
- ASP Ship Management Ltd, supplied additional documentation including:
    - Monthly records of safety/maintenance inspections of vessels;
    - Incident logs;
    - Emergency drills, and;
    - Hours of rest records maintained monthly by crew members.

    These were all found to be in order.

- The upkeep cost of the four ferry routes has fluctuated over the past three years, but the general trend is that costs are increasing on an annual basis in line with the age of the vessels. See graph at Appendix 2.

- The crossings are exempt from the EU directive which governs the recording of passenger numbers due to the geography and length of crossing, however the Scottish Government requests figures on an annual basis. It was confirmed that the ferries contain a black box to record passenger numbers.

Ferry Fare and Berthing, Income and cash handling

- There are no payment card facilities on the three council run services.

- Cash was accepted for foot passengers and a ticket was issued on the Luing Ferry. No ticket or receipt was issued on the Easdale ferry.

- Written cash handling procedures have not been supplied. A process for collection and banking of cash from the three council run ferries is in place, however the Council's Financial and Security regulations state in paragraph 7.46 that "Every transfer of money from one member of staff to another must be recorded in the appropriate departmental records by the signature of the receiving officer". No evidence of this taking place has been provided.

- Procedures were reviewed regarding Berthing, income and billing these were found to be clear and adhered to. Berthing fee records, user numbers and income figures were followed for April 2014, from receipt of figures to debtor's bills and payment. Debtor's bills were found to be issued on a timely basis and clear records of user numbers are available.

Timetabling

- The Argyll and Bute Council website has a section for ferry travel which includes links to the timetables on the Caledonian MacBrayne website. There is also a Ferry fares page on the Council website but this is difficult to locate and there is no link from the timetable page.

- Timetables were clearly displayed at the locations visited. The Luing Ferry ran on time during observations. The Easdale ferry has scheduled sailings during peak commuting periods with an on demand service for the remainder of the service. It was observed that the ferry did not arrive at a scheduled sailing time.

- During the "on demand" period there is a requirement to press a call button, however the instructions for the use of the call button at were not clearly explained or displayed.

6. CONCLUSION

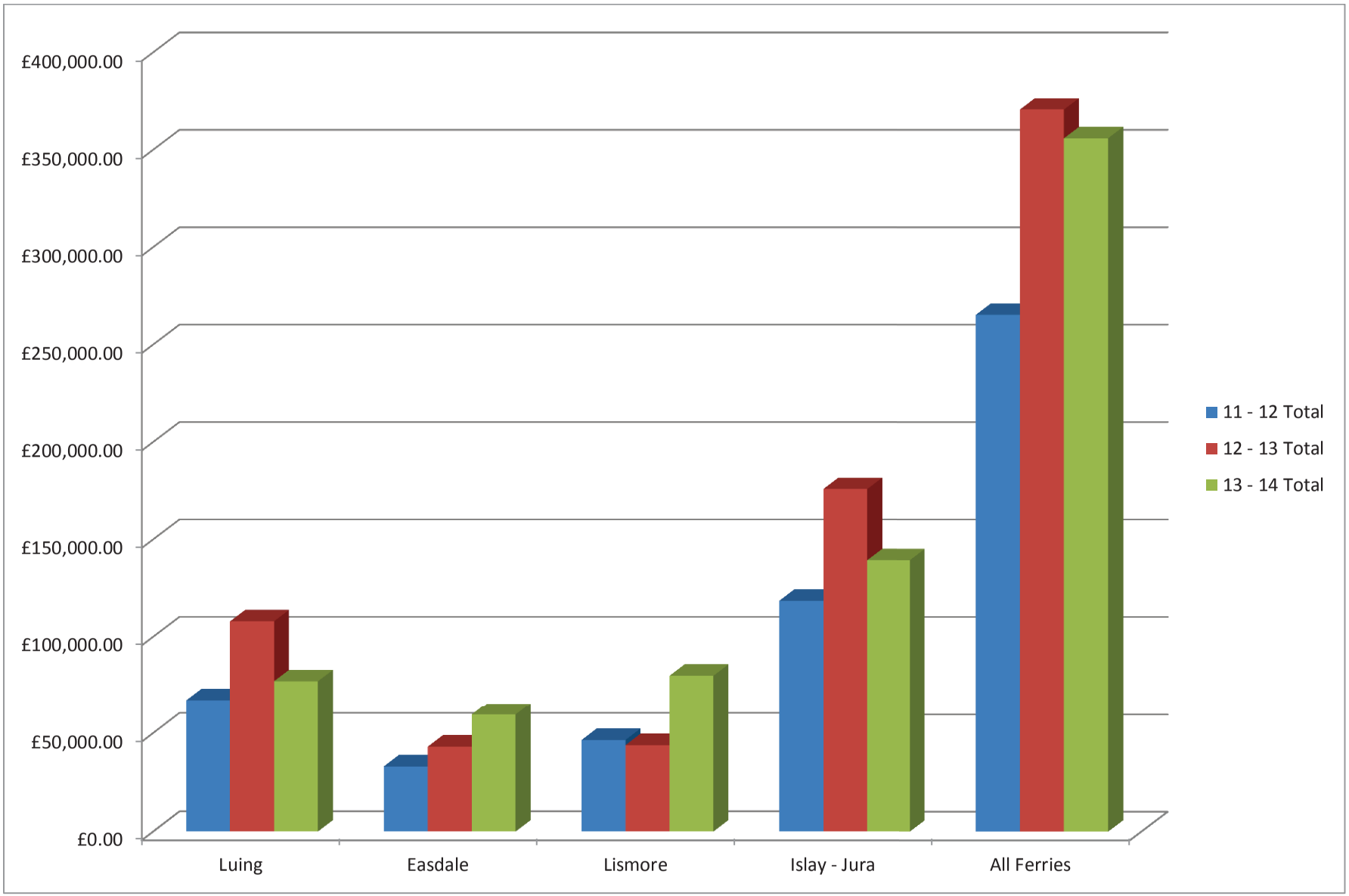
This audit has provided a Limited level of assurance. There are a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1. There are two high and three medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There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

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating High/ Medium or Low	Agreed Action	Responsible person agreed implementation date
1. Personal Protective Equipment				
Not all ferry operatives were wearing the appropriate Health and Safety statutory Personal Protective Equipment (PPE).	Risk of injury to staff and reputational damage.	High	**ASP will issue reminder notices and/or carry out further training with all staff regarding Personal Protective Equipment.**	**Marine Standards Superintendent, ASP Ship Management Ltd** **30 September 2014**
2. Rope Handling and Berthing				
On entering and exiting the ferries the ropes were either not attached (held) to the slip or attached loosely over a hoop fixed to the slipway.	Risk of injury to staff and/or passengers.	High	**ASP will issue reminder notices to all staff regarding their responsibilities with regard to rope handling and berthing.**	**Marine Standards Superintendent, ASP Ship Management Ltd** **30 September 2014**
3. Ticket Issuing				
Cash was accepted for foot passengers, no ticket or receipt was issued on the Easdale ferry.	Reputational damage. Incorrect passenger numbers are recorded.	Medium	**Management to review ticket issuing protocols.** **Ferry staff should be reminded of ticket issuing procedures.**	**Oban Harbour Master** **30 November 2014**

4. Cash Handling Procedures				
Written cash handling procedures have not been supplied.	Cash is unaccounted for.	Medium	**A written procedure for the transfer of cash from all ferries will be drafted, agreed and implemented.**	**Marine Operations Manager** **30 November 2014**
5. Timetabling				
The Easdale ferry did not arrive as scheduled according to the timetable.	Non adherence to published schedule.	Medium	**Roles and responsibilities of ferry staff should be updated and reissued, management to ensure staff are aware of timetable compliance.**	**Oban Harbour Master** **30 November 2014**

APPENDIX 2 UPKEEP COSTS FOR COUNCIL FERRY ROUTES, 2011 – 2014



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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	CHIEF EXECUTIVE'S UNIT
AUDIT DESCRIPTION	FINANCIAL SYSTEM AUDIT
AUDIT TITLE	CAPITAL CONTRACTS AND OPERATING LEASES
AUDIT DATE	AUGUST 2014

2014/2015

1. AUDIT SCOPE AND OBJECTIVES

A review of Capital contracts and Operational Leases has been planned as part of the 2014/15 Audit Plan. The Council's Capital Programme is a key tool in the delivery of its strategic vision.

The Capital Program, Planning and Management guide aims to bring structure to the process of Capital Programme planning, assisting in subsequent management and delivery. In addition, it aims to ensure clear alignment of the Programme with the council's governance and management structures, its key strategic plans, and its revenue budgeting process.

The total budgeted capital spend for the financial year 2013/14 is £33m and for operating leases the actual spend for the year ending 2013/14 is £0.7M which covers land and buildings, vehicles ,cars and equipment.

The scope of the audit is to review compliance with regulations set out in the Council's Constitution and Capital Project Planning and Management Guide and to review the protocols in place in relation to collection and collation of information relating to Operating Leases.

Objectives are as follows:

Capital Contracts

- Evidencing that there is a link between the Capital Program and the agreed corporate and service priorities of the Council as detailed in the Corporate Plan and Corporate Asset Management plan;
- Evidencing that there is a clear audit trail showing that Capital program projects have been subject to all appropriate controls in line with agreed policies and guidance including;
    - Evidencing that the Council's Business Gateway Model is adhered to as regards preparation of business cases; and
    - Evidencing that monitoring, reporting and impact assessment of projects are properly documented.

Operating Leases

- Evidence that operating leases are properly recorded and accounted for.

2. RISKS IDENTIFIED

- Infrastructure and asset base does not meet current and future requirements;
- Infrastructure and asset base is not being used or managed efficiently or effectively;
- Failure to comply with regulations and procedures detailed in the Capital Program, Planning and Management guide; and
- Inconsistent use/ presentation of information.

3. AUDIT OPINION

The level of assurance given for this report is Limited.

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

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

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

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

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

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

4. FINDINGS

The following findings were generated by the audit:

Capital Projects

- The Capital Programme Planning and Management Guide comprehensively details the various steps that Departments must follow to ensure clear alignment of the Capital programme with the Council's governance and management structures, its key strategic plans, and its revenue budgeting process.

- Supplementary guidance and procedures have been agreed in relation to the Strategic Action Log and this requires to be reflected in updated Capital Programming Management Guide.

- Eight projects were sampled from the forty projects included in the Capital Budget monitoring report dated 31st March 2014. Of the eight projects three related to strategic change, three to Service development and two to Asset sustainability.

- Of the projects sampled it was found that more recent projects (post 2013) had conformed with guidance. This reflects the improvements made to the capital planning processes by the Strategic Asset Management Board over the last three years.

- Documentation was found to be incomplete with a number of key documents not available. This included scoring sheets from three of the eight projects, an outline business case and post project analysis from all of the projects sampled.

- Record management procedures were found to be weak which compromised the availability of complete files as documentation is not held at a single point or location.

- Where documentation was complete there was a link to corporate and service priorities of the Council.

- Projects conformed to the Councils Gateway Model as regards to the preparation of business cases.

- Monitoring and reporting for the projects has been properly documented, however impact assessments were unavailable.

Operating Leases

- No guidelines or procedures were available for recording of leases or what controls should be in place to ensure effective and efficient operations of leases.

- Procedures are not coordinated between departments and consequently each department produces their own record of leases.

- Sampling highlighted discrepancies in records kept and physical equipment held.

- Due to recording discrepancies there is potential for mis-reporting of lease values.

5. CONCLUSION

This audit has provided a limited level of assurance. There are three recommendations for improvement identified as part of the audit and these are set out in Appendix 1. There are one high and two medium recommendations which will be reported to the Audit Committee. Appendix 1 sets out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

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

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Procedures and guidelines		**High/ Medium or Low**		
Record management procedures were found to be weak which compromised the availability of complete files as documentation is not held at a single point or location. Documentation was found to be incomplete with a number of key documents not available. This included scoring sheets from 3 of the 8 projects , an outline business case and post project analysis from all of the projects sampled	Failure to comply with approved guidance. Failure to provide assurance that projects are achieving best value for money. Failure to provide assurance that projects contribute to corporate and service priorities.	High	**All documentation will be held on the Asset Management Sharepoint Site.** **Organised in financial years.**	Head of Facility Services 31 March 2015
2. Procedures and guidelines		**High/ Medium or Low**		
Supplementary guidance and procedures have been agreed in relation to Strategic Action Log and this requires to be reflected in updated Capital Programming Management Guide	Failure to update procedures and guidelines risks projects not achieving best value for money.	Medium	**The Capital Programming and Management Guide will be reviewed annually and as**	Head of Facility Services 31 December 2014

			required.	
3. Procedures and guidelines		**High/ Medium or Low**		
No guidelines or procedures available for recording of leases. Procedures are not coordinated between departments. Discrepancies exist between records kept and physical equipment held. Potential for mis-reporting exists.	Failure to have robust information systems. Reduced Management assurance. Failure to secure best value.	Medium	**Leasing procedures will be documented and issued.**	Finance Manager – Corporate Support 31 December 2014

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Review of Risk Management Arrangements

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Contents

1 Executive Summary

1.1 Background

Effective risk management is a key element of the Council's overall governance arrangements. We agreed with the Audit Committee that we would review the Council's risk management arrangements with two key objectives:

- to assess the maturity of risk management arrangements to inform our audit strategy
- to review the evolving risk management approach and make recommendations for further improvement.

The Council's Audit Committee has the responsibility to review the effectiveness of risk management systems, and for ensuring that management is addressing key strategic risks. The Performance Review and Scrutiny Committee also considers risk management arrangements, in line with their role in scrutinising performance against strategic and corporate objectives.

Responsibility for risk management is delegated to the Strategic Management Team (SMT), with responsibility for risk management led by the Head of Strategic Finance. The Council has established a Strategic Risk Group comprising of the Chief Executive, Executive Directors, and representatives from Emergency Planning, Governance and Law, Improvement and HR, and Strategic Finance. This Group plays a key role in reviewing and assessing risks across the Council, and the mitigating actions to respond.

1.2 Audit Approach

Our review considered the way in which risk is managed at the Council, drawing on a risk maturity assessment tool (Appendix 2). We undertook a desktop exercise which reviewed terms of reference, the risk management policy and guidance, committee reports on the strategic risk register and the operational risk registers prepared by a sample of departments. We also reviewed the risk monitoring facilities on the Council's performance monitoring system, Pyramid. Interviews were undertaken with key contacts, including the Head of Strategic Finance and Risk Manager (see Appendix 1).

We considered the following risks as part of the review:

- roles and responsibilities at Committee and Executive level may not be clear, leading to confusion over lines of accountability
- the risk management process is not fit for purpose, meaning that the Council is not managing risk effectively
- risk may not be given sufficient priority by individuals and groups managing it, meaning that risks are poorly understood and addressed.

We did not consider the content of the risk register, nor consider in detail the process for managing operational risk.

1.3 Key findings

Assessment of risk maturity: Risk Managed

The first stage of risk based auditing is to assess the level of risk maturity within the Council. This allows us to determine our audit strategy, in line with guidelines from the Institute of Internal Auditors (IIA). The IIA define five stages of risk maturity (Table 1, below). We used an assessment tool based on IIA guidance "An approach to implementing Risk Based Auditing" and the HM Treasury's Risk Management Assessment Framework.

Table 1: Stages of Organisational Risk Maturity

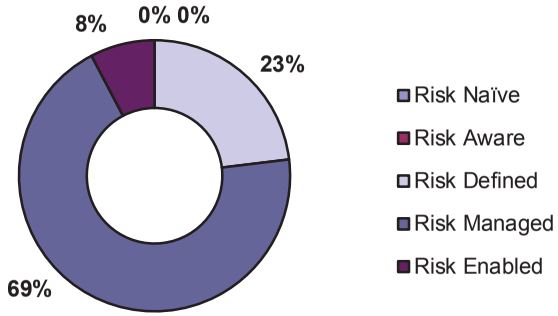
Stage	Key characteristics
Risk Naïve	No formal approach developed for risk management
Risk Aware	Scattered silo based approach to risk management
Risk Defined	Strategy and policies in place and communicated
Risk Managed	Council wide approach to risk management developed and communicated
Risk Enabled	Risk management and internal control fully embedded in the operations of the Council

Our detailed assessment is attached at Appendix 2, which assesses risk management practices against six categories:

- Leadership
- Risk strategy and policies
- Processes
- People
- Risk Handling
- Outcomes.

Figure 1, below outlines our assessment against the risk maturity questionnaire. Overall we found that risk management arrangements are well-developed and continue to embed across the Council. Plans are in place to ensure that arrangements continue to improve through, for example, participation in self-assessment exercises and CIPFA's benchmarking group. Improvements are logged in the Risk Management Action Plan. There were no areas where we assessed arrangements as risk naïve or risk aware.

Figure 1: Risk Maturity Assessments (Appendix 1)



During interviews, officers were confident that the key risks facing the Council are identified and monitored. Our assessment highlighted two potential areas for improvement, relating to the Council's definition of risk appetite, and consideration of the opportunities, or positive emerging risks.

Audit Opinion: Substantial

Our detailed findings in Section 2 identify 3 recommendations, which are intended to continue to improve the Council's overall risk management arrangements.

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

1.4 Overall Conclusions

Overall, at officer level, we found a good level of understanding about the risk management process, and clear engagement about new and emerging risks.

Ultimately, Council members are responsible for managing risks effectively. Member seminars have been held to review and agree the Strategic Risk Register. We hope that work to map sources of assurance relating to Strategic Risks will identify any areas of duplication or lack of clarity relating to accountability for risk management.

1.5 Acknowledgement

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

2 Detailed Findings

1.	Medium	Risk prioritisation

Finding and Implication	Proposed action	Agreed action *(Date / Ownership)*
The most recent Strategic Risk Register identifies 15 risks with gross risk scores ranging between 9 – 20, and residual risks classing 14 of the risks as 'amber' and one, relating to population and economic decline as a 'red' risk. Each of the risks is currently managed in the same way, with mitigation actions and planned actions reported to the Strategic Risk Group and Committees in the SRR. However, where risks remain 'red,' or above the risk appetite level we would recommend escalation of the risk to give management and the Audit Committee additional assurance that risks are being managed effectively.	We propose that where strategic risks remain 'red' after current mitigation measures: ▪ Action plans are produced to document owners and expected timescales (including long and medium term measures) for mitigating actions to become effective. ▪ Risk owners should be available to explain progress against risks to the Audit Committee or Performance Review and Scrutiny Committee, where requested.	Strategic Risk Group will review protocols considering proposed actions. A number of mitigations are already subject to delivery /realisation monitoring arrangements Date Effective: February 2015 Owner: Bruce West

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2.	Medium	Risk appetite

Finding and Implication	Proposed action	Agreed action *(Date / Ownership)*
The Council's current approach to defining the risk appetite for each strategic risk to use the residual risk scores from when the SRR was reviewed as a proxy. A more formal approach to defining risk appetite would mean that the Council could : ▪ use the gap between the current residual risk score and risk appetite to prioritise actions ▪ clarify areas where risks cannot fully be managed by the Council, eg population decline ▪ demonstrate the journey of improvement across individual risk categories ▪ acknowledge a willingness to take on risk in individual cases, where there is potential benefit to the Council to do so.	We propose that the Council's Strategic Risk Group facilitates initial discussions on risk appetite levels for individual risks, and develops a framework for monitoring progress.	Strategic Risk Group will lead developments on Risk Appetite and associated monitoring / mapping frameworks Date Effective: Feb 2015 Owner: Bruce West

3.	Information	Opportunities

Finding and Implication	Proposed action	Agreed action *(Date / Ownership)*
The Council's Risk Management Guidance for Services focuses on identifying both risks and opportunities that may impact on the achievement of Council objectives. However, in practice, we noted that most formal risk management within the SRR and ORRs focused on 'negative' risks, where there is a threat to the Council's objectives.	We recommend that update reports on the Strategic Risk Register should include a section on emerging opportunities, to ensure that risk management arrangements support informed decision-making.	SRG will consider Emerging Opportunities / positive risk and agree appropriate reporting mechanisms. Date Effective: 31 March 2015 Owner: Bruce West

A Risk Maturity Assessment

		Risk Naïve		Risk Aware		Risk Defined		Risk Managed		Risk Enabled
Key characteristics:		**No formal approach developed for risk management**		**Scattered silo based approach to risk management**		**Strategy and policies in place and communicated**		**Council wide approach to risk management developed and communicated**		**Risk management and internal control fully embedded in the Council's operations**
Category:		Explanation of risk maturity level								
Leadership										
How are the organisation's objectives identified and defined? Who are they communicated to?		No formal objectives set. No guidance on risk management offered		Objectives defined, but a process cannot be evidenced. Only senior staff have knowledge of objectives. Risk management encouraged but no guidance given		Objectives defined and agreed by the Board. Some staff aware of objectives. Some risk management guidance offered by senior management		Objectives defined following a review of the organisation. Staff are aware of the objectives. Senior management have developed and communicated risk management guidance to key people		Rigorous objective setting and risk management process occurs periodically. The output is fully embedded in the organisation and communicated to all staff

	Risk Naïve	Risk Aware	Risk Defined	Risk Managed	Risk Enabled
How has the risk appetite of the organisation been defined? How does this operate in practice? What is the organisational culture in terms of risk management?	No risk appetite in place. Risk management practices are reliant upon individual integrity.	No formal risk appetite in place but a cultural philosophy is in place. Risk management championed by a senior member of the organisation.	Risk appetite defined in risk methodology, but management apply common sense approach to the application. Board discuss risks as per management's views.	Risk appetite defined in terms of the risk scoring methodology and applied in practice to identify risks in need of further management. Board empower managers with risk management processes but retain oversight.	Risks outside of the risk appetite escalated to the right level of the organisation and decision making process is evidenced through debate. Board champion risk management and drive change through this.
Risk strategy and policies					
How has the strategy of the organisation in terms of risk management been identified and created?	No strategy for risk management in place	No formal strategy in place but a cultural philosophy is present (ie single person's approach communicated)	Documented strategy links to objectives but not developed in consultation with others	Strategy developed through analysis of existing arrangements and Council approved	Detailed strategy developed via consultation from across the organisation. Live document
How is the risk management strategy and/or policy applied in practice?	No strategy or policy in place or not applied	Strategy and/or policy verbally communicated but application not monitored	Application of documented strategy and/or policy by management	Strategy implemented by departmental instruction to other staff members	Staff engaged in strategy development and implementation. Everyone 'owns' the strategy

	Risk Naïve	Risk Aware	Risk Defined	Risk Managed	Risk Enabled
People					
How has the organisation ensured that its people are aware of risk management tools and techniques?	No training provided	Limited training provided	Training has been provided on understanding risks	Training has been provided on risk management strategies and ownership	Training is ongoing, with regular updates across the organisation and new methodologies being applied where relevant.
Who is responsible for risk management within the organisation?	One individual	Senior management	Individuals from across the organisation and management	Groups within each function in combination with management	All staff
Processes					
What process has been followed to identify and record risks?	Reactive responses to risks as they occur, no formal logging	Individual identification and logging of risks in own area	Key risks identified, logged and communicated in a consistent manner	Defined process followed to identify and log risks, all parts of organisation involved. Opportunities also part of process	Fundamental part of all activities, including projects. Risks identified, logged and ranked as matter of course, opportunities regularly being identified
What scoring system is used to assess risks? How is this applied in practice?	No scoring system	Some scoring occurs but not consistently applied across the organisation	Standard scoring process applied to corporate risks, but not across the organisation	Defined process for scoring risks that is consistently applied	Process is used to drive change - scoring is challenged and live

		Risk Naïve		Risk Aware		Risk Defined		Risk Managed		Risk Enabled
How have responses to the risks been identified (eg controls in the risk register), selected and implemented?		No responses to risks identified		Responses not documented but applied in a reactive manner		Responses documented and assessed for adequacy. Management rely upon othesr to implement actions		Responses selected based upon the need to the organisation. Assurance obtained that responses operating effectively.		Responses identified and implemented as the risk is identified. Assurance built into the controls. Staff identify and implement responses timely
What methods/controls are in place to review risks and monitor the operation of key controls?		None or management rely upon nothing bad happening		Risk logging is isolated and poorly reviewed. Some controls operate without any monitoring, whilst others are tested periodically.		Key risks are logged but rarely reviewed. Controls are monitored on a periodic basis, either through testing or reviews by audit		Risks are logged and regularly reviewed. Controls monitored regularly and assurance sought		Risks logged, ranked and live. Owners champion mitigation and controls. Controls monitored in line with importance. Assurance provided as a matter of course
Risk Handling										
How are risks reviewed by the organisation/audit unit? How often does this take place?		No formal review of risks		Some risks are reviewed, but infrequently		Risks are reviewed on a periodic basis by risk owners. Limited documentation		Risks are reviewed in consultation with others to meet the needs of the organisation and documentation exists		Risks are live, continuously reviewed and communicated across the organisation,

		Risk Naïve		Risk Aware		Risk Defined		Risk Managed		Risk Enabled
What evidence is there that risk management is effectively operating within the organisation? How is it evidenced in decision making?		Reliance placed on no risks crystallising		Management review risk management activities periodically, generally not in conjunction with relevant decision-making		Management required to report on risk management activity periodically and review new decisions in its light		Risk management integrated into decision making, assurance sought from one source and actions addressed		Risk management drives decision making, assurance actively sought from a variety of sources and improvement continuous
Outcomes										
How is risk management built into performance management processes?		Risk management exists in isolation		Performance reviews do not consider risk management unless major issue has arisen		Periodic reviews of performance include assessment of negative risk management performance		Periodic reviews of performance include assessment of positive and negative risk management performance		Continuous assessment of risk management performance, both positive and negative. Risks drive performance assessment
How well has the organisation achieved its desired outcomes? How much of this is attributed to effective risk management?		No outcomes achieved		Unknown risks materialised preventing outcomes being achieved or outcomes achieved due to luck rather than judgement		Some outcomes achieved, but some surprises present		Risk management believed to play a part in achieving all outcomes but cannot be evidenced as such		Risk management clearly demonstrates how outcomes have been achieved and is a primary reason

B Definition of internal audit ratings

Audit issue rating

Within each report, every audit issue is given a rating. This is summarised in the table below.

Rating	Description	Features	Report rating indicators
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in control that requires the immediate attention of management	• Key control not designed or operating effectively • Potential for fraud identified • Non compliance with key procedures / standards • Non compliance with regulation	• Multiple critical issues identified • Previously agreed actions of critical issues have not been addressed
Medium	Important findings that are to be resolved by line management.	• Impact is contained department and compensating controls would detect errors • Possibility for fraud exists • Control failures identified but not in key controls • Non compliance with procedures / standards (but not resulting in key control failure)	• Multiple important issues identified • Partial completion of previously agreed actions
Low	Findings that identify non-compliance with established procedures.	• Minor control weakness • Minor non compliance with procedures / standards	• No more than two important issues identified or multiple advisory issues • Minor previously agreed actions not completed
Information	Items requiring no action but which may be of interest to management or best practice advice	• Information for department management • Control operating but not necessarily in accordance with best practice	• Issues identified are only best practice in nature

ARGYLL & BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	CUSTOMER SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	LOCAL GOVERNMENT BENCHMARKING FRAMEWORK INDICATORS
AUDIT DATE	AUGUST 2014

2014/2015

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of the indicators required for the Local Government Benchmarking Framework (LGBF) as part of the 2014/2015 Internal Audit programme. The processes and procedures used by Argyll & Bute Council services for the collation of statistical information required for reporting LGBF indicators was reviewed in order to provide assurance that there was sufficient back up evidence to support the submission. Procedures and processes in place for all 11 indicators were reviewed.

2. AUDIT SCOPE AND OBJECTIVES

The main objective of the audit was to gain assurance that there was sufficient evidence available to verify the figures for each of the indicators required for the Local Government Benchmarking Framework.

3. RISKS IDENTIFIED

- Inability to verify information submitted leading to delay or qualification.

4. AUDIT OPINION

The level of assurance given for this report is substantial.

Level of Assurance	Reason for the level of Assurance given
High	Internal Control, Governance and the Management of Risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with.
Substantial	Internal Control, Governance and the Management of Risk have displayed a mixture of little residual risk, but other elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.

Limited	Internal Control, Governance and the Management of Risk are displaying a general trend of unacceptable residual risk and weaknesses must be addressed within a reasonable timescale, with management allocating appropriate resource to the issues.
Very Limited	Internal Control, Governance and the Management of Risk are displaying key weaknesses and extensive residual risk above an acceptable level which must be addressed urgently, with management allocating appropriate resource to the issues.

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

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

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

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

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

6. CONCLUSION

This audit has provided a substantial level of assurance. There are 2 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. Appendices 1 sets out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

5. FINDINGS

5.1 The following findings were generated by the audit:

Statutory Performance Indicator	Description	Verified	Comment
COPR 6	The average number of working days per employee lost through sickness absence	Yes	This Indicator has been verified however it should be noted that in some cases original figures required to be amended. Supporting evidence was in the form of multiple spreadsheets with a number of manual interventions and calculations taking place. This area is subject to a recommendation with the Sickness and Absence audit.
CORP 3b	The number and percentage of the highest paid 5% of earners among council employees, that are women (the indicator excludes teachers)	Yes	Source documents in form of downloads from Resourcelink were available to support this indicator.
COPR 4	The cost of collecting Council Tax per dwelling	Yes	Downloads of all relevant costs centres are taken from Oracle Financials and costs are apportioned as appropriate to reflect the true cost of Council Tax collection. There is a defined process in place to support the collation of figures required for this indicator.
CORP 7	Current year income from Council Tax	Yes	There are processes in place to support the collation of this figure.
CORP 8	The number of invoices paid within 30 calendar days of receipt as a percentage of all invoices paid	Yes	Source documents to support the figures were not readily available from the co-ordinator. Creditors were able to provide source documents to support the figures.

COPR Asset 1 & 2	Condition and suitability of operational accommodation	Yes	Internal Audit was provided with downloads from Concerto and source documents relating to condition surveys were readily available to support the figures.
C&L 1	The number of attendances per 1,000 population for – pools and for other indoor sports and leisure facilities, excluding pools in a combined complex	Yes	Council run pools recorded information on their Leisure Management system with reports being generated from this system to facilitate the collation of information. The computerised system currently in use has been found to be inadequate for purpose and is currently being replaced. Figures for Mid Argyll Pool have been estimated.
C&L 3	Visits to and use of Museums	Yes	Procedures are in place to record visitor numbers.
C&L 2	Library usage (number of visits per 1,000 population)	Yes	Library usage is recorded using a mixture of manual and electronic recording systems. The indicator has been verified in relation to supporting documentation provided however there are weaknesses in the collation methodology which could lead to variations. Consideration is being given to installing automatic counters in each of the libraries which would allow for more accurate recording of visitor figures in the future.

CORP 5b2	The number of complaints of domestic noise received during the year	Yes	UNIFORM (Database) is used to record all service requests and investigations, including that of noise, and the actions taken by the officers in investigating these service requests are recorded on the unique case reference. Information is then retrieved via Access reports from the UNIFORM system providing evidence to support the collation of this indicator.
ENV1, 1a, 2, 2a	Number of premises for refuse collection	Yes	There processes and procedures in place to support the figures. Numbers are taken from the Council Tax database and the Commercial Waste Database.

5.2 Roles and responsibilities of the co-ordinators need to be clarified. In some instances the co-ordinator could not provide working papers on a timely basis and this added to audit time.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Production of Statistics		**High/ Medium or Low**		
A review of the production of data for performance statistics found the process to be labour intensive. A number of manual operations take place when extracting data, some data is rekeyed, manually analysed and then entered into another system	Incorrect figures being reported leading to follow up actions which may be unnecessary. Inefficient use of resource	Medium	A review of the current manual provision of statistical information will be undertaken with consideration given to amending production of data via excel and pivot tables to ensure accuracy. This interim process will be in put place until implementation of Leave Management within Resourcelink Phase 4 Project which is due for completion March 2016	**Head of Improvement & HR** **31/12/14 (1st Action interim)** **31/03/16 (2nd Action)**
2. Roles and Responsibilities				
In some instances the co-ordinator could not provide working papers on a timely basis.	Additional audit time expended	Medium	Roles and responsibilities of the LGBF indicator co-ordinators to be clarified.	**Programme Manager, Customer Services** **December 2014**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	CUSTOMER SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	NPDO
AUDIT DATE	AUGUST 2014

2014/2015

1. BACKGROUND

A review of Non Profit Distributing Organisation (NPDO) contract monitoring arrangements within Customer Services has been planned as part of the 2014/15 Internal Audit programme.

The Special Projects Team (SPT) is comprised of four staff, Quality Improvement Officer (QIO), Finance Manager, Resource Worker and Administration Assistant. Its general remit is to assist Council services to deliver effective and efficient solutions to large scale, sensitive or intractable service issues. The SPT also has the direct remit for contract management and development of the schools NPDO contract. As part of this work the SPT has concentrated on minimising the cost of the contract to the Council whilst ensuring the required service levels are achieved.

Since 2006 the core business of the SPT has been the management of the schools NPDO contract with the Council's partner, ABC Schools. Between 2006 and 2008 this largely encompassed overseeing the construction and design development of the NPDO schools. Since 2008 the SPT shifted focus from building related issues to those associated with operating the facilities and contractual provisions related to that.

This has included:

- Liaising with the schools and ABC Schools through regular contractual meetings to anticipate and address issues relating to settling in;

- Operating the contractual mechanisms to ensure that ABC Schools' performance levels have been maintained. This has included applying the deduction mechanism where appropriate;

- Managing and reporting on the long term affordability of the project as circumstances have changed (e.g. late handovers, increased NDR and utility costs, etc.);

- Minimising the legal and financial risk to the Council arising from instances of poor performance by the contractor (e.g. Sports centre roof, external works handover, etc.);

- Identifying opportunities for additional efficiencies through operation of contractual mechanisms where appropriate (e.g. Insurance premium sharing, change in law provisions), and;

- Looking at possible refinancing of the project.

2. SCOPE AND OBJECTIVES

The audit scope and objective is to assess if a robust contract monitoring and payment process is in place which;

- Allows performance and availability of asset(s) to be assessed;
- Allows for accurate payments to be made; and
- All records are maintained and referenced and recorded appropriately.

3. RISKS IDENTIFIED

The audit scope for examination of risk is as undernoted:

- Contract compliance checking is inadequate leading to inaccurate payments being made;
- Information is not available or recorded appropriately to allow performance or availability of asset to be assessed;
- Buildings are not fit for purpose impacting on service outcomes, and;
- Council does not maximise opportunities for contract efficiencies.

4. AUDIT OPINION

The level of assurance given for this report is High.

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

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

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

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

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

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

5. FINDINGS

A copy of the Special Projects Procedural manual was obtained which detailed all the documentation, meetings and processes carried out by the Special Projects Team. Corresponding documentation detailed in the manual was obtained from the SPT to ensure that processes outlined in the manual were being adhered to and reflected the audit requirements as per the scope and objectives outlined above. The findings are as follows:

- A robust contract monitoring procedure is in place with regular interaction taking place between the Special Projects Team and ABC schools and MITIE PFI (Service Provider).
- Records and supporting schedules were found to be comprehensive and accurate and made full reference back to the appropriate contract performance criteria.
- Detailed financial contract monitoring protocols are in place and it was evidenced that deductions in relation to availability of service and for performance are being actively managed. Correspondence with both ABC schools and MITIE as regards settlement of these claims has been reviewed to ensure that all necessary means have been pursued to ensure that the deductions are agreed by all parties.
- Periodic long term affordability forecasts are prepared in relation to potential future cost pressures such as Non Domestic Rates, utility costs and general Retail Price Index (RPI) as the Council is liable for any variation in these costs.

6. CONCLUSION

This audit has provided a High level of assurance. There was one low recommendation for improvement identified as part of the audit and this is set out in Appendix 1. Appendix 1 sets out the action management have agreed to take as a result of the recommendation, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

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

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Procedures and guidelines		**High/ Medium or Low**		
Communication: Each school has a point of contact person who acts as a liaison between the school and the SPT to ensure that issues raised by the school/team are progressed effectively and efficiently by MITIE. While the head teacher is regularly advised that issues have been resolved, notification to the special contacts persons that issues have been resolved is carried out on an Ad-Hoc basis by the SPT.	Failure to communicate that issues raised are being addressed or have been resolved.	Low	Include the point of contact person at each NPDO school in communication with the Head Teacher in notification to the Head Teacher of issues resolved to reduce the risk that faults are overlooked.	QIO – Special Projects Team 30 September 2014

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	CUSTOMER SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	INSURANCE ARRANGEMENTS
AUDIT DATE	AUGUST 2014

2014/2015

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Insurances within Customer Services as part of the 2014/15 Internal Audit programme.

Argyll and Bute Council is required to purchase insurance and related services in relation to its portfolio requirements. The following is an indicative list of the type of insurance that is required; property, contents, works in progress, business continuity, motor vehicles, professional indemnity, employers liability and public liability.

The procurement of such services in the Scottish Public Sector takes place within the framework of European, UK and Scottish legislation. These are based on five key principles –equal treatment, transparency, proportionality, mutual recognition, and non-discrimination. The rules for Public Procurement are bound by;

- EU Treaty Obligations.
- EC Procurement Directives.
- Public Contracts (Scotland) Regulations 2012

Argyll and Bute Council budgeted expenditure for Insurance and related services for 14/15 is £902k.

2. AUDIT SCOPE AND OBJECTIVES

The audit will cover the arrangements in place for securing Insurance services. We will include a review of internal controls and other procurement and governance arrangements. We will also review risk monitoring and risk reduction measures to provide a reasonable assurance that management's objectives are furthered and supported. Areas to be reviewed include:

- Compliance with Procurement procedures manual;
- Roles and responsibilities including contractual delegations and thresholds;
- Contract specification and tendering protocols;
- Information /data systems, and;
- Claim, risk reduction and monitoring arrangements.

3. RISKS IDENTIFIED

- Council fails to secure best value.
- Failure to meet Public procurement rules.
- Failure to have robust information and monitoring protocols.

4. AUDIT OPINION

The level of assurance given for this report is substantial.

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

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

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

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

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

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

5. FINDINGS

The following findings were generated by the audit:

Procurement of Insurance tender:

- The provision of Insurances and Related services was carried out during July/September 2011 under the Public Contracts (Scotland) Regulations 2006 which have since been replaced by the 2012 regulations.

- The placement of a Prior Information Notice on Public Contracts Scotland was carried out resulting in 14 companies noting their interest of which 2 submitted a tender namely Zurich Municipal and Risk Management Partners Ltd. It was noted in the Contract Award Recommendation Report that the reason given for the low response was due to the Council choosing to deal directly with Insurances companies rather than via a broker. Zurich Municipal was the successful tenderer.

- The procedures carried out during the tender process adhered to the appropriate guidelines outlined in the Procurement Manual.

- The scoring mechanism used by the Council was reviewed and found to be in line with the appropriate guidelines.

- All potential liabilities should be covered by the insurance cover taken out by the Council. It was found that Rothesay Academy had taken out an insurance policy to cover trophies, which was not required as cover is provided by the main insurance policy.

- The tender document used was a generic tender document which had been edited in order to fit the required guidelines for the Insurance tender. However in reading through the document a number of errors were noted namely the date specified for questions to be submitted Re the tender documents was 10th August 2012 rather than 10th August 2011. The contract end date was shown as 31st September 2014 with the possible extension to 31st September 2016.

Claims, risk reduction and monitoring arrangements

- Procedures and protocols are in place for dealing with claims however documentation was found to refer to previous claims handling agents and requires to be updated.

- A random sample of each type of claim was selected and the procedures governing how each claim should be processed was checked to ensure that guidelines are being adhered to. All claims chosen were found to have been properly handled as per the guidelines supplied.

- In reviewing a sample of incident reports it was noted that the reporting for some areas was more comprehensive than other areas. All reports should include a comprehensive incident report with copies of all relevant documents and appropriate photographs.

- Claims analysis data is provided by Zurich however limited evidence exists in relation to management use /risk reduction control activity.

- As part of the Insurance agreement Zurich provide a training fund with access to a range of specialist training. This fund has been accessed however it has not been fully utilised as there was some uncertainty around co-ordinating roles.

6. CONCLUSION

This audit has provided a substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1. There are 2 medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There are a further 4 low recommendations which are not reported to the Audit Committee. Appendix 1 sets out the actions management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Incident Reporting		**High/ Medium or Low**		
In reviewing a sample of incident reports it was noted that the reporting for some areas was more comprehensive than other areas.	Failure to have a comprehensive incident report can result in the Council being liable for claims it would otherwise be able to challenge.	Medium	**Legal Services to issue e-mail outlining responsibility to ensure that incident reports are comprehensive**	**31 August 2014** **Insurance Assistant**
2. Tendering Procedures		**High/ Medium or Low**		
It was noted there was a low response to the Invite to Tender due to the approach adopted .i.e. dealing directly with brokers.	Procurement strategy can impact on value for money.	Medium	**Council's traditional requirements for single supplier of all insurances was the industry norm at time of tender.** **Procurement and legal to review sourcing strategy at time of insurance renewal.**	**31 December 2014** **Procurement Commission Manager** **Legal Services Manager-Commercial**

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	DEVELPOMENT AND INFRASTRUCTURE SERVICES
AUDIT DESCRIPTION	SYSTEM BASED AUDIT
AUDIT TITLE	Section 75 Planning Obligations
AUDIT DATE	April 2014

2014/2015

1. BACKGROUND

Section 75 of the Town and Country Planning (Scotland) Act 1997 empowers planning authorities to enter into planning obligations with persons having an interest in land to restrict or regulate the development or use of land. An agreement entered into under Section 75 of the 1997 Act is a voluntary agreement between the land owner and the Council, or any other person having an interest in the land. It is recognised that positive obligations (including developer contributions) can be encompassed within this provision.

The majority of Section 75 (s75) planning obligations in Argyll and Bute Council are straightforward single issue planning obligations which create obligations in relation to such matters as road or visibility splay improvements or tie ownership of a dwelling house erected upon a croft to the remainder of the croft land. Other obligations may include the construction of affordable dwellings, financial contributions to deliver affordable housing, or the provision of infrastructure off site.

A review was undertaken of the processes followed in regard to the s75 planning obligation entered into in respect of the application for planning permission made by Drum Development Company (Waitrose). The planning application was a Local Application for the Erection of a Class 1 food store, petrol filling station, associated access, parking landscaping and all associated ancillary development on land south of Hermitage Academy, Cardross Road, Helensburgh. Following conclusion of the s75 planning obligation £868,000 was deposited with Argyll and Bute Council as a result of the Section 75 obligation. A further £20,000 was retained by Barr for the 'Gateway Project', construction was undertaken by Barr Construction during Waitrose build. In terms of the Section 75 planning obligation there are express timeframes in which the developers contributions paid require to be expended on projects (10 years and 15 years). If projects are not complete and funds unutilised within the agreed timeframes any unspent part of the contribution and accrued interest is required to be returned to the Landowner.

The Waitrose s75 planning obligation was unprecedented in Argyll and Bute in terms of the financial contributions that required to be made by the Applicant and the variety of mitigation measures that required to be addressed to make the development acceptable. It is considered that the mitigation contributions required maximised the funding opportunity arising from the application for the development.

A further four Section 75 obligations were reviewed using Argyll & Bute Council's website (Planning Section). Whilst guidance and procedures were in place and were being followed they could benefit from being updated and consolidated.

2. AUDIT SCOPE AND OBJECTIVES

This report has been prepared as a result of the Internal Audit review of Section 75 (s75) Planning Obligations within Development & Infrastructure, Planning as part of the 2014/2015 Internal Audit programme.

The main objective of the audit was to ensure:

- Compliance with Section 75 legislation and Guidance
- Compliance with Council policies and procedures
- Governance and Monitoring procedures were fit for purpose
- Income /Use of Funding verification

3. RISKS IDENTIFIED

- Failure to maximise funding opportunities arising from Development applications
- Council or applicant does not comply with terms of Section 75 obligation
- Reputational loss to Council
- Processes not fit for purpose resulting in un-necessary delays and stifling economic development

4. AUDIT OPINION

The level of assurance given for this report is substantial in terms of the process in place surrounding the majority of single issue s75 obligations, however in terms of the Waitrose development monitoring and governance arrangements require to be improved.

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

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

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

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

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

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

5. FINDINGS

The following findings were generated by the audit:

5.1 Argyll & Bute Council's Local Plan - Planning Gain allows the Council to secure developers contributions (planning gain) via s75 planning obligations.

5.2 Argyll & Bute Council follows national policy and guidance as contained in the Scottish Planning Policy and the Planning Obligations and Good Neighbour Agreements Circular 3/2012, this is transposed into the Local Development Plan and associated supplementary Guidance.

5.3 In terms of the Scottish Government 'Planning Obligations and Good Neighbour Agreements Circular 3/2012, Argyll & Bute Council's processes comply in the following areas:

- S75 obligations are identified and progressed in a timely and transparent manner;
- Potential development area schedules are included in the local plan;
- Within the policies in the local plan there is reference that section 75 planning obligations may be entered into;
- There is drafting templates in terms of s75 obligations for use in circumstances that are likely to be repeated;
- Monitoring takes place to ensure that obligations are met.

5.4 If a planning application is considered relevant for s75 obligation Planning & Regulatory Service work closely with Legal Services in terms of progressing the signing of the relevant paperwork with the applicant. Correspondence is held on the Electronic Document Management system and on the Council's website.

5.5 Internal written guidance/procedures in relation to s75 Planning are provided in notes contained in a memo dated July 1997. Other documented procedures and processes that are in place in relation to s75 planning obligations are fragmented and out of date.

5.6 In relation to the procedural guidance contained within the memo dated 1997 the Waitrose planning obligation was completed one day over the internal guidance of 4 months. A further four s75 obligations were reviewed and documents held on the Planning section of the website were reviewed. The s75 obligation for a development in Dunoon was found to have been

negotiated over a two year period, delayed due to mitigating circumstances on the part of the applicant. It was found that there are no documented guidelines around the circumstances in which s75 negotiations should continue beyond the guidance period.

5.7 The speed of determining planning applications which are subject to s75 planning obligations is monitored on a quarterly and annual basis by the Scottish Government. In 2013/14 (most up to date figures) Argyll and Bute Council entered into 11 legal obligations for Local Applications out of 1,072 applications determined. The time taken to conclude these was an average of 30.3 weeks from the date of validation of the application for planning permission. The National average is 48.8 weeks so Argyll and Bute are performing above average in terms of the time taken to conclude such applications.

5.8 The Waitrose development proposal did not comply with the Councils Development Plan without mitigation therefore became subject to s75 planning obligation. The s75 planning obligation contained the mitigation in terms of impact on the open space protection area, impact on business &industry allocation and impact on town centre. The Waitrose s75 planning obligation was unprecedented in Argyll and Bute in terms of the financial contributions that required to be made by the Developer. The s75 planning obligation set out 11 separate projects which will require to be undertaken by several different departments within the Council. In terms of the s75 planning obligation there are express timeframes for the developers contributions paid in respect of the projects to be expended (10 years and 15 years). If the projects are not complete and funds not utilised within the timeframe the unspent money and accrued interest is required to be returned to the Landowner.

5.9 Scottish Government Circular 3/2012: Planning Obligations and Good Neighbour Agreements states that; *"Planning authorities should have mechanisms and procedures in place for confirming that infrastructure and facilities to be provided under planning obligations are delivered. Planning authorities should designate a responsible officer for this purpose".* The Head of Planning and Regulatory Services is the officer responsible for ensuring compliance with s75 planning obligations. Authority is delegated to the four Area Team Leaders and the Development Manager where necessary. The majority of s75 obligation monitoring is straightforward for single issue obligations and there is a process in place to ensure the obligation is fulfilled. There was a project plan in place to assign tasks to Council departments and to deliver the mitigation required in respect of the Waitrose Agreement and expend the Developers contributions. There was evidence that the Developer had complied with their obligations under the Waitrose Agreement and that the payment of contributions had been monitored. There was evidence of a monitoring and reporting framework, however, there were weaknesses in the reporting lifecycle in place in respect of the Waitrose Development.

5.10 Monies received were treated in accordance with s75 Planning obligations. Strategic Finance (Treasury) has deposited the income received in a separate interest bearing account. A temporary loan has been created and interest applied. Strategic Finance has a clearly documented flowchart outlining processes to be followed in terms of receipt and draw down of funds upon verification of use as per s75 Planning obligations.

6. CONCLUSION

The level of assurance given for this report is substantial in terms of the process in place surrounding the majority of single issue s75 obligations, however in terms of the Waitrose development monitoring and governance arrangements require to be improved. There was evidence of a monitoring and reporting framework, however, there were weaknesses in the reporting lifecycle in place in respect of the Waitrose Development to ensure that the projects are complete within the agreed timeframe mitigating the risk that unutilised funds require to be returned to the Landowner. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1. There are 3 high recommendations which are reported to the Audit Committee. Appendix 1 sets out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

Thanks are due to staff within Planning, Legal Services and Strategic Finance for their co-operation and assistance during the Audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Procedures and Processes		**High/ Medium or Low**		
Internal written guidance/procedures in relation to s75 Planning are provided in notes contained in a memo dated July 1997. Other documented procedures and processes that are in place in relation to s75 planning obligations are fragmented and out of date.	Management assurance is undermined.	High	Review existing procedural guidance and produce updated and consolidated hand book including full process mapping	Development Manager, Development & Infrastructure March 2015
2. Reporting		**High/ Medium or Low**		
If projects are not complete and funds not utilised within the timeframe any unspent part of the contribution and accrued interest is required to be returned to the Landowner. There was evidence of a monitoring and reporting framework, however, there were weaknesses in the reporting lifecycle in place in respect of the Waitrose Development.	Failure to comply with Section 75 Guidance prepared by the Scottish Government Council is exposed to legal challenge and reputational damage. Management assurance is undermined. Resources required to	High	6 monthly highlight Reports to be produced	Development Manager, Development & Infrastructure December 2014

	be repaid impacting in performance levels.			
3. Completion Exceptions		**High/ Medium or Low**		
Within the memo dated 1997 the guidance given states that s75 obligations should be completed within a 4 month timeframe. Five s75 obligations were reviewed and documents held on the Planning section of the website reviewed. The s75 obligation for a development in Dunoon was found to have been negotiated over a two year period, delayed due to mitigating circumstances on the part of the applicant. There were no documented guidelines around the circumstances in which s75 negotiations should continue beyond the 4 month period.	Failure to comply with Section 75 Guidance prepared by the Scottish Government Council is exposed to legal challenge and reputational damage.	High	New guidance to be produced as part of finding no 1	Development Manager, Development & Infrastructure March 2015

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	DEVELOPMENT AND INFRASTRUCTURE SERVICES
AUDIT DESCRIPTION	RISK BASED AUDIT
AUDIT TITLE	CREMATORIUM
AUDIT DATE	AUGUST 2014

2014/2015

1. BACKGROUND

This report has been prepared as a result of the Internal Audit review of Crematoriums within Development and Infrastructure as part of the 2014/15 Internal Audit programme.

In the latter part of 2012 considerable public concern was expressed over the accuracy of information given to bereaved parents about the existence or non-existence and final resting place of the ashes of their babies who had been cremated. The circumstances which led to this are in relation to historical practices at the local authority-run Mortonhall Crematorium in Edinburgh. The subsequent media coverage led to over 250 families registering enquiries with that Investigation seeking to establish whether ashes had been recovered from the cremation of their babies. The publicity also led to similar, though less numerous, enquiries being made of other Cremation Authorities, including Glasgow City Council, Aberdeen City Council, Fife Council and Falkirk Council. A core concern was that in a number of cases in which parents had been told that, following the cremation of their babies, there had been or would be no ashes, there were in fact instances in which ashes had been buried or scattered at a part of the crematorium that might or might not be readily identifiable. A number of findings and recommendations have now been published and it is deemed appropriate to review the position in relation to our service provision.

Argyll and Bute Council operates one Crematorium, located at Cardross, Helensburgh. Four Staff are directly employed, with Net operating costs of £169,000.

2. AUDIT SCOPE AND OBJECTIVES

The main objectives of the audit are:

- To review current policies, guidance and practice in relation to the handling of all recoverable remains. (< 1 Year old)
- To review current policies, guidance and practice in relation to the handling of all recoverable remains. (General Population)
- To ascertain whether parents and other bereaved relatives receive clear and consistent advice and information about the disposal of such remains and have their wishes adhered to; and that any such remains are treated sensitively and compassionately.
- To review the report published by Lord Bonomy taking cognisance of recommendations where relevant.

- To review administrative protocols including cash handling, billing and invoicing, record keeping, security and storage of records.

3. RISKS IDENTIFIED

- SRR: Reputation. Trust and Integrity of the Council is undermined leading to diminishing reputation resulting in negative external scrutiny.
- SRR: Council fails to maintain its general reputation with residents, the Community and the wider Local Government Community.
- Policies and Protocols are not clearly defined leading to potential non-compliance with any legislative requirement.

4. AUDIT OPINION

The level of assurance given for this report is substantial.

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

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

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

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

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

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

5. FINDINGS

The following findings were generated by the audit:

Policies & Procedures

- A policy is in place whereby ashes (if exist) resulting from the cremation process are actively recovered in all cases.
- In the last 22 years, there have been 14 cremations of non-viable foetuses with ashes recovered in all but three instances. Ashes were recovered from all 16 stillborn babies and 10 babies of less than one year old from the same period.
- In these 3 instances, parents had been notified that there would be no identifiable remains resulting from the cremation. Parents also signed disclaimers confirming this.
- Parents and /or bereaved relatives receive consistent advice in regards to likelihood of recovery of ashes and alternative options available.

- Only 20% of relatives choose to have their loved ones ashes scattered within the grounds of Cardross Crematorium, however, the Strewing of ashes policy does not fully explain that the interment process is not individual and that more than one canister of ashes can be interred at one time.
- Cremation does not take place where cause of death is unascertained, however, changes to be imposed by the Scottish government on 01 April 2015 indicate that an independent medical referee is no longer required, this is a cause for concern with management.
- Walk through testing of operating practices provided evidence of a clear and methodical approach with sign off and identification checks in place.
- Documentation was complete and record cards kept with the deceased/remains at each stage of the process.
- Record cards are marked “OK” to proceed with cremation, however there is no authorisation field for completion.
- All staff are aware of their responsibilities for each of their respective duties within the process.
- Files are sequentially numbered and securely retained in fireproof cabinets.
- Ashes are clearly labelled and stored on a table for collection, however, due to the open nature of the storage there is a risk that the containers could be damaged and ashes spilled.
- Where ashes are to be interred these are retained for an extended period prior to interment in case applicant has a change of mind.
- There is limited storage for bodies, however, when the current cremator is replaced in the near future, the tender will include a cold storage unit. Should there be an abnormally busy period such as a pandemic incident, business continuity/emergency planning would ensure an external storage facility is secured.
- There is a maintenance contract in place to ensure prompt repair should the apparatus breakdown.
- A new policy has been drawn up to cover both burial and cremation and was found to cover all relevant areas of the service, however, a service manual detailing procedures for all aspects of the service has yet to be completed.

Lord Bonomy's Report

- All ashes produced following the cremation process are in line with the definition of "all that is left in the cremator at the end of the cremation process and following the removal of any metal". (2.4)
- Practices at Cardross Crematorium enabled ashes to be recovered in all pre one year old cremations with the exception of 3 non-viable foetuses. (2.6)
- Infant trays are used to aid the recovery of ashes, however, there have been some instances where the casket has been too big to fit in the tray, therefore, arrangements have been made to purchase bigger trays. (2.7)
- The cremation process demonstrates commitment to sensitive treatment of babies and needs of parents and families, by following Institute of Cemetery & Crematorium Management (ICCM) policy entitled "The Sensitive Disposal of Foetal Remains" and the Federation of Burial and Cremation Authority's (FBCA) "Code of Cremation Practice".(2.11)
- Form A was used in all applications; there has been no shared cremations of non-viable foetuses, babies nor infants to date. (2.14)
- For two of the three non-viable foetuses that produced no ashes, the hospital forms requesting cremation had clear message stating that "there will be no identifiable remains resulting from the cremation"; on the other infant application form a hand written note from hospital stated that there may be no remains from cremation. All of these forms were signed by parents. Newer forms all state that there may be no remains.
- Application forms are consistently used and meet government requirements and are in line with the new Scottish Government process, new forms are being prepared for implementation on 1 April 2015. (2.16-17)
- The application form requires the applicant to specify how ashes should be dealt with and by whom following the cremation. There is also a note stating that dispersal of cremated remains will take place a few days after the cremation, however, Internal Audit were advised that ashes are retained for longer than this in case the applicant changes their mind. (2.18 – 21)
- Application forms are required to be witnessed by independent party. (2.22)

- Applicant's relationship to deceased is declared on form A and scrutinised by crematorium staff (2.23 – 24)
- The lawn area location of where ashes are scattered/ buried or whether they are collected and by whom is recorded on a computerised system. (2.35)
- Register of cremations goes back to the first cremation that took place at Cardross Crematorium in 1961, this is in line with requirements of both the Scottish council on Archives and the recommendations on Lord Bonomy's report. The Scottish Council on Archives also requires that applications for a cremation, interment or monument erection be kept for 10 – 15 years, however Lord Bonomy's report requests this be for a minimum of 50 years. All forms of application, certificates and other official documents relating to a cremation are retained in fireproof cabinets for the last 25 years and older ones in boxed storage awaiting shredding, it has not been ascertained how far these go back. (2.39)
- Argyll and Bute Council are involved in benchmarking and sub-groups of the FBCA, however there is no attendance at working groups of the National Committee. Staff at Cardross Crematorium are updated via bulletins from the FBCA. (2.40, 2.56 – 2.62)
- Argyll and Bute Council does not issue a notice to applicant confirming location of ashes unless specifically requested nor of when they are collected. Book of memory forms are sent to the applicant approximately one month following cremation.(2.41)
- All staff hold a Certificate of Proficiency in the Practical and Ethical Operation of Cremation Equipment, with full regard for regulation currently in force and in accordance with the ethical standards prescribed within the federation's code of cremation practice. (2.46)
- Parents are informed at the undertaker stage that there may be no ashes and they should consider burial as an option. (2.48)
- Accurate information is expressed clearly and consistently with the undertaker at the time of arranging a funeral including in particular, information about the prospects of recovering ashes and option of burial. (2.53)
- Undertakers discuss plans for local memorials (book of remembrance, plaques and headstones) with parents and these are followed up by Crematorium one month later. (2.55)
- Crematorium staff are familiar with and are considering how to progress the many recommendations within the Lord Bonomy Report.

Administrative Protocols

- There is some ambiguity regarding whether the undertaker or the applicant is responsible for paying of invoices for crematoria services. Legal services has advised that where problems arise the responsible person would be assessed on individual basis depending on how the undertaker states relationship to client.
- Management has not explored the use of the Customer Service Centre to aid the administration of payments and enquiries (identifiers will need to be set-up to ensure accessibility of booking arrangements).
- There are no documented procedures in place regarding cash handling and billing processes.
- Cash and cheques are received and banked by crematorium staff. The details and amounts are also entered onto income sheets and input to the Cash Receipting System by clerical staff at Blairvadach resulting in some duplication of effort.
- The crematorium staff are not notified when a sundry debtor is paid at another location resulting in a delay in issuing title deeds.

Other observations

- There is no entry regarding Crematoria within the Service's Operational Risk Register.

6. CONCLUSION

This audit has provided a substantial level of assurance. There were a number of recommendations for improvement identified as part of the audit and these are set out in Appendix 1 and 2. There were one high and four medium recommendations set out in Appendix 1 which will be reported to the Audit Committee. There are 9 low recommendations which are not reported to the Audit Committee. Appendices 1 and 2 set out the action management have agreed to take as a result of the recommendations, the persons responsible for the action and the target date for completion of the action. Progress with implementation of actions will be monitored by Internal Audit and reported to management and the Audit Committee.

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

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Service Manual		**High/ Medium or Low**		
A service manual detailing procedures for all aspects of the service has yet to be completed.	A high quality service with a clear and consistent approach may not be provided by all staff.	Medium	Complete and issue service manual	Crematorium Superintendent and Service Officer – Grounds & Horticulture 31 October 2014
2. Scottish Government Changes		**High/ Medium or Low**		
Indications from the Scottish Government are that from April 2015 there will no longer be a requirement for a medical referee to authorise cremation. Final documentation has yet to be agreed between the FBCA and ICCM causing concern to crematorium staff.	Bodies may be cremated without appropriate authorisation.	Medium	Continue to monitor advice from Scottish Government, FBCA and ICCM. Argyll & Bute Council (ABC) procedures may need to be amended to take account of these changes. Outcome from national meetings in October 2014 and January 2015 will be monitored for	Crematorium Superintendent in consultation with Legal Services. 31 January 2015

			further guidance.	
3. Invoicing and Billing		**High/ Medium or Low**		
It is unclear as to whether the applicant or the undertaker is the customer of the Council.	Payment may not be made and the Council is unable to recover costs.	Medium	Initial meeting has taken place. A new protocol is being developed regarding debt recovery from funerals.	Streetscene Area Manager in consultation with Principal Accountant and Legal Services Manager - Commercial 31 March 2015
4. Cash Handling and Billing		**High/ Medium or Low**		
There are no procedures in place regarding cash handling and billing processes.	Invoices may not be issued in a timely manner and cash may be misappropriated.	Medium	Agree with support staff and strategic finance a cash handling and billing procedure and implement.	Crematorium Superintendent 31 October 2014
5. Operational Risk Register		**High/ Medium or Low**		
There is no entry in the Operational Risk Register in connection to Crematoria services.	Risks may not be addressed leading to failure in providing service.	High	Include Crematoria services in the Operational Risk register.	Streetscene Area Manager/Head of Roads and Amenity Services 31 November 2014

APPENDIX 2 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
6. Authorisation of Record Cards		**High/ Medium or Low**		
Record cards are marked "OK" to proceed with cremation, however there is no authorisation field for completion.	Deceased may be cremated without appropriate authorisation.	Low	Record cards to be amended to incorporate an authorisation field.	Crematorium Superintendent 31 November 2014
7. Storage of Remains		**High/ Medium or Low**		
Ashes are clearly labelled and stored on a large table for collection; however, there is no barrier to prevent accidental knock over and spillage.	Cremated remains of more than one person could be spilled and mixed resulting in disrespect and reputational damage.	Low	New container to be installed to separate individual containers containing ashes.	Crematorium Superintendent 30 September 2014
8. Storage of Bodies		**High/ Medium or Low**		
There is limited storage for bodies should there be an abnormally busy period or should the apparatus breakdown for an	Health and Safety regulations are not complied with.	Low	This will be further investigated on the installation of the new cremator, when the available space is	Crematorium Superintendent/ Streetscene Area Manager

extended period of time.			known. Additional storage capacity would only be in times of an epidemic, external facilities at hospitals and chapels of rest would provide the majority of storage. The service contract for the cremator has provided a fast and reliable service to date – there are small risks of this not continuing.	31 March 2016.
9. Infant Trays		**High/ Medium or Low**		
Infant trays are used to aid the recovery of ashes; however, there have been some instances where the casket has been too big to fit in the tray.	All remains may not be collected in the tray.	Low	In the process of sourcing a larger tray. This has become a problem with funeral directors offering families larger coffins.	Crematorium Superintendent 31 October 2014
10. Scattering of Ashes		**High/ Medium or Low**		
Families/relatives are not advised that	Misunderstanding of the process may intensify	Low	Letter being drafted to notify the applicant, this	Crematorium

scattering/interment is not individual as it is likely that the ashes of more than one deceased is scattered/interred at any one time.	parental upset leading to reputational damage.		will be incorporated with the literature, making families aware of the book of remembrance.	Superintendent 31 March 2015
11. Notice of Location/Collection of Ashes		**High/ Medium or Low**		
A notice is not sent to the applicant confirming that ashes have either been collected or scattered including where, when and by whom.	Confusion regarding final resting place of ashes leading to reputational damage.	Low	As per action 5 above letter is being drafted.	Crematorium Superintendent 31 March 2015
12. Customer Service Centre		**High/ Medium or Low**		
Management has not explored the use of the Customer Service Centre to aid the administration of payments and enquiries.	Best use may not be made of working time.	Low	Meeting to be arranged to explore.	Streetscene Area Manager and Crematorium Superintendent 31 December 2014

13. Duplicate Recording of Income		**High/ Medium or Low**		
There is some duplication of effort between Crematorium staff and office staff at Blairvadach regarding collection of income.	Best use may not be made of working time.	Low	Meeting to be held with local support staff with a view to minimising duplication by introducing new procedures.	Crematorium Superintendent 31 October 2014
14. Payment of Invoices		**High/ Medium or Low**		
The crematorium staff are not notified when a sundry debtor is paid at another location resulting in a delay in issuing title deeds.	Important documents may not be issued in a timely manner.	Low	Meeting to be held with support staff and strategic finance to put in place a control loop to notify crematorium staff when a sundry debtor is paid.	Crematorium Superintendent 31 October 2014

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Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**SYSTEM BASED AUDIT**
AUDIT TITLE	**Procurement & Commissioning (Utilities)**
AUDIT DATE	**August 2014**

2014/2015

1 BACKGROUND

This report has been prepared as a result of the Internal Audit review of Procurement and Commissioning (Utilities) within Customer Services as part of the 2014/2015 internal audit programme.

2 AUDIT SCOPE AND OBJECTIVES

The audit covered the arrangements in place for securing Utility services including Electricity (including street lighting), Heating Oils, Gas and Water. We reviewed the internal controls and governance arrangements. The areas reviewed were:

- Relevant compliance with Public Contracts (Scotland) Regulations 2006
- Relevant compliance with Utilities Contracts (Scotland) Regulations 2006
- Roles and Responsibilities including contractual delegations and thresholds
- Contract specification and tendering protocols
- Information/Data Systems
- Monitoring Arrangements

3 RISKS IDENTIFIED

- Council fails to secure best value
- Failure to meet public procurement rules
- Failure to have robust information and monitoring protocols resulting in reduced ability to identify poor performing sites and potential mis-reporting

4 AUDIT OPINION

The level of assurance given for this report is substantial.

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

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

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

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

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

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

5 FINDINGS

The following findings were generated by the audit:

5.1 The Council has a documented procurement manual which clearly outlines the procurement process. It provides documented procedures to be followed, including tendering protocols. Services are required to adhere to the process outlined in the manual. Scottish Procurement provides the Council with updates through Scottish Procurement Policy update notifications. The procurement board considers any changes or updates. The procurement manual is updated on a regular basis to reflect any legislative changes or new EU guidance.

5.2 The responsibilities of the procurement team are outlined in the procurement manual with purchasing officers identified to support the departments.

5.3 The department has noted that the Public Contracts (Scotland) Regulations 2006 and the Utilities Contracts (Scotland) Regulations 2006 have been replaced by the Public Contracts (Scotland) Regulations 2012 and Utilities Contracts (Scotland) Regulations 2012.

5.4 The Council is signed up to the National Energy Procurement Contract administered by Scottish Procurement. The main benefit to Council in this collaborative approach is that it achieves the best average market rate and economies of scale. National contracts are in place for electricity, natural gas, fuel oils and water.

5.5 Public bodies who participate in the national contract are obliged to provide Scottish Procurement with site data including annual consumption. As required, the Council maintain an ongoing dialogue with Scottish Procurement and follow the defined process for adding/deleting sites and updating their individual portfolio consumption when requested.

5.6 Spot purchases of heating oil are made, generally as a result of severe weather preventing the main contractor getting to a particular site. The standing orders of the Council allow departure from the procurement manual and from the constitution if certain conditions are met. There is a written procedure which details the process to be followed in relation to spot purchases of fuel oil in these circumstances. It was found that spot purchases adhered to this process.

5.7 The Council take advantage of a discount by paying in advance the annual Invoice for Scottish Water Business Stream. The discount for advance payment for the financial year 2012/2013 was £84,000. Paying in advance creates minimal exposure to overpayments being made, however, this is mitigated by reconciliations of accounts on an ongoing basis and at the year end.

5.8 Electricity billing is reliant on a mix of real time auto reading and manual meter reading and or estimated bills. This process is relatively time consuming particularly when calculating year end accrual entries.

5.9 Monitoring arrangements for energy consumption were found to be manually intensive and time consuming. The Council is currently undertaking a procurement process to purchase an electronic based monitoring recording database. This will provide accurate, timely information and should assist with consumption monitoring and allow for comparisons across sites.

6 CONCLUSION

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

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Audit Committee

External Audit Progress Report

AUDIT SCOTLAND

Prepared for Argyll & Bute Council Audit Committee
September 2014

Contents

Audit Progress

Audit Plans

1. Our Annual Audit Plan (AAP) for the 2013/14 Argyll and Bute Council (ABC) audit was presented to the Audit Committee on 14 March 2014. The audit plan set out the key risks facing ABC in financial year 2013/14, the actions taken by management to mitigate these risks and the main audit outputs for the year.

2. The table at Appendix 1 provides details of progress to date against the 2013/14 AAP.

Governance work

3. **Review of internal audit**. We completed our review of the internal audit service in terms of International Standards on Auditing 610 (Considering the Work of Internal Audit). Overall, we concluded that the internal audit service operates in accordance with Public Sector Internal Audit Standards (PSIAS) and has sound documentation standards and reporting procedures in place. Our review identified a number of areas where we planned to place formal reliance on the work of internal audit for the purposes of our financial statements responsibilities These areas were:

- Non Domestic Rates
- Council Tax
- Payroll
- Trade Payables and Purchasing
- Trade Receivables
- Cash and Bank
- Treasury management
- Capital accounting.

4. We issued a letter to the Head of Strategic Finance on 31 March 2014 advising him of those areas of internal audit work that we planned to rely upon.

5. **Internal Controls**. We have updated our knowledge of the organisation in relation to governance and accountability and completed our evaluation of the key financial systems. These are the systems that we consider to be key to providing us with assurance for the financial statements. We carried out our controls testing work and the results of this were reported to management on 3 July 2014.

6. Audit Scotland has received a large amount of correspondence relating to the council's activities. In response to some of these items, we have undertaken targeted audit work. The findings from this work are being reported to the council in the Report to Those charged with Governance on the 2013/14 Audit and in three separate letters addressed to the council's officers (known as 'management letters'). These findings are to be discussed at this meeting of the Audit Committee. They will also be summarised in the Annual Audit Report on the 2013/14 Audit which will be issued in October 2014.

Financial Statements

7. We received the unaudited financial statements on 30 June 2014 in accordance with the agreed timetable. The working papers were of a good standard and finance staff dealt with audit queries promptly

8. Our work on the financial statements is now substantially complete. The issues arising from the audit were discussed with officers at regular intervals during the course of the audit. The more significant issues arising were discussed with the Head of Strategic Finance at a meeting on 16 September 2014.

9. Our ISA 260 Report will be submitted to this meeting of the Audit Committee. This report sets out for the Audit Committee's consideration the matters arising from the audit of the financial statements for 2013/14.

Performance Audit and Best value

10. **Statutory report follow-up:** In October 2013, the Controller of Audit presented a statutory report to the Accounts Commission, under Section 102(1)(b) of the Local Government (Scotland) Act 1973. The Commission made findings on the report and the statutory report and the Commission's findings were published on 29 October 2013.

11. In its 2013 findings, the Commission expressed the need for urgent progress and requested a further report by the Controller of Audit. Follow-up audit work reviewed progress made by the council over the six-month period between the publication of the statutory report at the end of October 2013 and April 2014.

12. Summary findings from the follow-up audit report are:

- Argyll and Bute Council has responded constructively to the Accounts Commission findings on the 2013 statutory report and it is making progress with improvement work. It is, however, too early to assess the effectiveness of the actions and plans being implemented.
- The leadership and political dynamics of the council are more stable but the situation remains fragile. The risk to the council is currently reduced but there are difficult circumstances ahead and tough decisions to be made that will prove challenging to political management and ongoing stability.
- New political management arrangements provide a foundation for improved governance. The council needs to ensure councillors and officers have a shared understanding in practice about the roles and responsibilities as well as effective links within and across the new arrangements to ensure they meet their potential.
- Scrutiny still needs to improve. In particular, the council needs the commitment and engagement of councillors in the work of the Performance Review and Scrutiny

Committee and the Audit Committee, if these are to make an effective contribution to governance and accountability. The role of senior management will also be crucial.

13. The Commission has asked the Controller of Audit to report on progress by the end of 2015, with particular focus upon the effectiveness of the following:
    - Political management arrangements.
    - Scrutiny.
    - Roles and relationships, including between members and officers.

14. **National reports:** Audit Scotland's Performance Audit and Best Value (PABV) Group undertake a programme of studies on behalf of the Auditor General and Accounts Commission. The findings and key messages of each study are published in a national report. Recent studies of relevance to local government in Scotland have included a review of School Education (published June 2014) and Procurement in councils (published April 2014). The National Scrutiny Plan for Local Government was published in June 2014.

15. Full copies of these reports and all other national reports are available for download from the Audit Scotland website (www.audit-scotland.gov.uk).

16. **Impact reports:** In line with Audit Scotland's strategy to support improvement through the audit process and to maximise the impact of national performance audits follow up reviews were undertaken of a number of studies at a local level. In 2013/14 this included a targeted review of Arm's-length external organisations (ALEOs): are you getting it right? (June 2011) and Major Capital Investment in councils (March 2013).

17. In relation to ALEOs, we concluded that the council does not have any and accordingly, no further work was required. In relation to Major Capital Investment, we provided information to Audit Scotland's PABV Group on the extent to which the national report and good practice guidance and checklist were considered by the relevant council and any action taken as a result. We concluded that the council has made good progress in addressing relevant recommendations made in the report.

Technical Bulletins

18. Audit Scotland's Technical Services Unit prepares and issues Technical Bulletins (TBs) on a quarterly basis to provide auditors with guidance and information on technical developments in the quarter. Additionally, TBs are sent to audited bodies and other stakeholders to make them aware of the issues that have been notified to auditors. The most recent TB was issued in September 2014 (TB 2014/3). Key issues relating to the local authority sector are summarised at Appendix 2 for information.

19. It should be noted that the matters highlighted in Appendix 2 are not exhaustive; they highlight some of the key issues. It is important that the council has procedures in place to review technical guidance.

Appendix 1

2013/14 Planned Outputs

Outturn against 2013/14 annual audit plan as at 16 September 2014

Planned outputs	Planned reporting date	Date draft report submitted	Management response to draft	Final report submitted
Governance				
Internal audit reliance letter	31/03/2014	-	-	31/03/2014
Annual audit plan	31/03/2014	07/03/2014	10/03/2014	10/03/2014
Internal controls management letter	30/06/2014	30/06/2014	02/07/2014	03/07/2014
Financial Statements				
Report to management in terms of ISA 260 (Communication of audit matters to those charged with governance)	30/09/2014			
Independent auditor's report on the financial statements	30/09/2014			
Audit opinion on charitable trusts	30/09/2014			
Annual report to Members	31/10/2014			
Performance				
Targeted follow up of performance audit: ALEOs	31/05/2014	-	-	31/05/2014
Targeted follow up of performance audit: Major capital investment in councils	30/06/2014	-	-	27/06/2014

Appendix 2

Summary of Technical Bulletin issues

2014/3: September 2014

Topic	Issue
New accounts regulations from 2014/15	• The Local Authority Accounts (Scotland) Regulations 2014 have been issued to replace the 1985 regulations in respect of local authority annual accounts with effect from 2014/15. The Scottish Government has issued Finance circular 7/2014 to accompany the new regulations. • Key points in the regulations and circular include: – a new requirement for local authorities to undertake an annual review of their system of internal control and report this in an annual governance statement – the new requirement for an authority to undertake an adequate and effective internal auditing service in accordance with the Public sector internal audit standards – Regulation 8 sets out the process for the consideration of the unaudited annual accounts – Regulation 8(2) sets out the statements which must be included in the annual accounts
2013/14 guidance on accounting for decommissioning obligations	• The Local Authority (Scotland) Accounts Advisory Committee (LASAAC) has issued Guidance on asset decommissioning obligations to provide guidance on accounting for asset decommissioning obligations from 2013/14. The guidance is applicable to all relevant asset decommissioning obligations. Whilst LASAAC considered the matter in relation to landfill sites, the accounting will also apply to other obligations e.g. quarries, waste treatment facilities, etc. • The guidance outlines that retrospective restatement may be required in 2013/14 for any previously unrecognised obligations. This will have an immediate funding impact for the local authorities affected as they are required to fund the new capital expenditure and any unwinding of the discount. Scottish Ministers have issued statutory guidance which includes mitigation of the funding impact.

Topic	Issue
Draft 2015/16 Code	• The CIPFA/LASAAC Local Authority Code Board has issued an exposure draft of proposed amendments to the accounting Code for 2015/16. • The exposure draft proposes changes to the Code in respect of – the adoption of IFRS 13 Fair value measurement – heritage assets – accounting for employee pension contributions.

Agenda Item 11

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AUDIT SCOTLAND

Bruce West
Head of Strategic Finance
Argyll and Bute Council
Kilmory
Lochgilpheadl
Argyll
PA31 8RT

3 July 2014

Dear Bruce

Argyll and Bute Council 2013/14
Review of Internal Controls

Audit Scotland's Code of Audit Practice requires us to assess the systems of internal control put in place by management. In carrying out this work, we seek to gain assurance that Argyll and Bute Council:

- has systems for recording and processing transactions which provide a sound basis for the preparation of financial statements and the effective management of its assets and interests
- has systems of internal control which provide an adequate means of preventing or detecting material misstatement, error, fraud or corruption
- complies with established policies, procedures, laws and regulations.

In accordance with ISA 330 (The Auditor's Procedures in Response to Assessed Risks), specifically paragraphs 14 and 15, our audit judgements are based on current year testing of controls and, where appropriate, prior year results.

As you are aware, we are rolling out a new audit methodology this year which allows us to obtain assurances from previous years' audit work where no significant risks were identified. Our controls work has, therefore, been more focused compared to previous years. On the basis of the information put into our audit model, we identified that the payroll and trade payables systems would be fully tested and that we would obtain assurances from previous years' audit work for the remainder of the Council's key systems.

Where we have placed reliance on previous years' audit work, we have tested the key controls by undertaking a "walkthrough test". This involves updating our system controls and identifying whether there have been any changes to the control environment. We then select a transaction at random and check that internal controls have been applied correctly at each stage of its processing.

The table below summarises the key systems that were either fully tested during 2013/14 or those where we have placed reliance on previous years' audit work. In respect of a number of systems, we have placed reliance on the work of internal audit and their findings which were formally reported to management.

Bruce West
Head of Strategic Finance
Argyll and Bute Council

3 July 2014

Key System	External audit coverage	Reliance on aspects of internal audit work
Trade Payables	✔	✔
Payroll	✔	✔
Trade Receivables	✔ *	✔
Financial Ledger	✔ *	
Cash, income and banking	✔ *	✔
Council Tax collection and billing	✔ *	✔
Non domestic Rates collection and billing	✔ *	✔
Treasury Management	✔ *	✔
Capital accounting	✔ *	

* Reliance placed on previous years' audit work

Audit findings

A summary of those areas where identified risk requires management consideration is included in Appendix A. The following paragraphs also summarise the findings from our detailed controls testing work carried out in 2013/14.

Trade Receivables

For the month of January 2014, 19 daily reconciliations between Civica (trade debtors) and Oracle (ledger) were completed. In 7 cases, the preparer of the reconciliation had not signed the report. The box at the foot of the reconciliation statement should always be completed to identify who has prepared the report.

Sample testing of 20 credit notes identified one instance where a credit note had been raised to offset a debt which had been deemed irrecoverable. This is not a valid reason to raise a credit note. Write off procedures should be followed in all instances to write off irrecoverable debts.

Council Tax Billing and Collection

Sample testing of 30 discounts/exemptions identified one instance (class 13A Re-possessed property) where no application form had been received. Other forms of evidence had however been provided in support of the application.

An application form should always be obtained before any discount/exemption is applied to prevent the granting of inappropriate discounts/exemptions.

Overall Conclusion

Our overall assessment is that the key controls within the Council's main financial systems are operating satisfactorily. This allows us to take planned assurance on these systems for our financial statements audit work in 2013/14.

Bruce West
Head of Strategic Finance
Argyll and Bute Council

3 July 2014

Risk Identification

The issues identified in preparing this management letter are only those which have come to our attention during the course of our normal work and are not necessarily, therefore, all the risk areas that may exist. It remains the responsibility of management to determine the extent of the internal control system appropriate to Argyll and Bute Council. We would stress, however, that an effective system of internal control is an essential part of the efficient management of any organisation.

Acknowledgement

The contents of this letter have been discussed with relevant officers to confirm factual accuracy. The co-operation and assistance we received during the course of our audit is gratefully acknowledged.

Please do not hesitate to contact Russell Smith (0131 625 1949) or myself (0131 625 1931) if you have any queries on this management letter.

Yours sincerely

David Jamieson
Senior Audit Manager

Bruce West
Head of Strategic Finance
Argyll and Bute Council

3 July 2014

Appendix A

Action Plan

No.	Audit finding	Control risk	Proposed management response & action	Responsible officer	Date
1	**Trade Receivables**				
	For the month of January 2014, 19 daily reconciliations between Civica (trade debtors) and Oracle (ledger) were completed. For seven of the daily reconciliations, however, the preparer of the reconciliation had not signed the report.	Reconciliations may not be carried out correctly.	The paper copies in the file have all been signed although the name was not typed into the "Completed by" box. Staff have been instructed to complete this box in all cases.	Jennifer Gorman, Sundry debt administrator	Completed
2	**Trade Receivables**				
	Sample testing of 20 credit notes identified one instance where a credit note had been raised to offset a debt which had been deemed irrecoverable. This is not in accordance with the council's write off procedures.	Amounts which are recoverable could be written off.	The daily credit notes raised by departments are now all checked by the central debtor's team and this sort of error will be picked up and corrected in future. However there are occasions where debts may be deemed irrecoverable because of lack of evidence to substantiate the delivery of the service being invoiced, and in these cases credit notes will continue to be raised.	Jennifer Gorman, Sundry debt administrator	Completed

Bruce West
Head of Strategic Finance
Argyll and Bute Council

3 July 2014

No.	Audit finding	Control risk	Proposed management response & action	Responsible officer	Date
3	**Council Tax billing and collection**				
	Sample testing of 30 discounts/exemptions identified one instance where no application form had been received. However other forms of evidence had been provided.	Inappropriate discounts or exemptions may be applied.	Where the council has been unable to get an application completion by the council tax payer but has sufficient evidence to grant a discount or exemption, it will continue to grant these on a case by case basis. This is considered necessary to prevent issues arising when undertaking recovery action. These are relatively rare situations and will always be authorised by a senior officer.	Margaret Thomson, Revenues Supervisor	No further action required

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ARGYLL & BUTE COUNCIL **AUDIT COMMITTEE**
STRATEGIC FINANCE **26 SEPTEMBER 2014**

EXTERNAL & INTERNAL AUDIT REPORT FOLLOW UP 2014 – 2015.

1. EXECUTIVE SUMMARY

1.1 Internal Audit document the progress made by departmental management in implementing the recommendations made by both External Audit and Internal Audit. This report and attached appendices are the results from a review performed by Internal Audit for recommendations due to be implemented by 31 July 2014.

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

1.3 Appendix 1 is a statistical summary of all agreed recommendations arising from National, External and Internal Audit reports by department. Detailed is the number of recommendations due as at 31 July 2014, the number implemented, the number of agreed future recommendations and their status, e.g. on course etc.

1.4 Appendix 2 provides a summary as at 31 July 2014, of all outstanding recommendations from National, External and Internal Audit reports by department and service. Detailed is the report name along with the weakness identified, agreed management action, revised date, any previous implementation dates reported to the Audit Committee management comment and Pyramid status.

1.5 Appendix 3 provides a summary of all recommendations from National, External and Internal Audit reports by department and service that are due after 31 July 2014 and not on track to achieve the agreed implementation dates. Detailed is the report name along with the weakness identified, agreed management action, revised date, any previous implementation dates reported to the Audit Committee, management comment and Pyramid status.

2 RECOMMENDATIONS

2.1 The audit committee note the progress.

3 CONCLUSION

3.1 Of the 29 recommendations due for completion by 31 July 2014, 22 have been completed. Internal Audit is satisfied that progress is being made in addressing all 7 remaining recommendations and with the revised completion dates provided.

Good progress is being made on the 32 recommendations due after 31 July 2014 with 7 completed early, 1 action being superseded and timely identification of 6 requiring to be rescheduled.

4. IMPLICATIONS

4.1	Policy:	None
4.2	Financial:	None
4.3	Legal:	None
4.4	HR:	None
4.5	Equalities:	None
4.6	Risk:	None
4.7	Customer Service:	None

BRUCE WEST
HEAD OF STRATEGIC FINANCE

For further information please contact Kevin Anderson (01369 708505)

APPENDIX 1

SERVICE SUMMARIES

RECOMMENDATIONS DUE 01 MAY 2014 – 31 JULY 2014

SERVICE	Delayed but rescheduled	Complete	Total Of ACTION PLAN NUMBER
ADULT CARE	0	1	1
COMMUNITY & CULTURE	1	2	3
CUSTOMER & SUPPORT SERVICES	0	4	4
EDUCATION	2	1	3
FACILITY SERVICES	0	1	1
IMPROVEMENT & HR	0	3	3
ROADS & AMENITY SERVICES	0	2	2
STRATEGIC FINANCE	4	8	12
TOTAL	**7**	**22**	**29**

RECOMMENDATIONS DUE AFTER 31 JULY 2014

SERVICE	On Course	Complete	Delayed but rescheduled	Superseded	Total Of ACTION PLAN NUMBER
ADULT CARE	0	0	0	1	1
CHILDREN & FAMILIES	4	2	0	0	6
CUSTOMER & SUPPORT SERVICES	6	1	0	0	7
ECONOMIC DEVELOPMENT	2	0	0	0	2
EDUCATION	0	0	5	0	5
GOVERNANCE & LAW	0	2	1	0	3
IMPROVEMENT & HR	1	0	0	0	1
PLANNING & REGULATORY SERVICES	3	1	0	0	4
ROADS & AMENITY SERVICES	0	1	0	0	1
STRATEGIC FINANCE	2	0	0	0	2
TOTAL	**18**	**7**	**6**	**1**	**32**

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Recommendations Overdue 31 July 2014

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
DEPARTMENT	**CHIEF EXECUTIVE'S UNIT**				
SERVICE	**STRATEGIC FINANCE**				
REPORT NAME	**AUDIT SCOTLAND - SCOTLAND'S PUBLIC FINANCES: ADDRESSING THE CHALLENGES. A TARGETED FOLLOW-UP REPORT**				
2	The council has produced an action plan to address the key points contained in Audit Scotland's report "Using cost information to improve performance" published in May 2012. The action plan is to be taken forward principally through the Corporate Improvement Plan project related to productivity and service improvement. No dates are included in the action plan There is a risk that each of the action steps is not accomplished within a reasonable timescale. **LOW**	This will be taken forward on a number of fronts. Service prioritisation reviews will require an element of cost information to be considered. The Councils approach to benchmarking will require unit costs to be compared including the use of the SOLACE national benchmarking information. Progress has commenced within Roads and Amenity Services on developing service based financial performance measures and this will be reviewed and rolled out to all service and captured as part of the review of the Planning and Performance Management Framework.	31 March 2014 31 July 2014 **31 March 2015**	This has now become detached from service prioritisation. A separate project is being set up in Strategic Finance initially to scope what is required. A discussion paper will be shared with SMT and a consideration given as to how to take this forward.	**Delayed but rescheduled** Head of Strategic Finance
REPORT NAME	**REVIEW OF CAPITAL ACCOUNTING**				
1	The development of a comprehensive and overarching policy document in respect of capital expenditure, asset acquisitions, disposals and transfers, valuations and depreciation should be completed. **LOW**	A Capital Accounting policy document should be developed and issued to ensure appropriate and effective management, recording and control procedures are implemented across all aspects of capital accounting.	31 December 2013 28 February 2014, 30 June 2014 **30 August 2014**	Work has started on preparing the policy document and this will be completed by mid-August.	**Delayed but rescheduled** Finance Manager, Corporate Support

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
3	The Council has appropriate valuation processes in place although the policy is not documented. **LOW**	A Capital Accounting policy document should be developed and issued to ensure appropriate and effective management, recording and control procedures are implemented across all aspects of capital accounting.	31 December 2013 28 February 2014, 30 June 2014 **30 August 2014**	Work has started on preparing the policy document and this will be completed by mid-August.	**Delayed but rescheduled** Finance Manager, Corporate Support

REPORT NAME **REVIEW OF CASH, INCOME AND BANKING**

3	A review of Imprest Account details for Argyll & Bute Council showed that there are 223 Imprest Accounts in total. Of the 223, a high proportion were found to have bank accounts. However, for 24 there were no details and 88 had no bank accounts. **LOW**	Internal Audit understands that the current banking contract is due to be reviewed in 2012/2013 and the review of Imprest Accounts should coincide with this to see whether bank accounts are held with the most appropriate bank.	30 June 2013 31 July 2013, 30 June 2014 31 December 2013 **30 November 2014**	Bank tender is being worked on and should be complete by end of November.	**Delayed but rescheduled** Head of Strategic Finance

DEPARTMENT COMMUNITY SERVICES

SERVICE COMMUNITY & CULTURE

REPORT NAME **REVIEW OF LEISURE**

1	Of the 133 recommendation 115 were found to have been actioned; however Appendix 3 details those recommendations which were still outstanding at the time of our visit with a comment as to the reason for no action having as yet been taken. One of the main reasons for a recommendation still being outstanding was the comment 'Awaiting action by Property Services' **LOW**	Leisure management to invite Property Services to monthly Leisure management meetings or alternatively to request that Property Services provide an update of progress Re outstanding Property issues in advance of this meeting	31 May 2014 31 July 2014 **31 August 2014**	Due to summer holiday period it has not been possible to find a suitable meeting time with Property Services to finalise arrangements. Meeting now scheduled for 6th August 2014.	**Delayed but rescheduled** Leisure & Youth Services Manager

SERVICE **EDUCATION**

REPORT NAME **BUSINESS CONTINUITY (Educational Establishments)**

ACTION PLAN NO:	WEAKNESSES/GOOD PRACTICE: GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE OFFICER:
1	Hermitage Academy has a current school role of 1,335. Hermitage Academy have considered relocation sites for school pupils in the event of a disruptive incident but have been unable to provide any robust plans for the relocation of pupils in the event of such an incident occurring. **HIGH**	A review will be undertaken of the Critical Activity Plan for Hermitage with clear relocation site/sites being identified.	30 June 2014 **31 March 2015**	Completed liason between Governance and Community Services, The CARP has been reviewed and will be updated by Community Services as part of the annual review process. New completion date to coincide with the annual review.	**Delayed but rescheduled** Development Officer (Community Services)

REPORT NAME **REVIEW OF ADDITIONAL SUPPORT NEEDS**

6	Community Services are in the process of developing a monitoring system that compares the ASN assistant hours allocated for each school via the bid process to the actual number of hours currently being paid. The report also details the children being given ASN and the teachers assigned to SEN. Prior to the development of this system there was no practical means by which finance were able to explain the actual costs by area as recorded to the previously agreed SEN hours. Any changes to the agreed hours should be sanctioned by the Education Management Team with the monitoring system updated accordingly. Also Finance should adopt this monitoring tool for monthly budget monitoring. **HIGH**	The new monitoring system for ASN being currently developed by Education requires to be maintained and kept up-to-date with any changes to ASN hours. This system should then provide the underlying data for budget monitoring /preparation.	30 June 2014 **31 December 2014**	Routine updates to the monitoring system are being implemented, with planned reviews as part of the agreed programme. Initial review of budget monitoring/ASN allocation commenced July 2014	**Delayed but rescheduled** QIM (Budget Holder)

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Recommendations Due After 31 July 2014

ACTION PLAN NO:	WEAKNESSES/GOOD GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE
DEPARTMENT	**COMMUNITY SERVICES**				
SERVICE	**ADULT CARE**				
REPORT NAME	**REVIEW OF CAREFIRST**				
1	Training information is not held centrally with other staff training records or being passed on to the Improvement & Organisational Development (IOD) Team for update of individual staff records. **LOW**	A more robust process for the updating of staff training records held centrally within Social Work or on the Enrolment, Training and Certification (ETC) System and Resourcelink should be implemented, to ensure all staff training is on file and accessible by management and staff on request. This will enable monitoring of when refresher training is due and if further training needs are identified these can be addressed.	30 September 2014	Feedback from IOD notes that the training module of the Resource Link 4 project is in phase 2 and this will not start until December 2015. Until then corporate implementation social work records will continue to be recorded using ETC.	**Superseded** Head of Adult Care (Chair of Training Board)
SERVICE	**EDUCATION**				
REPORT NAME	**BUSINESS CONTINUITY (Educational Establishments)**				
5	The critical activity identified for Education is in relation to SQA Exams. SQA exams are not undertaken by Primary age pupils, however, SQA is identified as the critical activity in all Primary School CARP documents **LOW**	A review of the Critical Activities for Primary Education will be undertaken and CARP documents updated appropriately.	30 September 2014 **31 March 2015**	This was a joint action with Governance, who have agreed that Education will update the CARP's at the annual review.	**Delayed but rescheduled** Development Officer (Community Services)

REPORT NAME **REVIEW OF ADDITIONAL SUPPORT NEEDS**

ACTION PLAN NO:	WEAKNESSES/GOOD GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE
1	Reporting documentation was reviewed at the 4 schools visited. Whilst all schools detailed the needs of pupils and progress made, Kirn Primary produced a number of assessments of pupils not duplicated elsewhere but in the opinion of Internal Audit added value to the system. **LOW**	An assessment should be carried out of the reports produced at Kirn Primary with a view to whether these systems should be duplicated across the region with a view to best practice.	31 October 2014 **31 December 2014**	Identification of effective practice will be a core aspect of this assessment in order to support further ASN review activity.	**Delayed but rescheduled** Quality Improvement Manager (QIM)
2	Each year during February and March head teachers are required to complete a 'Request for additional Adult Support' which outlines for each pupil the main barriers to learning and the additional support required to address those barriers with an estimation of the number of assisted hours required to address their needs. Area Principal teachers then discuss with the QIM ASN each of the school bids with a view to assessing whether the needs identified are met via the additional support needs mechanism and whether the resource requested is reasonable. Rockfield Primary school requested 723 hrs of assistants but was allocated 297 hrs **MEDIUM**	The system by which schools bid each year for ASN resource should be reviewed as to whether this is the best mechanism to allocate resource to schools based on ASN need.	30 August 2014 **31 December 2014**	Initial scope of review methodologies being agreed as at 7 July 2014. Further work to be taken forward through the work of a Review Group during August-October 2014. Findings to be utilised to shape, as appropriate, revised approaches to ASN allocations.	**Delayed but rescheduled** Quality Improvement Manager (QIM)

ACTION PLAN NO:	WEAKNESSES/GOOD GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE
3	The exercise for assessing the ASN resource requirement takes place during the months of February and March which is too late as regards the budget setting process for the following financial year and too early for the subsequent year. The timetable for carrying out the assessment should be changed with a view to coinciding with the collation of the school census data and the setting of the financial budgets for the subsequent financial year. The months of September / October period would be more effective **MEDIUM**	The timetable for carrying out this assessment should be changed to bring it in line with the budget preparation process.	30 August 2014 **31 December 2014**	Revised ASN allocation timetable being agreed to match financial/budget setting as an integral aspect of the ASN review project.	**Delayed but rescheduled** Quality Improvement Manager (QIM)
4	There is no audit trail between the number of hours bid by schools to the hours agreed by the QIM as regards explanation's as to why changes have been made. **MEDIUM**	An audit trail should be available linking the initial ASN bids from Head Teachers for assisted hours to the hours finally agreed by the QIM ASN and Area Principal Teachers showing both the original bid hours and final agreed hours but especially the reasons for the changes made.	30 August 2014 **31 December 2014**	Revised administration, recording and updating procedures to be agreed as an integral aspect of the ASN review scope.	**Delayed but rescheduled** Quality Improvement Manager (QIM)

DEPARTMENT **CUSTOMER SERVICES**

SERVICE **GOVERNANCE & LAW**

REPORT NAME **BUSINESS CONTINUITY (Educational Establishments)**

ACTION PLAN NO:	WEAKNESSES/GOOD GRADE:	AGREED ACTION:	DATES :	COMMENT/EXPLANATION:	PYRAMID: RESPONSIBLE
2	A clearly defined and documented testing programme has not yet been established in relation to Business Services)/Governance and Continuity. A table top exercise in Business Continuity has taken place with operational staff from various Services in Oban. Twenty staff from various Services took part in this exercise. The focus of the workshop was to allow discussion on how a decision by one service may impact on another service and how they may have to work together to deal with issues that may arise. There are plans to hold similar events in other areas of Argyll & Bute. **MEDIUM**	A table top exercise will be organised for Head Teachers	30 September 2014 **30 November 2014**	The next Head Teachers meeting at which this can take place is 4 November 2014, therefore the date of implementation has been changed to 30 November 2014.	**Delayed but rescheduled** Development Officer (Community Services)/Governance & Law

ARGYLL & BUTE COUNCIL
STRATEGIC FINANCE

AUDIT COMMITTEE
26 SEPTEMBER 2014

AUDIT COMMITTEE DEVELOPMENT DAY ACTION PLAN

1. SUMMARY

1.1 This report provides a progress update to in respect of the Audit Committee Development Day Action Plan for 2014/15.

2. RECOMMENDATIONS

2.1 The Audit Committee note the content of this report.

3. DETAIL

3.1 The Audit Committee at its development day agreed a number of actions which have been collated and presented in Appendix 1.

3.2 The draft action plan follows a thematic approach covering the undernoted areas;

- Assurance Mapping,
- Audit Committee Effectiveness,
- Delivering Impact.

3.3 All action points are on track and where appropriate papers are on agenda including:

- Assurance Mapping
- Audit Committee Effectiveness – CIPFA appendices

4. CONCLUSION

4.1 The action plan is currently on track.

5. IMPLICATIONS

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

For further information please contact Internal Audit (01546 604294)

Kevin Anderson
Chief Internal Auditor
27 September 2014

Appendix 1 – Audit Committee Development Day: Action Plan

No.	Issue arising	Proposed action	Lead responsibility	By (date):	Comment
Assurance mapping					
1.	Lack of clarity about sources of assurance and the respective roles of the Audit Committee and Performance Review and Scrutiny Committee	A draft outline of assurance mapping process/options will be presented to the June Audit Committee Assurance map to consider respective roles of the PRS Committee and the Audit Committee including: ▪ clarity of roles ▪ areas of overlap ▪ scope for collaboration	Grant Thornton	27 June 2014	Assurance mapping paper prepared.
Audit Committee Effectiveness					
2.	Clarity about potential gaps against new Audit Committee best practice guidance	Use CIPFA Checklist to review current performance of the Audit Committee, and areas for improvement. Scope to include: ▪ Defining success criteria for the Committee for 2014-15 ▪ How the committee considers the effectiveness of internal audit and external audit, including progress reporting.	Chair of the AC, but facilitated by CIPFA/GT partnership	Sept 2014	Discussion paper on Sept agenda
3.	Increasing the impact of the audit committee, and the understanding of the role the committee plays in the internal control framework	▪ Chair / Vice-Chair to reflect on content of the Annual Report, including PSIAS developments and risk management achievements ▪ Chair to present Annual Report to the Council meeting in November 2014	Chair of the AC	November 2014	Not due
4.	Managing the length of meetings and quality of discussion	Chair and Vice Chair to consider key papers for discussion at pre-agenda meetings, and allocate any papers that can be noted only.	Chair and Vice Chair of the AC	June 2014 and ongoing	On track

No.	Issue arising	Proposed action	Lead responsibility	By (date):	Comment
Delivering impact					
5.	Accountability / Officer ownership of actions and attendance at Audit Committee meetings	▪ BW to ensure that SMT members attend Audit Committee Meetings where required.	Head of Strategic Finance	Sept 2014	On track
6.	Ensuring that the Audit Committee can influence the scope and coverage of internal audit to meet their assurance requirements	▪ IA to prepare indicative 2015-16 annual audit plan for December audit committee meeting, to ensure that Audit Committee members have the opportunity to influence the plan ▪ IA to develop an outline scoping protocol to ensure that individual audits are focused on areas of concern to the Audit Committee	Internal audit	December 2014	On -track
7.	Improving the impact of internal audit	▪ To review the format of progress reports, to ensure that they focus on key risks ▪ To ensure that internal audit findings are clear, and risks properly articulated	Internal audit	September 2014	On-going

ARGYLL & BUTE COUNCIL **AUDIT COMMITTEE**
STRATEGIC FINANCE **26 SEPTEMBER 2014**

DEVELOPMENT OF ASSURANCE MAPPING EXERCISE

1. SUMMARY

This report describes the process that Grant Thornton and the internal audit team have adopted to map the Council's key risks, and the source and level of assurance that the Council receives on those risks, and a worked example of the approach.

This approach will be used to support the Council's developing risk appetite framework. This report therefore seeks approval for the structure adopted and any comments to improve the usefulness of the approach.

2. RECOMMENDATIONS

2.1 The Audit Committee review the structure of the assurance mapping exercise, and consider whether the approach meets the needs of the Council and Committee.

3. ASSURANCE MAPPING

3.1 There are many sources of assurance across the Council that can be used to provide evidence on the effectiveness of the management of risk and internal control. Our aim is to understand the sources of assurance and their scope so that the Audit Committee and internal audit can focus most effectively on the areas of higher risk. The assurance framework is based on a 'three lines of defence" model, as outline in Appendix 1

3.2 The draft assurance framework is attached as Appendix 2 to this report. We will use this approach to conclude on the strength of arrangements across each of the three lines of defence to make recommendations for:

- additional assurance process improvements
- areas for internal audit coverage in the 2015-16 programme of work
- reducing any areas of duplication or 'over' assurance, to ensure that resources are focused on key priorities.

3.3 Our assessment will consider the evidence that exists about the effectiveness of internal controls, testing of the data quality of performance measures and other management information used by the Council's senior management.

3.4 We will also review and document which risk each element of the internal control environment contributes assurance to, differentiating between those committees or groups that receive reports for noting, but who would query anything that seemed inconsistent – minimum assurance – and those committees/groups who actively review and challenge the information and reports they are given – maximum assurance. This will provide the Audit Committee with an overview of the sources of assurance, and any areas of duplication.

4. CONCLUSION

We have developed our approach to assurance mapping, to provide the Audit Committee with an overview of the types of assurance in place. At this stage, we would welcome a discussion about whether the approach meets the needs of the Committee, or whether additional information or assessments would be useful.

5. IMPLICATIONS

5.1	Policy:	Action plan sets out a number of areas of improvement in how Internal Audit operate.
5.2	Financial:	None
5.3	Legal:	Not a legal requirement but sets out actions to improve compliance with professional standards.
5.4	HR:	Requirement for staff training
5.5	Equalities:	None
5.6	Risk:	Will improve risk focus on Internal Audit.
5.7	Customer Service:	Sets out improvements that should lead to better customer service for internal customers.

For further information please contact Internal Audit on (01546 604759)

3 September 2014

APPENDIX 1: Three Lines of Defence Model

	Source	Nature of assurance
1st line	"Front line"/business operations	Examples include performance data, risk registers, and other management information. It provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved. This type of assurance can lack independence and objectivity, but its value is that it comes from those who know the business, culture and day-to-day challenges.
2nd line	Oversight of management activity	This is separate from day to day delivery, but is not independent of the Council's management arrangements. Typically Heads of Service and Directors will set boundaries by drafting and implementing policies and procedures, and provide oversight over business processes and risks. Oversight can include reviews of practice against policies, or self-evaluation of performance, including PSIF assessments. These roles, and management assurances, therefore provide assurance oversight for the Council and audit committee members. The nature of this assurance is management insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It is considered more objective than first line assurance.
3rd line	Independent assurance providers	This relates to independent and more objective assurance, including internal audit, work specifically designed to provide the Audit Committee with an independent and objective opinion on the framework of governance, risk management and control. Other sources of external assurance include external audit, Education Scotland and the Care Inspectorate. It is important that internal audit, external audit and other scrutiny bodies work effectively together to the maximum benefit of the Council. This assurance draws on the first and second lines of defence, but provides an independent view for the Audit Committee. It is, however, important, that in each case, the Committee understands the scope and limits of the assurance provided by each assurance provider.

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ARGYLL AND BUTE COUNCIL **AUDIT COMMITTEE**

STRATEGIC FINANCE **26 September 2014**

AUDIT COMMITTEE EFFECTIVENESS: PRACTICAL GUIDANCE

1.0 EXECUTIVE SUMMARY

1.1 This is an introduction paper for discussion in relation to CIPFA's guidance on the function and operation of audit committees in local authorities which provides a view of best practice for audit committees in local authorities throughout the UK.

1.2 The guidance incorporates CIPFA's 2013 Position Statement: Audit Committees in Local Authorities. This statement sets out CIPFA's view of the role and functions of an audit committee.

1.3 The Position Statement emphasises the importance of audit committees being in place in all local authorities. It also recognises that audit committees are a key component of governance. It states:

The purpose of an audit committee is to provide to those charged with governance1 independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and annual governance processes.

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1.4 Attention is drawn to the attached Appendices D & E which are self-assessment tools for an audit committee. Discussion requires to take place with regards to whether a) The audit committee wishes to undertake a self-assessment using these and b) The format and timeline of any such review.

1.5 Without prejudging the outcome of any self-assessment utilising appendices D & E, it may be the case that revisions will be then required to the Audit Committee Terms of reference and therefore it would be also appropriate to note detail of Appendix B.

1.6 Improving the effectiveness of the Audit Committee is a priority area as discussed at the Audit Committee away day. In order to ascertain a baseline position it would be beneficial if members could complete appendix D on an individual basis and submit their return to the Chief Internal Auditor.

2.0 Recommendations:

2.1 Discussion document only

For further information contact: Kevin Anderson, Internal Audit, 01369 708505

APPENDICES
Appendix B
Appendix D
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APPENDIX B

Suggested Terms of Reference – Local Authorities

This appendix contains suggested terms of reference for local authorities.

In developing the terms of reference for an organisation, care should be taken to ensure that the specific regulations appropriate for the authority are taken into account.

In addition, where the terms of reference refer to internal audit, regard should be had for how the internal audit charter has allocated responsibilities to the committee. Some of the internal audit responsibilities identified in the terms of reference may not be carried out by the audit committee, but by others.

SUGGESTED TERMS OF REFERENCE – LOCAL AUTHORITIES

Statement of purpose

Our audit committee is a key component of [name of authority]'s corporate governance. It provides an independent and high-level focus on the audit, assurance and reporting arrangements that underpin good governance and financial standards.

The purpose of our audit committee is to provide independent assurance to the members [or identify others charged with governance in your authority] of the adequacy of the risk management framework and the internal control environment. It provides independent review of [name of authority]'s governance, risk management and control frameworks and oversees the financial reporting and annual governance processes. It oversees internal audit and external audit, helping to ensure efficient and effective assurance arrangements are in place.

Governance, risk and control

- To review the council's corporate governance arrangements against the good governance framework and consider annual governance reports and assurances.

- To review the Annual Governance Statement prior to approval and consider whether it properly reflects the risk environment and supporting assurances, taking into account internal audit's opinion on the overall adequacy and effectiveness of the council's framework of governance, risk management and control.

- To consider the council's arrangements to secure value for money and review assurances and assessments on the effectiveness of these arrangements.

- To consider the council's framework of assurance and ensure that it adequately addresses the risks and priorities of the council.

- To monitor the effective development and operation of risk management in the council.

- To monitor progress in addressing risk-related issues reported to the committee.

- To consider reports on the effectiveness of internal controls and monitor the implementation of agreed actions.

- To review the assessment of fraud risks and potential harm to the council from fraud and corruption.

- To monitor the counter-fraud strategy, actions and resources.

Internal audit

- To approve the internal audit charter.

- To review proposals made in relation to the appointment of external providers of internal audit services and to make recommendations.

- To approve the risk-based internal audit plan, including internal audit's resource requirements, the approach to using other sources of assurance and any work required to place reliance upon those other sources.

- To approve significant interim changes to the risk-based internal audit plan and resource requirements.

- To make appropriate enquiries of both management and the head of internal audit to determine if there are any inappropriate scope or resource limitations.

- To consider reports from the head of internal audit on internal audit's performance during the year, including the performance of external providers of internal audit services. These will include:

    a) Updates on the work of internal audit including key findings, issues of concern and action in hand as a result of internal audit work.

    b) Regular reports on the results of the Quality Assurance and Improvement Programme.

    c) Reports on instances where the internal audit function does not conform to the Public Sector Internal Audit Standards and Local Government Application Note, considering whether the non-conformance is significant enough that it must be included in the Annual Governance Statement.

- To consider the head of internal audit's annual report:

    a) The statement of the level of conformance with the Public Sector Internal Audit Standards and Local Government Application Note and the results of the Quality Assurance and Improvement Programme that supports the statement – these will indicate the reliability of the conclusions of internal audit.

b) The opinion on the overall adequacy and effectiveness of the council's framework of governance, risk management and control together with the summary of the work supporting the opinion – these will assist the committee in reviewing the Annual Governance Statement.

- To consider summaries of specific internal audit reports as requested.
- To receive reports outlining the action taken where the head of internal audit has concluded that management has accepted a level of risk that may be unacceptable to the authority or there are concerns about progress with the implementation of agreed actions.
- To contribute to the Quality Assurance and Improvement Programme and in particular, to the external quality assessment of internal audit that takes place at least once every five years.
- To consider a report on the effectiveness of internal audit to support the Annual Governance Statement, where required to do so by the Accounts and Audit Regulations
- To support the development of effective communication with the head of internal audit.

External audit

- To consider the external auditor's annual letter, relevant reports, and the report to those charged with governance.
- To consider specific reports as agreed with the external auditor.
- To comment on the scope and depth of external audit work and to ensure it gives value for money.
- To commission work from internal and external audit.
- To advise and recommend on the effectiveness of relationships between external and internal audit and other inspection agencies or relevant bodies.

Financial reporting

- To review the annual statement of accounts. Specifically, to consider whether appropriate accounting policies have been followed and whether there are concerns arising from the financial statements or from the audit that need to be brought to the attention of the council.
- To consider the external auditor's report to those charged with governance on issues arising from the audit of the accounts.

Accountability arrangements

- To report to those charged with governance on the committee's findings, conclusions and recommendations concerning the adequacy and effectiveness of their governance, risk management and internal control frameworks; financial reporting arrangements, and internal and external audit functions.

- To report to full council on a regular basis on the committee's performance in relation to the terms of reference and the effectiveness of the committee in meeting its purpose.

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APPENDIX D

Self-assessment of Good Practice

This appendix provides a high-level review that incorporates the key principles set out in CIPFA's Position Statement: Audit Committees in Local Authorities and Police and this publication. Where an audit committee has a high degree of performance against the good practice principles then it is an indicator that the committee is soundly based and has in place a knowledgeable membership. These are the essential factors in developing an effective audit committee.

A regular self-assessment can be used to support the planning of the audit committee work programme and training plans. It can also inform an annual report.

	Good practice questions	Yes	Partly	No
Audit committee purpose and governance				
1	Does the authority have a dedicated audit committee?			
2	Does the audit committee report directly to full council? (Applicable to local government only.)			
3	Do the terms of reference clearly set out the purpose of the committee in accordance with CIPFA's Position Statement?			
4	Is the role and purpose of the audit committee understood and accepted across the authority?			
5	Does the audit committee provide support to the authority in meeting the requirements of good governance?			
6	Are the arrangements to hold the committee to account for its performance operating satisfactorily?			
Functions of the committee				
7	Do the committee's terms of reference explicitly address all the core areas identified in CIPFA's Position Statement?			
	• Good governance			
	• Assurance framework			
	• Internal audit			
	• External audit			
	• Financial reporting			
	• Risk management			
	• Value for money or best value			
	• Counter fraud and corruption			
8	Is an annual evaluation undertaken to assess whether the			

	committee is fulfilling its terms of reference and that adequate consideration has been given to all core areas?			
9	Has the audit committee considered the wider areas identified in CIPFA's Position Statement and whether it would be appropriate for the committee to undertake them?			
10	Where coverage of core areas has been found to be limited, are plans in place to address this?			
11	Has the committee maintained its non-advisory role by not taking on any decision-making powers that are not in line with its core purpose?			
Membership and support				
12	Has an effective audit committee structure and composition of the committee been selected? This should include:			
	• Separation from the executive			
	• An appropriate mix of knowledge and skills among the membership			
	• A size of committee that is not unwieldy			
	• Where independent members are used, that they have been appointed using an appropriate process.			
13	Does the chair of the committee have appropriate knowledge and skills?			
14	Are arrangements in place to support the committee with briefings and training?			
15	Has the membership of the committee been assessed against the core knowledge and skills framework and found to be satisfactory?			
16	Does the committee have good working relations with key people and organisations, including external audit, internal audit and the chief financial officer?			
17	Is adequate secretariat and administrative support to the committee provided?			
Effectiveness of the committee				
18	Has the committee obtained feedback on its performance from those interacting with the committee or relying on its work?			
19	Has the committee evaluated whether and how it is adding value to the organisation?			
20	Does the committee have an action plan to improve any areas of weakness?			

APPENDIX E

Evaluating the Effectiveness of the Audit Committee

Assessment key	
5	Clear evidence is available from a number of sources that the committee is actively supporting improvements across all aspects of this area. The improvements made are clearly identifiable.
4	Clear evidence from some sources that the committee is actively and effectively supporting improvement across some aspects of this area.
3	The committee has had mixed experience in supporting improvement in this area. There is some evidence that demonstrates their impact but there are also significant gaps.
2	There is some evidence that the committee has supported improvements, but the impact of this support is limited.
1	No evidence can be found that the audit committee has supported improvements in this area.

Areas where the audit committee can add value by supporting improvement	Examples of how the audit committee can add value and provide evidence of effectiveness	Self-evaluation, examples, areas of strength and weakness	Overall assessment: 5 – 1 See key above
Promoting the principles of good governance and their application to decision making	Providing robust review of the AGS and the assurances underpinning it. Working with key members/governors to improve their understanding of the AGS and their contribution to it. Supporting reviews/audits of governance arrangements. Participating in self-assessments of governance arrangements. Working with partner audit committees to review governance arrangements in partnerships.		
Contributing to the development of an effective control environment.	Monitoring the implementation of recommendations from auditors. Encouraging ownership of the internal control framework by appropriate managers. Raising significant concerns over controls with appropriate senior managers.		
Supporting the establishment of arrangements for the governance of risk and for effective arrangements to manage risks.	Reviewing risk management arrangements and their effectiveness, e.g. risk management benchmarking. Monitoring improvements. Holding risk owners to account for major/strategic risks.		
Advising on the adequacy of the assurance framework and considering whether assurance is deployed efficiently and effectively.	Specifying its assurance needs, identifying gaps or overlaps in assurance. Seeking to streamline assurance gathering and reporting. Reviewing the effectiveness of assurance providers, e.g. internal audit, risk management, external audit.		

Areas where the audit committee can add value by supporting improvement	Examples of how the audit committee can add value and provide evidence of effectiveness	Self-evaluation, examples, areas of strength and weakness	Overall assessment: 5 – 1 See key above
Supporting the quality of the internal audit activity, particularly by underpinning its organisational independence.	Reviewing the audit charter and functional reporting arrangements. Assessing the effectiveness of internal audit arrangements and supporting improvements.		
Aiding the achievement of the authority's goals and objectives through helping to ensure appropriate governance, risk, control and assurance arrangements.	Reviewing major projects and programmes to ensure that governance and assurance arrangements are in place. Reviewing the effectiveness of performance management arrangements.		
Supporting the development of robust arrangements for ensuring value for money.	Ensuring that assurance on value for money arrangements is included in the assurances received by the audit committee. Considering how performance in value for money is evaluated as part of the AGS.		
Helping the authority to implement the values of good governance, including effective arrangements for countering fraud and corruption risks.	Reviewing arrangements against the standards set out in CIPFA's *Managing the Risk of Fraud* (Red Book 2). Reviewing fraud risks and the effectiveness of the organisation's strategy to address those risks. Assessing the effectiveness of ethical governance arrangements for both staff and governors.		
Promoting effective public reporting to the authority's stakeholders and local community and measures to improve transparency and accountability.	Improving how the authority discharges its responsibilities for public reporting; for example, better targeting at the audience, plain English. Reviewing whether decision making through partnership organisations remains transparent and publicly accessible and encouraging greater transparency.		

[Enter name of Committee here – Audit, Council, Communities etc.]

[Enter date of Committee here]

2.0 RECOMMENDATIONS

3.1

3.2

5.0 CONCLUSION

5.1

5.2

6.0 IMPLICATIONS

6.1 Policy

6.2 Financial

6.3 Legal

6.4 HR

6.5 Equalities

6.6 Risk

6.7 Customer Service

For further information contact: Kevin Anderson, Internal Audit, 01369 708505

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