BROMSGROVE DISTRICT COUNCIL

MEETING OF THE AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

WEDNESDAY 22ND JULY 2020
AT 6.00 P.M.

VIRTUAL MEETING - SKYPE - VIRTUAL

MEMBERS: Councillors L. C. R. Mallett (Chairman), P. J. Whittaker (Vice-Chairman), S. J. Baxter, A. J. B. Beaumont, S. G. Hession, J. E. King, A. D. Kriss, C. J. Spencer, K. J. Van Der Plank

Mr. J. Cypher (Parish Councils' Representative)

AGENDA

1. Apologies for Absence and Named Substitutes

2. Declarations of Interest and Whipping Arrangements

   To invite Councillors to declare any Disclosable Pecuniary interests or Other Disclosable Interests they may have in items on the agenda, and to confirm the nature of those interests.

3. To confirm the accuracy of the minutes of the Audit, Standards and Governance Committee meeting held on 5th March 2020 (Pages 1 - 8)

4. Standards Regime - Monitoring Officers' Report (Pages 9 - 18)

5. Model Code of Conduct (Report to follow)

6. Regulation of Investigatory Powers Act (Pages 19 - 68)

7. Grant Thornton - Bromsgrove District Council Audit Plan Addendum - Covid 19 (Pages 69 - 74)

8. Internal Audit - Progress Report 2019/20 & 2020/21 (Pages 75 - 142)

9. Internal Audit Annual Report including Audit Opinion 2019/20 (Pages 143 - 174)

10. Financial Savings Monitoring Report for September to December 2019 (Pages 175 - 178)

11. Risk Champion - Verbal Update Report (Councillor K. Van Der Plank)

12. Audit, Standards and Governance Committee Work Programme (Pages 179 - 180)

K. DICKS
Chief Executive

Parkside
Market Street
BROMSGROVE
Worcestershire
B61 8DA

14th July 2020

If you have any queries on this Agenda please contact
Jo Gresham

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GUIDANCE ON VIRTUAL MEETINGS

Due to the current Covid-19 pandemic Bromsgrove District Council will be holding this meeting in accordance with the relevant legislative arrangements for remote meetings of a local authority. For more information please refer to the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police Crime Panels meetings) (England and Wales) Regulations 2020.

Please note that this is a public meeting conducted remotely by Skype conferencing between invited participants and live streamed for general access via the Council's YouTube channel.

You are able to access the agenda for the meeting from the Committee Pages of the website. The livestream of the meeting is available from the Committee Pages of the website or via the link below.

Audit, Standards and Governance Committee - 22nd July 2020

If you have any questions regarding the agenda or attached papers please do not hesitate to contact the officer named above.

Notes:

As referred to above, the virtual Skype meeting will be streamed live and accessible to view. Although this is a public meeting, there are circumstances when Council might have to move into closed session to consider exempt or confidential information. For agenda items that are exempt, the public are excluded and for any such items the live stream will be suspended and that part of the meeting will not be recorded.

Bromsgrove District Council
www.bromsgrove.gov.uk

INFORMATION FOR THE PUBLIC

Access to Information

The Local Government (Access to Information) Act 1985 widened the rights of press and public to attend Local Authority meetings and to see certain documents. Recently the Freedom of Information Act 2000 has further broadened these rights, and limited exemptions under the 1985 Act.

- You can attend all Council, Cabinet and Committee/Board meetings, except for any part of the meeting when the business would disclose confidential or "exempt" information.
- You can inspect agenda and public reports at least five days before the date of the meeting.
- You can inspect minutes of the Council, Cabinet and its Committees/Boards for up to six years following a meeting.
- You can have access, upon request, to the background papers on which reports are based for a period of up to six years from the date of the meeting. These are listed at the end of each report.
- An electronic register stating the names and addresses and electoral areas of all Councillors with details of the membership of all Committees etc. is available on our website.
- A reasonable number of copies of agendas and reports relating to items to be considered in public will be made available to the public attending meetings of the Council, Cabinet and its Committees/Boards.
- You have access to a list specifying those powers which the Council has delegated to its Officers indicating also the titles of the Officers concerned, as detailed in the Council's Constitution, Scheme of Delegation.

You can access the following documents:

- Meeting Agendas
- Meeting Minutes
- The Council's Constitution

at www.bromsgrove.gov.uk

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B R O M S G R O V E D I S T R I C T C O U N C I L

MEETING OF THE AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

5TH MARCH 2020, AT 6.00 P.M.

PRESENT: Councillors L. C. R. Mallett (Chairman), P. J. Whittaker (Vice-Chairman), S. J. Baxter, A. J. B. Beaumont, J. E. King, A. D. Kriss, C. J. Spencer and K. J. Van Der Plank

Observers: Mr. Jackson Murray, Mr. Neil A. Preece (Grant Thornton) and Councillor G. N. Denaro

Officers: Mr. A. Bromage, Ms. J. Pickering and Mrs. J Gresham

42/19 **APOLOGIES FOR ABSENCE AND NAMED SUBSTITUTES**

Apologies for absence were received from Parish Councillor J. Cypher. Councillor P. Whittaker arrived at 6.10pm.

43/19 **DECLARATIONS OF INTEREST AND WHIPPING ARRANGEMENTS**

There were no declarations of interest nor of any whipping arrangements.

44/19 **TO CONFIRM THE ACCURACY OF THE MINUTES OF THE AUDIT, STANDARDS AND GOVERNANCE COMMITTEE MEETING HELD ON 23RD JANUARY 2020**

The minutes of the meeting of the Audit, Standards and Governance Committee held on 23rd January 2020 were submitted.

RESOLVED that the minutes of the Audit, Standards and Governance Committee meeting held on 23rd January 2020 be approved as a correct record.

45/19 **STANDARDS REGIME - MONITORING OFFICERS' REPORT**

The Executive Director, Finance and Resources presented the report and in doing so drew Members' attention to the report, detailing that there had been a number of complaints at District level regarding the use of social media. It was stated that the Independent Member would be attending a future meeting in order to make recommendations regarding training for Members.

Both the Member Development Steering Group and the Constitution Review Working Group continued to meet regularly.

In January 2020 there was a Code of Conduct training session which was attended by both Bromsgrove and Redditch Members.

The Constitution Review Working Group continued to make constructive changes to the constitution including the timing of questions and motions for full Council.

RESOLVED that the Monitoring Officer's report, be noted.

46/19 **ANNUAL REPORT**

The Chairman presented the report to Members and explained to the Committee that it had been requested that the annual report for Audit, Standards and Governance be more detailed than in previous years. He thanked the Democratic Services Officer for producing a more substantial report.

The Chairman reiterated the thanks from the foreword in the report including the work of Risk Champion, Councillor K. Van Der Plank, in her work with Heads of Service. He also thanked officers and the internal and external auditors for all of their hard work throughout the municipal year.

RESOLVED that the draft annual report for the Audit, Standards and Governance Committee be noted and presented at Council as a final version.

7/19 **GRANT THORNTON AUDIT PLAN 2019/20**

The Chairman welcomed Mr. Jackson Murray as the new Engagement Lead for Grant Thornton. The Audit Plan 2019/20 was presented by which set out the work that Grant Thornton planned to undertake including the understanding of the organisational operations of the Council and any associated risks. It also detailed how Grant Thornton would carry out the financial statements and provide a Value for Money conclusion.

Members' attention was drawn to page 19 of the main agenda pack, which detailed the Significant Risks to the Council. These risks included the value of the pension fund liability and the valuation of land and buildings and the concept of materiality when undertaking the audit.

The Committee was informed that there were key matters that might impact on the audit including Brexit and Coronavirus. He also explained the Financial Reporting Council (FRC) was challenging audit firms to raise the bar on financial reporting which meant auditors having to undertake more work when carrying out an audit.

Members raised several questions regarding the report asking whether the increased work for auditors meant an increase in fees for the Authority. Grant Thornton drew Members' attention to page 29 of the appendix and explained that the majority of work set out in the table included any proposed variations or fee changes once the new audit recommendations are in place. Members also questioned whether the Council was meeting the requirements expected by an audit in order to keep the possibilities of fees changes to a minimum. The Committee was informed that there were difficulties in the previous year and lessons were learnt regarding information provided from the outset and therefore this year's preparation was going very well. It was clarified to Members that there would be opportunities to flag to officers if there was likely to be a budget change during the audit process and there could be a pause in the audit rather than build up additional hours at an extra cost to the Council.

Members questioned whether the systems at Bromsgrove District Council were too complicated. The Executive Director of Finance and Resources stated that there had been changes made in the team and, along with the introduction of the new Enterprise Resource Planning system, would guarantee that there was greater capacity and capability in the team. It was confirmed that the team prepared a prescribed set of accounts and that they were complicated and that hopefully the Redmond report (included in the report for agenda item 7) would provide some conclusion that the prescribed accounts were too complicated and make recommendations to make them simpler.

Members thanked Mr. Murray for providing a comprehensive report.

RESOLVED that the Audit Opinion Plan 2019/20 be noted.

48/19 **GRANT THORNTON - SECTOR REPORT AND AUDIT PROGRESS UPDATE**

The Engagement Manager, Grant Thornton presented a refreshed sector update report which was presented at the previous meeting.

Members' attention was drawn to page 42 of the main agenda pack, which detailed the information on key issues and informed Members that progress was on track. He also discussed that there had been training provided to Finance Officers in February 2020. Members asked whether there would be an opportunity for Members to receive training. The Executive Director of Finance and Resources agreed to disseminate training information to Committee Members.

RESOLVED that the Grant Thornton – Sector report and audit progress update be noted.

49/19 **GRANT THORNTON - INFORMING THE RISK ASSESSMENT**

The Committee were presented with the Grant Thornton - Informing the Risk Assessment report by the Engagement Manager, Grant Thornton. The purpose of this report was to contribute to the understanding of how the Council worked in order to carry out an effective risk assessment. This process was useful as it enabled the auditor to make rebuttals should the situation arise as they know how the Council's processes worked.

It was confirmed that the answers to the questions posed to the Council's management by Grant Thornton were as expected.

The Chairman thanked Grant Thornton and stated that this was a very useful document. Members questioned whether there was any work being done around big issues like IT fraud, for example hacking. The Committee was informed that work was carried out annually that covered this kind of issue but not by them. Members were pleased to see the information regarding Whistleblowing on page 65 of the main report. The Executive Director Finance and Resources confirmed that there was also information on the Whistleblowing process on the staff intranet and there was a strong anti-fraud culture at the Council. She also stated that there would be a refresh of the Whistleblowing policy once the current organisation-wide culture work had been completed.

RESOLVED that the Informing the Risk Assessment report be noted.

50/19 **INTERNAL AUDIT - PROGRESS REPORT**

The Head of Internal Audit Shared Service presented a monitoring report that informed the Committee of the progress of any internal audit work for 2019/20.

Members were informed that as a direct response to their request the way in which the report was presented had been amended and it was hoped that the new format provided a clearer overview and more context for the reports. The three reports that were included in the reporting were Council Tax, SLM contract management and Planning Applications and S106 funding. The recommendations and implementation dates were included in these reports which would enable the Committee to monitor the progress going forward. It was noted by the Head of Internal Audit Shared Services that there were no high risk recommendations in these reports. The Executive Director, Finance and Resources stated that there was an annual fraud report undertaken by the Council. She also resolved to investigate the historic compliance report that used to appear on the Audit, Standards and Governance Committee's work programme.

The Chairman thanked the Head of Internal Audit Shared Services and stated that all of the changes across reports and appendices were really useful and the dashboard style of them was much clearer.

RESOLVED that the Internal Audit Progress Report be noted.

51/19 **INTERNAL AUDIT - DRAFT AUDIT PLAN**

The Head of the Internal Audit Shared Service presented the Internal Audit Plan 2019/20 and in so doing noted that the draft copy of this report had been considered by Members at the previous meeting of the Committee. No material changes had been made since the previous meeting of the Committee. He did explain that there had been omissions from the draft report such as People and Recruitment as it was felt that audit resources would be better placed in other areas. This was still applicable in this version of the report.

The Committee's attention was drawn to pages 133-134 of the papers which showed what was included in the plan and the proposed resource that was necessary.

Members questioned the number of penalty points that the Dolphin Centre had received. The Executive Director, Finance and Resources resolved to look at the contract and report back to Members in respect of this matter.

There was discussion regarding the fleet repairs and whether they had been completed. The Head of the Internal Audit Shared Service undertook to ask officers and feedback to Members of the Committee.

The Chairman once again thanked the Head of Internal Audit Shared Services for the report.

RESOLVED that

a) the Internal Audit Plan be approved and that;
b) the Key Performance Indicators be approved.

52/19 **RISK CHAMPION - VERBAL UPDATE REPORT (COUNCILLOR K. VAN DER PLANK)**

Councillor K. Van der Plank provided the Committee with a verbal update, in her capacity as Risk Champion.

It was noted that Councillor K. Van der Plank had visited the Head of Planning to discuss risks at an Operational and Strategic level. Members discussed the need for some risks to be placed on the Corporate Risk Register. The Executive Director Finance and Resources undertook to take any recommendations to the Corporate Management Team (CMT) and Councillor G. Denaro resolved to take them to future Leader's meetings.

The Chairman thanked Councillor K. Van der Plank for her detailed update.

RESOLVED that the verbal update from the Risk Champion be noted.

53/19 **BUSINESS CONTINUITY (PRESENTATION)**

The Executive Director, Finance and Resources gave a presentation on the Business Continuity Plan at Bromsgrove District Council. It was agreed that this was a timely presentation given the current outbreak of COVID-19. It was explained to Members that there was a Duty Officer rota which ran 24 hours a day, 7 days a week and the Duty Officer and the second call duty officer were responsible for any issues that arose during that time. Recently there had been out of hours calls regarding heavy flooding in the district.

Members were concerned that there could be an impact from the current situation regarding Coronavirus and the Council's Business Continuity Plans might need to be triggered in respect of the implications for the external facing services at the Council such as bin collections and benefits. Officers resolved to find out the information concerning this and

assured the Members that there were discussions regarding exactly this currently being undertaken. It was also discussed that the Health and Safety Officer was ensuring that information was being signposted to staff. Officers explained that most staff had the ability to work from home if necessary and that laptops were being sourced to be provided to those that need them.

Members indicated the importance of them being kept informed by officers of what was happening in order to inform residents if they were asked.

RESOLVED that the presentation on Business Continuity, be noted.

54/19 **AUDIT, STANDARDS AND GOVERNANCE COMMITTEE WORK PROGRAMME**

Members considered the Audit, Standards and Governance Committee's Work Programme for 2019/20.

RESOLVED that the Audit, Standards and Governance Committee's Work Programme for 2019/20, be updated to include the items discussed and agreed during the course of the meeting.

The meeting closed at 7.42 p.m.

Chairman

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

22nd July 2020

MONITORING OFFICER'S REPORT

Relevant Portfolio Holder	Councillor Geoff Denaro (for Governance)
Portfolio Holder consulted	No
Relevant Head of Service	Claire Felton, Head of Legal, Equalities and Democratic Services and Monitoring Officer
Wards affected	All Wards
Ward Councillor consulted	N/A

1. SUMMARY OF PROPOSALS

1.1 This report sets out the position in relation to key standards regime matters which are of relevance to the Audit, Standards and Governance Committee since the last meeting of the Committee in March 2020.

1.2 It has been proposed that a report of this nature be presented to each meeting of the Committee to ensure that Members are kept updated with any relevant standards matters.

1.3 Any further updates arising after publication of this report, including any relevant standards issues raised by the Parish Councils' Representative(s), will be reported on orally by Officers/the Parish Representative(s) at the meeting.

2. RECOMMENDATION

That, subject to Members' comments, the report be noted.

3. KEY ISSUES

Financial Implications

3.1 There are no financial implications arising out of this report.

Legal Implications

3.2 Chapter 7 of Part 1 of the Localism Act 2011 ('the Act') places a requirement on authorities to promote and maintain high standards of conduct by Members and co-opted (with voting rights) Members of an authority. The Act also requires the authority to have in place arrangements under which allegations that either a district or parish councillor has breached his or her Code of Conduct can be investigated,

together with arrangements under which decisions on such allegations can be made.

Service / Operational Implications

Member Complaints

3.3 All of the Parish complaints have been resolved locally. There have been a number of complaints at District level, which are being managed locally.

The New Normal

3.4 Following the nation being placed in lockdown in March 2020 the way Council meetings have been held has become very different. Following new legislation Councils are now able to hold their meetings virtually, which not only ensures that the Councils' business continues but also that the public are able to participate where necessary and observe public meetings.

3.5 Democratic Services have worked closely with the IT Team to ensure that all Members were able to access the appropriate software on their Council equipment and were confident in its operation. They have also worked with other teams, such as Planning to ensure these meetings were conducted in the appropriate manner, to enable decisions to be made.

3.6 In order for these meetings to run smoothly there has been the need to make small amendments to the Council's constitution, which were agreed by all Group Leaders and agreed through the Urgent Decision process. All Urgent Decisions that have been taken are available on the Council's website to ensure transparency.

3.7 As it was appreciated that virtual meetings would need careful planning and managing officers created a Remote Meeting Protocol which detailed a number of key areas for both Members and officers to be mindful of, including the calling of meetings, access to documents, pre arrangements, the inclusion of external participants, the role of the Chairman, etiquette when attending a virtual meeting, the meeting itself and how the debate would be run, how exempt items would be dealt with and how any technical problems would be handled.

3.8 Officers held one to one sessions with Members initially to check connectivity and then a number of practice and mock meetings were held. Whilst it was appreciated that there would be a number of teething problems Officers were keen to ensure that any virtual meetings ran as

smoothly as possible and were a satisfactory experience for both those participating and those viewing the meeting.

3.9 In order to meet the requirements of the new legislation all public meetings have been live streamed to the Council's You Tube channel, with a link being provided on the Council's website to access these. This allows the public to continue to see that Council business is carrying on and that decisions are being made in an appropriate manner.

3.10 To date a number of Planning Committee meetings have taken place remotely, together with Overview and Scrutiny Board and Cabinet meetings. A meeting of the Worcestershire Regulatory Services Board, which was made up of representatives from all districts has also taken place virtually and was hosted by this Council. A meeting of full Council is scheduled to take place remotely on 5th August 2020.

Customer / Equalities and Diversity Implications

3.11 There are no direct implications arising out of this report. Details of the Council's arrangements for managing standards complaints under the Localism Act 2011 are available on the Council's website and from the Monitoring Officer on request.

4. RISK MANAGEMENT

The main risks associated with the details included in this report are:

- Risk of challenge to Council decisions; and
- Risk of complaints about elected Members.

5. APPENDICES

Appendix 1 – Remote Meeting Protocol

6. BACKGROUND PAPERS

Chapter 7 of the Localism Act 2011.

AUTHOR OF REPORT

Name: Claire Felton
Email: c.felton@bromsgroveandredditch.gov.uk

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BROMSGROVE DISTRICT COUNCIL
REMOTE MEETING PROTOCOL

Introduction
This protocol is made in line with the requirements of the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020 No.392 (the Regs) and will apply to the conduct of all Virtual Meetings of the Council and its various Committees and Sub-Committees.

Remote attendance is permitted provided certain conditions are satisfied. These include that the Councillor is able to hear and be heard by the other Councillors in attendance and be heard by any members of the public entitled to attend the meeting. A visual solution is preferred, but audio is sufficient.

This also relates to members of the public attending the meeting also being able to be heard by all those attending the meeting.

The regulations are clear that a meeting is not limited to those present in the same place, but includes electronic, digital or virtual locations (internet locations, web addresses or conference call telephone numbers).

This protocol should be read in conjunction with the wider requirements for meetings as set out in the Councils Constitution and where the specifics for a Virtual Meeting are not detailed then the normal meeting rules should be assumed unless the meeting Chairman states otherwise.

This protocol will be kept under regular review.

Skype for Business
Skype for Business is the system which has been adopted by the Council for hosting remote / virtual meetings. It has functionality for audio, video, and screen sharing and has accessibility for a member of an organisation or the public to join a meeting.

1. Calling of Virtual Meetings

1.1 All virtual meetings will be considered called when the relevant Notice of meeting and Agenda are published on the Councils website. This shall be at least five clear working days before a meeting and detail date, time and web attendance details.

1.2 Members and Officers should note that the start times of virtual meetings may differ from the usual time of a meeting, therefore all attendees are encouraged to check their agendas in advance to ensure they have the correct details.

1.3 This will be accompanied by such reports as are available and clearly set out details on how, and by when, members of the public can submit their questions and comments in advance of the meeting.

2. Access to Documents

2.1 Democratic Services will publish the agenda and reports for committee meetings on the Council's website and will notify councillors by email in line with usual practice. Paper copies of agendas will be made available to attendees to assist with participating in virtual meetings.

(Printed copies will not be available for inspection at the Council's offices and this requirement was removed by the Regulations.)

3. Pre meeting arrangements

3.1 Officers hosting virtual Council meetings will ensure that all public questions and comments received by the relevant cut off time (where meeting rules allow for these) will be published on the website and available to all Members and officers attending the meeting prior to the start of the meeting.

3.2 In respect of Planning Committee meetings the updated public speaking rules as set out in the Council's constitution will apply.

3.3 Any Member, not a member of the relevant committee, wishing to participate in the virtual meeting must submit their request by email to Democratic Services at least 24 hours in advance of the meeting taking place (for example a Member wishing to speak to Cabinet or Portfolio Holders at Overview and Scrutiny Board) in order to be provided with the relevant information to join the meeting.

3.4 For a Ward Councillor wishing to speak at Planning committee, Members should refer to the updated Planning Procedure Rules within the Council's Constitution.

3.4 All members of the committee whose meeting has been called will be sent a Skype for Business Outlook Calendar invitation by email.

3.5 The Outlook Calendar invitation will always be set as, at least 15 minutes prior the commencement of the virtual meeting start time.

4. Including external participants

4.1 All employees and Councillors have Skype for Business on their Council owned equipment (it can also be made available on personal mobile phones) linked to their email account and therefore they can join a meeting.

4.2 External participants (for example WCC Highways Officers at Planning Committee meetings) can be sent the meeting request via email and if a participant is included in this way, they can access the meeting by voice call as a guest. This needs to be controlled at the appropriate time in the meeting by the Democratic Services Officer.

4.3 Alternatively there is also provision for a conference call number and ID to be given to external people who are calling in, which is another mechanism for them to join the meeting. Again, this will be done by the Democratic Services Officer as part of the meeting administration.

5. Starting the Meeting

5.1 The Chairman will give a brief overview and introduction to the meeting, explaining how it is anticipated that the virtual meeting will be run.

5.2 At the start of the meeting, the Chairman will check all required attendees are present by asking each Member and Officer to introduce themselves and in the case of Members confirm that they have received and read the agenda and any supplementary documentation.

5.3 The Chair will ask all Councillors and Officers to **turn off all unnecessary microphones** unless they were speaking. This prevents background noise, coughing etc which is intrusive and disruptive during the meeting. The Democratic Services Officer will also keep a watch on this and will be able to turn off participant mics when they are not in use. Councillors would then need to turn their microphones back on when they wished to speak.

6. Chairman of Virtual Meetings

6.1 Subject to being available to virtually join the meeting, the Chairman of the committee whose meeting has been called shall lead the meeting and exercise their discretion to ensure that the virtual meeting is conducted, as much as reasonably practicable, in line with the requirements of this protocol.

6.2 Where the Chairman is not available the usual rules around Vice Chairman, another member, chosen by the members present shall apply.

6.3 Where the Chairman is required to interpret the Councils Constitution in light of the requirements for virtual participation hey shall take advice from the Monitoring Officer, other Legal Officer or Democratic Services Officer prior to the meeting or in virtual attendance at the meeting. The Chairman's decision will be final.

6.4 The rules of quorums for virtual meetings are the same as those applicable to non virtual meetings and as set out in the Council's constitution.

7. Etiquette When Attending a Virtual Meeting

Members and officers attending a virtual meeting should ensure:

- They must ensure that in advance of the meeting that their Council device is fully charged and operational and remains so throughout the length of the meeting.
- They should be available and logged in to any virtual meeting at least 15 minutes prior to the start to ensure equipment if working.
- They have no audible background noise when participating in the meeting
- Turn off smart speakers such as Amazon Echo (Alexa), Google Home or smart music devices. These could inadvertently record phone or video conversations, which would not be appropriate during the consideration of confidential items and can also cause interference.
- They mute their microphone when they are not speaking
- They join and stay for the duration of the meeting unless specifically asked to leave by the Chairman
- On each occasion that they speak, they clearly state their name
- They do not speak when somebody else is speaking/ interrupt anybody already speaking
- If a specific page is referred to in the agenda, ensure the page number is read out.
- The chat function is used solely for the purpose of making the Chairman/Democratic Services Officer aware that you wish speak (otherwise it is very distracting if other questions/conversations are happening within the chat simultaneous to the meeting).
- Members may also wish to think about their location during the duration of a meeting and the background which will be displayed whilst they are participating by video.
- Members also need to remember that the meeting. whilst being remote, may also be available by video to the public and is a public meeting and they should therefore behave in the same manner as they would if attending a meeting on Council premises.

- It is suggested that during formal committee meetings Members and officers also give consideration to how they are dressed.

8. The Meeting and Debate

8.1 The Chairman will go through the list of Members 'in attendance' following presentation of each item and ask each Member in turn if they have any comments or questions on that item that they would like to discuss in more detail.

8.2 Any member who has declared an interest in an item and stated that they will not be partaking in the vote, either at the start of the meeting or prior to the meeting, will not be included in the debate for that item and must remove themselves both by video and sound from the meeting (in line with standard practice when declaring any pecuniary interest).

8.3 For Members of the Committee who wish to speak in the debate, they should click on the meeting chat facility and simply write their name. The Chairman/Democratic Services Officer will then be aware you wish to speak and can take the requests in the appropriate order. Officers should also use this mechanism if they wish to speak.

8.4 When referring to reports or making specific comments, Councillors should refer to the report and page number so that all Members of the Committee and any members of the public that may be "observing" have a clear understanding of what is being discussed at all times.

8.5 If the debate appears to be coming to an end, the Chairman may ask if any other Member wishes to speak before concluding the debate.

9. Proposing / Seconding / Voting

9.1 As the Chairman takes comments from each member in attendance any member wishing to propose or second a proposal being discussed will state this clearly and officers will record this information

9.2 When the Chairman is satisfied that they have allowed sufficient debate and have a proposer and seconder for the item being discussed they will pass to the Democratic Services Officer present who will then call out the name of each Member present (in the form of a roll call). When the Member's name is called they will be required to clearly state 'for', 'against', 'abstain' to indicate their vote.

9.3 The Democratic Services Officer will then clearly state the result of the vote and the Chair will then move onto the next agenda item.

9.4 Details of how Members voted will not be kept or minuted unless a formal Recorded Vote was requested by a Member before the vote took place and the normal process for recorded votes was followed.

10. Public Participation

10.1 Officers in attendance of the meeting will, at the relevant time and upon request of the Chairman, read out, verbatim, public comments as received and published in advance of the virtual meeting.

10.2 Any public speakers at the meeting will, at the invitation of the Chairman, be given the opportunity to speak at the relevant time. The Democratic Services Officer will ensure that they are not able to speak at any other point within the meeting.

10.3 At the discretion of the Chairman any member of the public speaking, when not invited to do so or when asked by the Chairman to cease speaking may be removed from the meeting by the Chairman.

11. Confidential/Exempt Items

11.1 There are times when council meetings are not open to the public, when confidential, or "exempt" issues – as defined in Schedule 12A of the Local Government Act 1972 – are under consideration. It is important to ensure that there are no members of the public at remote locations able to hear or see the proceedings during such meetings.

11.2 If the discussion of a confidential/exempt item is required, prior to the meeting each member will be asked to record in an email. confirmation verifying that their venue is secure, that no member of the public has access and that no recording of the proceedings is being made.

11.3 At the start of the confidential item webcasting will temporarily be suspended, and any member in attendance who has not returned their verification email will be asked by the Chair to leave the meeting.

11.4 Any Councillor in remote attendance who fails to disclose that there are in fact persons present, such as those who may be able to see and/or hear the meeting, who are not entitled could be in breach of the Council's Code of Conduct.

11.5 If there are members of the public and press listening to the open part of the meeting, then the Democratic Services Officer will, at the appropriate time when the meeting goes into exempt session, remove the participant from the meeting.

11.6 It may be good practice to turn off smart speakers such as Amazon Echo (Alexa), Google Home or smart music devices. These could inadvertently record phone or video conversations, which would not be appropriate during the consideration of confidential items.

12. Leaving a Virtual Meeting

12.1 Once all business on the agenda is concluded the Chairman will close the meeting and invite all Members and officers who have joined the meeting to log out.

12.2 Members should all leave the meeting quickly and quietly.

13. Technical Issues

13.1 If a member encounters IT problems causing them to drop out of the virtual meeting they should use best endeavours to re-join as quickly as possible, eg by recalling the joining number, contacting IT services or a Democratic Services Officer.

13.2 At any point during a virtual meeting should any aspect of the IT fail, either at the Council source, for an individual Member or for a participating Member of the public, the Chairman will use their discretion and call a short adjournment of up to fifteen minutes if necessary in order for this to be rectified.

13.3 If a Members' IT equipment fails for any reason during the debate around a quaisi judicial meeting that Member would be unable to vote on that particular item. This corresponds with arrangements for a physical meeting, where a member would not be permitted to vote where they had left the meeting for any reason.

13.3 If it is not possible to address the fault and the meeting becomes inquorate through this fault, the meeting will be abandoned until such time as it can be reconvened. If the meeting is quorate, then it should continue.

13.4 Members attending remotely would be aware of the problems and accept that the meeting would continue without them, and a vote taken without their attendance.

13.5 If the meeting was due to determine an urgent matter or one which is time-limited and it has not been possible to continue because of technical difficulties, the Chief Executive, Leader and relevant Cabinet Member, in consultation with the Monitoring Officer shall explore such other means of taking the decision as may be permitted by the Council's constitution.

14. Disability

14.1 It is also important for authorities to ensure that the needs of any disabled Members and virtual participants are taken into account when considering the practicality of a remotely attended meeting.

15. Interpretation of Procedure Rules

15.1 Where the Chairman is required to interpret the Council's existing Procedure Rules in light of the requirements of remote participation, they shall take advice from the Democratic Services Officer, Legal Advisor or Monitoring Officer prior to making a ruling. However, the Chairman's decision shall be final.

16. Disorderly Conduct

16.1 In line with the Procedure Rules at Part 20 of the Councils Constitution, if a Councillor persistently disregards the ruling of the person presiding by behaving improperly or offensively or deliberately obstructs business, the person presiding may direct that the Councillor be not heard further.

16.2 If the Councillor continues to behave improperly after such a direction, the person presiding may direct that either the Councillor leaves the meeting or that the removed from the meeting or that the meeting is adjourned for a specified period.

16.3 Disorderly conduct by members of the public and Council officers will also not be tolerated. The Chairman will reserve the right to exclude such a person should they behave in an inappropriate matter.

BROMSGROVE DISTRICT COUNCIL

AUDIT, GOVERNANCE AND STANDARDS COMMITTEE

22nd July 2020

REGULATION OF INVESTIGATORY POWERS ACT 2000

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder consulted	Yes
Relevant Head of Service	Claire Felton, Head of Legal, Equalities and Democratic Services and Monitoring Officer
Wards affected	All Wards
Ward Councillor consulted	N/A
Non-Key Decision	

1. SUMMARY

1.1 The Council, along with other public bodies, has powers under the Regulation of Investigatory Powers Act 2000 ["RIPA"] to carry out covert surveillance in certain circumstances.

1.2 This report is the annual update to members on RIPA matters and any update to the Policy that has been made since the last report, to comply with the requirement set out at 3.3.

2. RECOMMENDATIONS

The Committee is asked to RESOLVE that

2.1 the Council's RIPA Policy as reviewed, be endorsed; and

2.2 the update on RIPA activity be noted, described in this report.

NOTE Members are requested to read and review the Council's policy electronically. There will be a hard copy available on the evening of the committee meeting and beforehand in the Members' room.

3. KEY ISSUES

Financial Implications

3.1 The Policy is lengthy and costly to print, so a small number of printed copies will be made available in the Members' Room.

Legal Implications

3.2 The Regulation of Investigatory Powers Act 2000 ["RIPA"] gave local authorities powers to conduct covert surveillance under certain circumstances. The Act also regulates the use 'Covert Human Intelligence Sources' ["CHIS"] and obtaining certain Communications Data.

3.3 The revised Code of Practice for Covert Surveillance and Property Interference 2018 (paragraph 4.47) advised that elected members should at least on an annual basis review the RIPA policy and the authority's use of the Act. This report is published in compliance with that requirement and also to draw attention to the updating of the Policy.

3.4 Local Authority powers are at the lower end of the scale and changes in legislation since the Act was originally introduced, have resulted in further restrictions on their use:

- the use of surveillance was restricted to criminal investigations and in 2012;
- the Protection of Freedoms Act 2012 introduced a requirement for local authorities to obtain approval from the Magistrates Court for any proposed surveillance activity;
- A threshold for the level of crime being investigated was raised to include only 'serious crime' (as defined).

3.5 The regime is overseen by the Investigatory Powers Commissioner's Office, and includes inspections of organisations by an Inspector appointed by the Commissioner, usually about every three years.

3.6 Any organisation which had investigatory powers under RIPA is required to have in place a Policy governing all aspects of the regime, including the need for updating and officer training, regardless of whether the powers are exercised. The Council's Policy is regularly updated to comply with any changes in the legislation, guidance and codes of practice which apply to the regime. Changes are notified to the Council by an external trainer and RIPA expert, who also provides training and advice on RIPA issues.

Service / Operational Implications

3.7 From the outset, the Council's use of RIPA powers was always low. There are a number of reasons for this: A rigid process has to be followed to establish that a proposed surveillance activity is both "necessary" and "proportionate"; a senior officer has to evaluate the proposal against a number of criteria and would now have to be referred to the Magistrates Court to be confirmed. Then there would have been major resource implications for any authorised surveillance to have been undertaken.

3.8 Since the changes introduced in 2012 as described in 3.3 above, the Council has not exercised its powers under RIPA at all. The Surveillance Commissioner has noted that in recent years authorities like ours have granted far fewer RIPA authorisations and some have granted none at all in the last three years. The reasons include the legislative changes and also reduced resources, greater access to data-matching and overt, rather than covert law enforcement.

3.9 At the time of the Council's last physical inspection, in 2015, RIPA powers had not been exercised by the Council since 2012. In 2018, a further three years on, during which no RIPA activity had been undertaken, the Surveillance Commissioner conducted a remote, light-touch review.

3.10 One of the points of feedback provided by the Commissioner in 2018 was a reminder of the importance of regular, ongoing internal oversight of the actual or potential use of these powers, which should be managed through your Senior Responsible Officer. The Inspector advised that officers need to maintain their levels of training lest, however remote a possibility it may appear, the powers need to be used. The Senior Responsible Officer [SRO] is Jayne Pickering, Director of Finance and Resources, who holds a meeting every six months to review any RIPA issues, consider any training or other issues relating to RIPA. These meetings used to take place quarterly, but due to the lack of RIPA activity, the SRO decided that twice a year would be sufficient. The Inspector has been advised of this and has not raised a concern.

3.11 It is not possible for the Council to 'opt out' of the RIPA regime, which means that although we have not used these powers for years, we are still required by the Commissioner to keep our officers briefed on it, aware of its potential use and crucially, trained in the completion of applications and their approval.

3.12 The Council is a member of the National Anti-Fraud Network [NAFN], which is hosted by Thameside MBC and which provides data and intelligence services under the RIPA regime to public sector organisations in relation to fraud investigations. Over 90% of local authorities are members of NAFN. Membership enables the Council to avail of its expertise, without having to have our own staff for the purpose.

3.13 Members' attention is drawn to the recent amendment to the Policy since last year's report, the inclusion of a section on 'Obtaining Communications Data'.

Customer / Equalities and Diversity Implications

3.14 There are no direct implications arising out of this report, providing information to elected members and seeking their approval of the Council's RIPA policies and procedures.

4. RISK MANAGEMENT

The Council is required to comply with the statutory provisions and guidance governing the RIPA regime and any recommendation made by the Inspector on behalf of the Commissioner.

Officers need to be aware of the RIPA powers so that there is no risk of surveillance or CHIS activity being undertaken without he correct approvals being in place.

5. APPENDICES

The Council's RIPA Policy

6. BACKGROUND PAPERS

None

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Bromsgrove District Council and Redditch Borough Council

Regulation of Investigatory Powers Act 2000

Policy

Version 7.3

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Document Control

Organisation	Bromsgrove District Council and Redditch Borough Council
Owner	Principal Solicitor
Protective Marking	Unclassified

Revision History

Revision Date	Revised By	Version	Description of Revision
Jan 2013	Sarah Sellers		Not recorded.
30/8/2013	Clare Flanagan	August 2013	• Document history page added. • References to 'urgent oral authority' removed. • Appendix 5 (about accessing Comms data) removed, now unnecessary.
1/9/2013	Clare Flanagan	August 2013	Update to Appendix 2 to remove all 'grounds for use' except prevention of crime.
28/8/2015	Nicola Brothwell	V4.0	Version numbering introduced. Removal of mention of staff who have left the Council.
19/1/2016	Nicola Brothwell	V5.0	Minor updates to list of Authorising Officers. OSC guidance on use of social media added.
18/5/2016	Nicola Brothwell	V6.0	Chris Phillips has now left the council, so his name is removed from the policy.

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Revision Date	Revised By	Version	Description of Revision
10/04/2017	Sarah Sellers	V7.0	Amalgamated polices of both BDC and RBC into one policy. Updated advice on use of social media and use of non-RIPA surveillance.
11/01/2019	Nicola Brothwell	V7.1	Change authorisation period for juvenile CHIS from 1 to 4 months. IPCO has taken over from IOCCO and OSC, so all references updated.
4/02/2019	Nicola Brothwell	V7.2	Liz Tompkin removed as an Authorising Officer.
16/6/2020	Nicola Brothwell	V7.3	Addition of section ‘Obtaining Communications Data

Contents

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Introduction

The purpose of this policy is to explain the scope of Regulation of Investigatory Powers Act 2000 and the circumstances where it applies to the Council. It provides guidance on the authorisation procedures to be followed in the event that you need to undertake surveillance, setting it into context so that its importance may be appreciated.

The subject covered by this policy is complicated but of major importance. If, having read this document, you are unclear about any aspect of the process, or you have questions which are not answered explicitly by the content of this document, these should be referred either to one of the Authorising Officers or to the Head of Legal and Democratic Services for assistance.

If, having taken advice, doubt exists as to whether the circumstances require an authorisation for consideration under this legislation, you should submit an application form to be authorised. This will demonstrate to any examining body that Bromsgrove District Council / Redditch Borough Council have taken their responsibilities seriously with regards to the protection of a person's privacy against the need for the activity to take place in operational terms. If you do not secure an authorisation it leaves any evidence gathered open to challenge under section 78 of the Police and Criminal Evidence Act 1984 (PACE,) as amended, as well as challenges for breach of privacy against the Council.

To assist with oversight of the Council's RIPA processes Jayne Pickering (Executive Director of Finance and Corporate Resources) has been appointed as the Senior Responsible Officer who will be responsible for the integrity of the process. However it must be stressed that all staff involved in the process must take their responsibilities seriously. This will assist with the integrity of the Council processes and procedures.

On advice from the OSC (now superseded by the IPCO), and to reflect the operation of shared services across the two organisations, the separate RIPA policies for Bromsgrove District Council (BDC) and Redditch Borough Council (RBC) have been merged into one single policy. References made to "the Council" should be read as references to either BDC or RBC as the context requires.

Claire Felton

Head of Legal and Democratic Services

Bromsgrove District Council and Redditch Borough Council

Updated: March 2017

What are the origins of RIPA?

The Human Rights Act 1998 brought into UK law many of the provisions of the 1950 European Convention on Human Rights and Fundamental Freedoms. Article 8 requires the Council to have respect for people's private and family lives, their homes, and their correspondence. These subjects can be referred to as "Article 8 rights".

The Human Rights Act makes it unlawful for any local authority to act in a way which is incompatible with the European Convention on Human Rights. However, these are not absolute rights and there is a specific qualification giving the Council the ability to interfere with a person's Article 8 rights to the effect that:-

Such interference is in accordance with the law if:

- is **necessary**
- and is **proportionate**

These three points are clarified further in the next paragraphs.

When we talk of interference being "in accordance with the law", this means that any such interference is undertaken in accordance with the mechanism set down by the Regulation of Investigatory Powers Act (RIPA for short) and the Home Office Covert Surveillance Codes of Practice. The Codes of Practice deals with the use of Covert Surveillance and the use of persons such as informants and Undercover Officers who gather information in a covert capacity (Covert Human Intelligence Source or CHIS for short – refer to Page 14).

However a considerable amount of observations are carried out in an overt capacity by Council employees carrying out their normal functions such as parking enforcement, general patrolling etc. These activities are general and routine and do not involve the systematic surveillance of an individual. RIPA is not designed to prevent these activities or regulate them.

RIPA also applies to the Accessing of Communications Data under Part 1, Chapter 2 of the legislation. The Council has produced separate guidance dealing with the accessing of communications data under the SPOC (Single Point of Contact) provisions.

The Council has numerous statutory duties and powers to investigate the activities of private individuals and organisations within its jurisdiction for the benefit and protection of the greater public. Some of these investigations may require surveillance or the use of a CHIS. These may include

- benefit fraud
- environmental health
- housing

— planning

— criminal investigations by audit such as fraud offences

RIPA aims to provide a framework to control and supervise covert activities such as surveillance and the use of a CHIS in these criminal investigations. It aims to balance the need to protect the privacy of individuals against the need to protect others by the Council carrying out its enforcement functions. There are two separate codes of practice, Covert Surveillance and CHIS.

Any covert activity carried out under this legislation must meet the test of necessity and proportionality. These are dealt with on page 25 of this policy.

When does RIPA apply and who does it apply to?

RIPA applies to Public Authorities such as Local Authorities and permits them to conduct Covert Surveillance activities and use Covert Human Intelligence Sources (CHIS) such as informants and undercover officers (see pages 12 and 14) However, on 1 November 2012 two significant changes came into force that affect how local authorities use RIPA.

- **Approval of Local Authority Authorisations under RIPA by a Justice of the Peace**: The amendments in the Protection of Freedoms Act 2012 mean that local authority authorisations under RIPA for the use of Directed Surveillance or use of Covert Human Intelligence sources (CHIS) can only be given effect once an order approving the authorisation has been granted by a Justice of the Peace (JP). **This applies to applications and renewals only, not reviews and cancellations.**

- **Directed surveillance crime threshold**: Amendments to the Regulation of Investigatory Powers (Directed Surveillance and Covert Human Intelligence Sources) Order 2010 ("the 2010 Order") mean that a local authority can now only grant an authorisation under RIPA for the use of **Directed Surveillance** where the local authority is investigating criminal offences which attract a maximum custodial sentence of six months or more or criminal offences relating to the underage sale of alcohol or tobacco under sections 146, 147 or 147A of the Licensing Act 2003 or section 7 of the Children and Young Persons Act 1933.

The crime threshold, as mentioned is only for Directed Surveillance.

The only lawful reason for Local Authorities to conduct activity under RIPA is **prevention and detection of crime** in respect of its Core Functions. As from 1 November 2012 there is no provision for a Local Authority to use RIPA to conduct covert activities for disorder such as anti-social behaviour unless there are criminal offences involved which attract a maximum custodial sentence of six months.

As a local authority Bromsgrove District Council and Redditch Borough Council and its staff have a responsibility to adhere to the RIPA legislation and the Human Rights Act.

In addition to applying to all staff employed by the two Councils who are engaged in activities that involve the protection and detection of crime, the policy will also apply to the following categories of staff:

- Contract or agency staff working at Bromsgrove District Council / Redditch Borough Council undertaking such activity as is covered by the RIPA and associated legislation and guidance.

- From 01 June 2010 all staff who are employed by Bromsgrove District Council as part of the Worcestershire Regulatory Services.

- All staff employed by Redditch Borough Council but whose duties include performing services for Bromsgrove District Council under any secondment arrangements or under section 113 of the Local Government Act 1972.

- All staff employed by Bromsgrove District Council but whose duties include performing services for Redditch Borough Council under any secondment arrangements or under section 113 of the Local Government Act 1972.

European Convention on Human Rights

The RIPA Codes of Practice state where there is an interference by a public authority with the right to respect for private and family life guaranteed under Article 8 of the European Convention on Human Rights, and where there is no other source of lawful authority, the consequence of not obtaining an authorisation under the 2000 Act may be that the action is unlawful by virtue of section 6 of the Human Rights Act 1998.

Public authorities are therefore strongly recommended to seek an authorisation under RIPA where the surveillance is likely to interfere with a person's Article 8 rights to privacy by obtaining private information about that person, whether or not that person is the subject of the investigation or operation. Obtaining an authorisation will ensure that the action is carried out in accordance with law and subject to stringent safeguards against abuse.

Definition of core functions

Recent case law has established that a public authority may only use the powers under the 2000 Act when in performance of its core functions. These are defined by section 28(3) of the 2000 Act. It has been held that disciplinary investigations are ordinary functions whereas the investigation of benefit fraud would be a core function. Using the RIPA application and monitoring process when exercising core functions assists with protecting the Council from challenges under section 78 of PACE. However, surveillance in the case of serious disciplinary issue would be outside of RIPA. Any type of surveillance outside of RIPA should still meet the same tests of necessity and proportionality and advice should be sought from Legal Services prior to any such surveillance taking place.

Private information

Private information includes any information relating to a person's private or family life. Private information should be taken generally to include any aspect of a person's private or personal relationship with others, including family and professional or business relationships.

Whilst a person may have a reduced expectation of privacy when in a public place, covert surveillance of that person's activities in public may still result in the obtaining of *private information*. This is likely to be the case where that person has a reasonable expectation of privacy even though acting in public and where a record is being made by a *public authority* of that person's activities for future consideration or analysis.

Private life considerations are particularly likely to arise if several records are to be analysed together in order to establish, for example, a pattern of behaviour, or if one or more pieces of information (whether or not available in the public domain) are covertly (or in some cases overtly) obtained for the purpose of making a permanent record about a person or for subsequent data processing to generate further information. In such circumstances, the totality of information gleaned may constitute *private information* even if individual records do not. Where such conduct includes surveillance, a directed surveillance authorisation may be considered appropriate.

If you need to conduct surveillance or use a CHIS as part of investigating a criminal matter which might result in court proceedings or proceedings before some other form of tribunal, you should consider whether private information is likely to be gained as a result of the activities and whether RIPA applies.

What happens if RIPA is ignored?

If Investigators undertake covert activity to which this legislation applies without the relevant authority being obtained and the case progresses to criminal proceedings, the defence may challenge the validity of the way in which the evidence was obtained under Section 78 of PACE. Should the evidence then be disallowed by a court, the prosecution case may be lost with a financial cost to the Council.

The person who was the subject of your surveillance may complain to the Ombudsman who may order the Council to pay compensation. The activity may also be challenged through the civil courts under the Human Rights Act 2000 for breach of privacy.

There is also a requirement to report errors to the Investigatory Powers Commissioner's Office or IPCO (formerly the OSC), such as surveillance activity which should have been authorised but which was carried out outside of RIPA. (See section on errors)

A properly obtained and implemented authorisation under RIPA will provide the Council with lawful authority to interfere with the rights of the individual. It is not simply enough that an authorisation for surveillance is obtained. It must be properly obtained, implemented, managed, reviewed and cancelled.

Surveillance outside of RIPA

As explained earlier there may be a necessity for the Council to undertake surveillance which does not meet the criteria to use the RIPA legislation such as in cases of serious disciplinary investigations. The Council still must meet its obligations under the Human Rights Act and therefore any surveillance outside of RIPA must still be necessary and proportionate having taken account of the intrusion issues. The decision making process and the management of such surveillance must be well documented.

There is a requirement for the Councils' Senior Responsible Officer (SRO) to regularly monitor surveillance outside of RIPA. Therefore before any such surveillance takes place, advice must be sought from the Head of Legal Services or the Principal Solicitor.

What is surveillance?

Surveillance

Surveillance is defined in paragraph 1.9 of the Revised Codes of Practice as:

Surveillance, for the purpose of the 2000 Act, includes monitoring, observing or listening to persons, their movements, conversations or other activities and communications. It may be conducted with or without the assistance of a surveillance device and includes the recording of any information obtained.

Covert surveillance

Covert Surveillance is defined in paragraph 1.10 of the Revised Codes of Practice as:

Surveillance is covert if, and only if, it is carried out in a manner calculated to ensure that any persons who are subject to the surveillance are unaware that it is or may be taking place.

If activities are open and not hidden from the persons subject to surveillance, such as Officers conducting Council business openly, e.g. a market inspector walking through markets, the RIPA framework does not apply because that is "Overt Surveillance". Equally, if you tell the subject that surveillance may take place, the surveillance is overt.

RIPA does not regulate Overt Surveillance. However, remember the Council's responsibilities to ensure that whatever action is taken is compliant with the Human Rights Act and is a necessary and proportionate response to the issue being dealt with.

RIPA regulates two types of Covert Surveillance which are

- **Directed Surveillance**
- **Intrusive Surveillance**

Directed surveillance

Directed Surveillance is defined in paragraph 2.2. of the Revised Codes of Practice as:

Surveillance is directed surveillance if the following are all true:

- it is covert, but not intrusive surveillance;
- it is conducted for the purposes of a specific investigation or operation;
- it is likely to result in the obtaining of private information about a person (whether or not one specifically identified for the purposes of the investigation or operation);
- it is conducted otherwise than by way of an immediate response to events or circumstances the nature of which is such that it would not be reasonably practicable for an authorisation under Part II of the 2000 Act to be sought.

Thus, the planned covert surveillance of a specific person, where not intrusive, would constitute directed surveillance if such surveillance is likely to result in the obtaining of private information about that, or any other person.

Immediate response to events

There may be occasions when officers come across events unfolding which were not pre-planned which then require them to carry out some form of observation. This will not amount to Directed Surveillance. However it will amount to surveillance outside of RIPA and must still be necessary and proportionate and take account of the intrusion issues. As there is no provision to obtain an urgent oral authorisation it is important that officers do not abuse the process and they must be prepared to explain their decisions in court should it be necessary. Therefore they should document their decisions, what took place and what evidence or information was obtained.

Recording of telephone conversations

The recording of telephone conversations connected to criminal investigations (outside of the Councils monitoring at work policy with its own equipment) falls under RIPA which provides that where one party to the communication consents to the interception, it may be authorised in accordance with section 48(4) of the 2000 Act. In such cases, the interception is treated as directed surveillance.

There may be occasions where this is required such as a witness who has text or voicemail evidence on their mobile telephone and we need to examine the phone.

Intrusive surveillance:

Intrusive surveillance is defined in section 26(3) of the 2000 Act as covert surveillance that:

- is carried out in relation to anything taking place on any residential premises or in any private vehicle; and

- involves the presence of an individual on the premises or in the vehicle or is carried out by means of a surveillance device.

Local authorities are not permitted to carry out Intrusive Surveillance.

Where surveillance is carried out in relation to anything taking place on any residential premises or in any private vehicle by means of a device, without that device being present on the premises, or in the vehicle, it is not intrusive unless the device consistently provides information of the same quality and detail as might be expected to be obtained from a device actually present on the premises or in the vehicle. Thus, an observation post outside premises, which provides a limited view and no sound of what is happening inside the premises, would not be considered as intrusive surveillance.

A risk assessment should be carried out of the capability of equipment being used when filming residential premises and private vehicles to ensure that the activity does not meet the criteria of Intrusive Surveillance.

Commercial premises and vehicles

Commercial premises and vehicles are therefore excluded from the definition of intrusive surveillance. However they are dealt with under the heading of Property Interference contained within the Police Act 1997.

Bromsgrove District Council/ Redditch Borough Council has no authority in law to carry out Intrusive Surveillance or activity under the Police Act 1997.

Covert Human Intelligence Source (CHIS)

A CHIS could be an informant or an undercover officer carrying out covert enquiries on behalf of the council. However the provisions of the 2000 Act are not intended to apply in circumstances where members of the public volunteer information to the Council as part of their normal civic duties, or to contact numbers set up to receive information such as the Benefit Fraud Hot Line. Members of the public acting in this way would not generally be regarded as sources unless they repeatedly provide information about particular issues, which is covered later in this section of the policy.

Under section 26(8) of the 2000 Act a person is a source if:

— he establishes or maintains a personal or other relationship with a person for the covert purpose of facilitating the doing of anything falling within paragraph (b) or (c);

— he covertly uses such a relationship to obtain information or to provide access to any information to another person; or

— he covertly discloses information obtained by the use of such a relationship or as a consequence of the existence of such a relationship.

By virtue of section 26(9)(b) of the 2000 Act a purpose is covert, in relation to the establishment or maintenance of a personal or other relationship, if and only if, the relationship is conducted in a manner that is calculated to ensure that one of the parties to the relationship is unaware of the purpose.

By virtue of section 26(9)(c) of the 2000 Act a relationship is used covertly, and information obtained as above is disclosed covertly, if and only if it is used or, as the case may be, disclosed in a manner that is calculated to ensure that one of the parties to the relationship is unaware of the use or disclosure in question.

Conduct and use of a source

The **use of a** source involves inducing, asking or assisting a person to engage in the conduct of a source or to obtain information by means of the conduct of such a source.

The **conduct of a source** is any conduct falling within section 29(4) of the 2000 Act, or which is incidental to anything falling within section 29(4) of the 2000 Act.

The **use of a source** is what the Authority does in connection with the source and the **conduct** is what a source does to fulfill whatever tasks are given to them or which is incidental to it. **The Use and Conduct require separate consideration before authorisation.**

When completing applications for the use of a CHIS you are stating who the CHIS is, what they can do and for which purpose.

When determining whether a CHIS authorisation is required, consideration should be given to the covert relationship between the parties and the purposes mentioned in a, b, and c above.

Management of sources

Within the provisions there has to be;

(a) a person who has the day to day responsibility for dealing with the source and for the source's security and welfare **(Handler)**

(b) at all times there will be another person who will have general oversight of the use made of the source **(Controller)**

At all times there will also be a person who will have responsibility for maintaining a record of the use made of the source.

The **Handler** will have day to day responsibility for:

- dealing with the source on behalf of the authority concerned;
- directing the day to day activities of the source;
- recording the information supplied by the source; and

- monitoring the source's security and welfare;

The Controller will be responsible for the general oversight of the use of the source.

Tasking

Tasking is the assignment of activity to the source by the Handler or Controller by, asking him to obtain information, to provide access to information or to otherwise act, incidentally, for the benefit of the relevant public authority. Authorisation for the use or conduct of a source is required prior to any tasking where such tasking requires the source to establish or maintain a personal or other relationship for a covert purpose.

In some instances, tasking will not require the source to establish a personal or other relationship for a covert purpose. For example a source may be tasked with finding out purely factual information about the layout of commercial premises. Alternatively, a Council Officer may be involved in the test purchase of items which have been labelled misleadingly or are unfit for consumption. In such cases, it is for the Council to determine where, and in what circumstances, such activity may require authorisation.

Should a CHIS authority be required, all of the staff involved in the process should make themselves fully aware of the contents of the CHIS codes of Practice.

Management responsibility

Bromsgrove District Council/ Redditch Borough Council will ensure that arrangements are in place for the proper oversight and management of sources including appointing a Handler and Controller for each source prior to a CHIS authorisation.

The Handler of the source will usually be of a rank or position below that of the Authorising Officer.

It is envisaged that the use of a CHIS will be infrequent. Should a CHIS application be necessary, the CHIS Codes of Practice should be consulted by those considering the use of such tactics to ensure that the Council can meet its management responsibilities under the Code.

Security and welfare

The Council has a responsibility for the safety and welfare of the source and for the consequences to others of any tasks given to the source. Before authorising the use or conduct of a source, the Authorising Officer should ensure that a risk assessment is carried out to determine the risk to the source of any tasking and the likely consequences should the role of the source become known. The ongoing security and welfare of the source, after the cancellation of the authorisation, should also be considered at the outset.

Persons who repeatedly provide information

It is possible that members of the public repeatedly supply information to Council staff on either one particular subject or investigation or a number of investigations. It is important that Council staff make the necessary enquiries with the person reporting the information to ascertain how the information is being obtained. This will not only assist with evaluating the information but will determine if the person is establishing or maintaining a relationship with a third person to obtain the information, and then provide it to the Council staff. If this is the case, the person is likely to be acting as a CHIS and there is a potential duty of care to the individual which treating them as a duly authorised CHIS would take account of. Therefore Council staff should ensure that they are aware of when a person is potentially a CHIS by reading the below sections. If further advice is required contact the RIPA Coordinating Officer.

Record management for CHIS

Proper records must be kept of the authorisation and use of a source. The particulars to be contained within the records are;

a. the identity of the source;

b. the identity, where known, used by the source;

c. any relevant investigating authority other than the authority maintaining the records;

d. the means by which the source is referred to within each relevant investigating authority;

e. any other significant information connected with the security and welfare of the source;

f. any confirmation made by a person granting or renewing an authorisation for the conduct or use of a source that the information in paragraph (d) has been considered and that any identified risks to the security and welfare of the source have where appropriate been properly explained to and understood by the source;

g. the date when, and the circumstances in which, the source was recruited;

h. the identities of the persons who, in relation to the source, are discharging or have discharged the functions mentioned in section 29(5)(a) to (c) of the 2000 Act or in any order made by the Secretary of State under section 29(2)(c);

i. the periods during which those persons have discharged those responsibilities;

j. the tasks given to the source and the demands made of him in relation to his activities as a source;

k. all contacts or communications between the source and a person acting on behalf of any relevant investigating authority;

l. the information obtained by each relevant investigating authority by the conduct or use of the source;

m. any dissemination by that authority of information obtained in that way; and

n. in the case of a source who is not an undercover operative, every payment, benefit or reward and every offer of a payment, benefit or reward that is made or provided by or on behalf of any relevant investigating authority in respect of the source's activities for the benefit of that or any other relevant investigating authority.

Please refer to the section headed “Documentation and Central Record” (page 31) for further information regarding the holding of records relating to CHIS sources/ authorisations by the Information Management Team.

RIPA application and authorisation process

As mentioned earlier, on 1 November 2012 two significant changes came into force that effects how local authorities use RIPA.

- **Approval of Local Authority Authorisations under RIPA by a Justice of the Peace**: The amendments in the Protection of Freedoms Act 2012 mean that local authority authorisations under RIPA for the use of Directed Surveillance or use of Covert Human Intelligence sources (CHIS) can only be given effect once an order approving the authorisation has been granted by a Justice of the Peace (JP). **This applies to applications and renewals only, not reviews and cancellations.**

- **Directed surveillance crime threshold**: Amendments to the Regulation of Investigatory Powers (Directed Surveillance and Covert Human Intelligence Sources) Order 2010 (“the 2010 Order”) mean that a local authority can now only grant an authorisation under RIPA for the use of Directed Surveillance where the local authority is investigating criminal offences which attract a maximum custodial sentence of six months or more or criminal offences relating to the underage sale of alcohol or tobacco under sections 146, 147 or 147A of the Licensing Act 2003 or section 7 of the Children and Young Persons Act 1933.

This crime threshold, as mentioned, is only for Directed Surveillance.

Application, review, renewal and cancellation forms

No covert activity covered by RIPA or the use of a CHIS should be undertaken at any time unless it meets the legal criteria (see above) and has been authorised by an Authorising Officer and approved by a JP/Magistrate as mentioned above. The activity conducted must be in strict accordance with the terms of the authorisation.

The effect of the above legislation means that all applications and renewals for covert RIPA activity will have to have a JP’s approval. It does not apply to Reviews and Cancellations which will still be carried out internally.

The procedure is as follows:-

All applications and renewals for Directed Surveillance and use of a CHIS will be required to have a JP's approval.

The applicant will complete the relevant application form ensuring compliance with the statutory provisions shown above. The application form will be submitted to an Authorising Officer for consideration. If authorised, the applicant will also complete the required section of the judicial application/order form (See Appendix 6). Although this form requires the applicant to provide a brief summary of the circumstances of the case on the judicial application form, this is supplementary to and does not replace the need to supply the original RIPA authorisation as well.

It will then be necessary within Office hours to arrange with Her Majesty's Courts & Tribunals Service (HMCTS) administration at the magistrates' court to arrange a hearing. The hearing will be in private and heard by a single JP.

Details of how to contact the local Courts for out of hours applications will be circulated to managers to be passed on to staff when required.

Officers who may present the application at these proceedings will need to be formally designated by the Council under section 223 of the Local Government Act 1972 to appear, be sworn in and present evidence or provide information as required by the JP. The list of officers currently authorised can be found on the RIPA page of Orb. For further authorisations please contact the RIPA Coordinating Officer.

Upon attending the hearing, the officer must present to the JP the partially completed judicial application/order form, a copy of the RIPA authorisation form, together with any supporting documents setting out the case, and the original authorisation form.

The original RIPA authorisation should be shown to the JP but will be retained by the local authority so that it is available for inspection by the Commissioners' offices and in the event of any legal challenge or investigations by the Investigatory Powers Tribunal (IPT).

The JP will read and consider the RIPA authorisation and the judicial application/order form. They may have questions to clarify points or require additional reassurance on particular matters. These questions are supplementary to the content of the application form**. However the forms and supporting papers must by themselves make the case. It is not sufficient for the local authority to provide oral evidence where this is not reflected or supported in the papers provided**.

The JP will consider whether he or she is satisfied that at the time the authorisation was granted or renewed, there were reasonable grounds for believing that the authorisation was necessary and proportionate. They will also consider whether there continues to be reasonable grounds. In addition they must be satisfied that the person who granted the authorisation or gave the notice was an appropriate designated person within the local authority and the

authorisation was made in accordance with any applicable legal restrictions, for example that the crime threshold for directed surveillance has been met.

The JP may decide to:

- Approve the Grant or renewal of an authorisation
- Refuse to approve the grant or renewal of an authorisation
- Refuse to approve the grant or renewal and quash the authorisation

Approve the Grant or renewal of an authorisation

The grant or renewal of the RIPA authorisation will then take effect and the local authority may proceed to use the surveillance requested.

Refuse to approve the grant or renewal of an authorisation

The RIPA authorisation will not take effect and the local authority may **not** use the surveillance requested in that case.

Where an application has been refused the applicant may wish to consider the reasons for that refusal. If more information was required by the JP to determine whether the authorisation has met the tests, and this is the reason for refusal the officer should consider whether they can reapply, for example, if there was information to support the application which was available to the local authority, but not included in the papers provided at the hearing.

For, a technical error, the form may be remedied without going through the internal authorisation process again. The officer may then wish to reapply for judicial approval once those steps have been taken.

Refuse to approve the grant or renewal and quash the authorisation

This applies where the JP refuses to approve the authorisation or renew the authorisation and decides to quash the original authorisation. However the court must not exercise its power to quash the authorisation unless the applicant has had at least 2 business days from the date of the refusal in which to make representations. If this is the case the officer will inform the Legal team who will consider whether to make any representations.

Whatever the decision the JP will record their decision on the order section of the judicial application/order form. The court administration will retain a copy of the local authority RIPA authorisation form and the judicial application/order form. The officer will retain the original authorisation and a copy of the judicial application/order form.

If approved by the JP, the date of the approval becomes the commencement date and the three months duration will commence on this date. The officers are now allowed to undertake the activity.

The original RIPA authorisation form and the copy of the judicial application/order form should be forwarded to the Central Register and a copy retained by the applicant and by the AO. This will enable the AO to check what was authorised and monitor any reviews and cancellation to determine if any errors occurred and if the objectives were met.

There is no complaint route for a judicial decision unless it was made in bad faith. If the applicant has any issues they must contact the Legal Department for advice. A local authority may only appeal a JP decision on a point of law by judicial review. If such a concern arises, the Legal team will review the case and consider what action, if any, action should be taken.

All the relevant forms for authorisation through to cancellation must be in writing using the standard forms which are available from the Intranet site and the Information Management Team, but officers must ensure that the circumstances of each case are accurately recorded on the application form.

If it is intended to undertake both directed surveillance and the use of a CHIS on the same surveillance subject the respective applications forms and procedures should be followed and both activities should be considered separately on their own merits.

An application for an authorisation must include an assessment of the risk of any collateral intrusion or interference (see collateral intrusion on page 27). The Authorising Officer will take this into account, particularly when considering the proportionality of the directed surveillance or the use of a CHIS.

Applications

All the relevant sections on an application form must be completed with sufficient information for the Authorising Officer to consider Necessity, Proportionality and the Collateral Intrusion issues. Risk assessments should take place prior to the completion of the application form. Each application should be completed on its own merits of the case. **Cutting and pasting or using template entries should not take place as this would leave the process open to challenge.**

All applications will be submitted to the Authorising Officer via the Line Manager of the appropriate enforcement team, in order that they are aware of the activities being undertaken by the staff. The Line Manager will perform an initial quality check of the application. However they should not be involved in the sanctioning of the authorisation. Completed application forms are to be initialed by Line Managers to show that the quality check has been completed.

Applications whether authorised or refused will be issued with a unique number by the Authorising Officer, taken from the next available number in the Central Record of Authorisations. To obtain this number please contact Information Management Team on 01527 64252 ext. 3258.

If authorised the applicant will then complete the relevant section of the judicial application/order form and follow the procedure above by arranging and attending the

Magistrates Court to seek a JP's approval (see procedure above RIPA application and authorisation process).

Duration of applications

Directed Surveillance	3 Months
Renewal	3 Months
Covert Human Intelligence Source	12 Months
Juvenile Sources	4 Months
Renewal	12 months

All Authorisations must be cancelled by completing a cancellation form. They must not be left to simply expire (see cancellations page 23).

Reviews

The reviews are dealt with internally by submitting the review form to the authorising officer. There is no requirement for a review form to be submitted to a JP.

Regular reviews of authorisations should be undertaken to assess the need for the surveillance to continue. The results of a review should be recorded on the central record of authorisations. Particular attention is drawn to the need to review authorisations frequently where the surveillance provides access to confidential information or involves collateral intrusion.

In each case the Authorising Officer should determine how often a review should take place. This should be as frequently as is considered necessary and practicable and they will record when they are to take place on the application form. This decision will be based on the circumstances of each application. However reviews will be conducted on a monthly or less basis to ensure that the activity is managed. It will be important for the Authorising Officer to be aware of when reviews are required following an authorisation to ensure that the applicants submit the review form on time.

Applicants should submit a review form by the review date set by the Authorising Officer. They should also use a review form for changes in circumstances to the original application so that the need to continue the activity can be reassessed. However if the circumstances or the objectives have changed considerably or the techniques to be used are now different, a new application form should be submitted and will be required to follow the process again and be approved by a JP. If in doubt seek advice. The applicant does not have to wait until the review date if it is being submitted for a change in circumstances.

Managers or Team Leaders of applicants should also make themselves aware of when the reviews are required to ensure that the relevant forms are completed on time.

Renewal

If at any time before an authorisation would cease to have effect, the Authorising Officer considers it necessary for the authorisation to continue for the purpose for which it was given, he may renew it in writing for a further period of three months.

Should it be necessary to renew a Directed Surveillance or CHIS authorisation, this must be approved by a JP.

Applications for renewals should not be made until shortly before the original authorisation period is due to expire but the applicant must take account of factors which may delay the renewal process (e.g. intervening weekends or the availability of the relevant authorising officer and a JP to consider the application).

The applicant should complete all the sections within the renewal form and submit the form to the authorising officer.

Authorising Officers should examine the circumstances with regard to Necessity, Proportionality and the Collateral Intrusions issues before making a decision to renew the activity. A CHIS application should not be renewed unless a thorough review has been carried out covering the use made of the source, the tasks given to them and information obtained. The Authorising Officer must consider the results of the review when deciding whether to renew or not. The review and the consideration must be documented.

If the Authorising officer refuses to renew the application the cancellation process should be completed. If the AO authorises the renewal of the activity the same process is to be followed as mentioned earlier for the initial application.

A renewal takes effect on the day on which the authorisation would have ceased and lasts for a further period of three months.

Cancellation

The cancellation form is to be submitted by the applicant or another investigator in their absence. The Authorising Officer who granted or last renewed the authorisation must cancel it if they are satisfied that the directed surveillance no longer meets the criteria upon which it was authorised. Where the Authorising Officer is no longer available, this duty will fall on the person who has taken over the role of Authorising Officer or the person who is acting as Authorising Officer.

As soon as the decision is taken that directed surveillance should be discontinued, the applicant or other investigating officer involved in the investigation should inform the Authorising Officer. The Authorising Officer will formally instruct the investigating officer to cease the surveillance, noting the time and date of their decision. This will be required for the cancellation form. The date and time when such an instruction was given should also be recorded in the central record of authorisations (see paragraphs 5.18 in the Codes of Practice). **You must record the amount of time spent on the surveillance.**

The officer submitting the cancellation should complete in detail the relevant sections of the form and include the period of surveillance and what if any images were obtained and any images containing third parties. The Authorising Officer should then take this into account and issue instructions regarding the management and disposal of the images etc.

The cancellation process should also be used to evaluate whether the objectives have been achieved and whether the applicant carried out what they stated was necessary in the application form. This check will form part of the oversight function. Where issues are identified they will be brought to the attention of the line manager and the Senior Responsible Officer (SRO). This will assist with future audits and oversight.

Who can grant a RIPA authorisation?

Officers who are designated "Authorising Officers" may authorise the use of directed surveillance or the use of a CHIS.

Please refer to Appendix 1 for the list of Authorising Officers, to show name, departmental details, contact number and levels of Authority.

The Chief Executive Officer or in his absence the Deputy Chief Executive and Executive Director - Leisure, Environment & Community Services will authorise cases where confidential information is likely to be gathered or in the case of a juvenile or vulnerable CHIS.

The Head of Legal and Democratic Services will inform the Information Management Team of any changes to the list of Authorising Officers and will amend the policy accordingly. The intranet will also be updated appropriately.

Urgent oral authorisations

As from 1 November 2012 there is now no provision under RIPA for urgent oral authorisations.

Local sensitivities

Authorising Officers and Applicants should be aware of particular sensitivities in the local community where the directed surveillance is taking place, or of similar activities being undertaken by other public authorities which could impact on the deployment of surveillance. This should form part of the risk assessment.

It should be noted that although this is a requirement there is no provision made within the application form for this information. Therefore applicants should cover this area where they feel it is most appropriate such as when detailing the investigation or proportionality or within the separate risk assessment form. However it must be brought to the attention of the Authorising Officer when deciding whether to authorise the activity.

Authorising officers' responsibility

Authorising officers should not be responsible for authorising investigations or operations in which they are directly involved, although it is recognised that this may sometimes be unavoidable such as where it is necessary to act urgently. Where an Authorising Officer authorises such an investigation or operation the Central Record of authorisations (see page 31) should highlight this and it should be brought to the attention of a Commissioner or Inspector should his next inspection.

Authorising Officers must treat each case individually on its merits and satisfy themselves that the authorisation is in accordance with the law, **necessary** for the prevention and detection of crime, that the crime attracts a custodial sentence of a maximum of 6 months or more, or is an offence relating to the underage sale of alcohol or tobacco under sections 146, 147 or 147A of the Licensing Act 2003 or section 7 of the Children and Young Persons Act 1933.

The Authorising Officer must believe the surveillance is **proportionate** to what it seeks to achieve, taking into account the **collateral intrusion** issues, and that the level of the surveillance is appropriate to achieve the objectives. If any equipment such as covert cameras or video cameras are to be used, the Authorising Officer should know the capability of the equipment before authorising its use. This will have an impact on collateral intrusion, necessity and proportionality. They should not rubber-stamp a request. It is important that they consider all the facts to justify their decision. They may be required to justify their actions in a court of law or some other tribunal.

Authorising Officers are responsible for determining when reviews of the activity are to take place (see Reviews on page 22).

Authorising Officers must also pay particular attention to Health and Safety issues that may be raised by any proposed surveillance activity. Under no circumstances, should the Authorised Officer approve any RIPA form unless, and until s/he is satisfied the health and safety of Council employees/agents are suitably addressed and/or risks minimised, so far as is possible, and proportionate to/with the surveillance being proposed.

Before authorising surveillance the Authorising Officer should also take into account the risk of intrusion into the privacy of persons other than those who are directly the subjects of the investigation or operation (collateral intrusion). Measures should be taken, wherever practicable, to avoid or minimise unnecessary intrusion into the lives of those not directly connected with the investigation or operation.

In the absence of your particular Line Manager or Head of Department the application should be submitted to another Authorising Officer for authorisation (see list of Authorising Officers - Appendix 1).

Necessity and proportionality

Obtaining a RIPA authorisation will only ensure that there is a justifiable interference with an individual's Article 8 rights if it is necessary and proportionate for these activities to take place.

It must be necessary for the **prevention and detection of crime and that** the crime attracts a custodial sentence of a maximum of 6 months or more, or is an offence relating to the underage sale of alcohol or tobacco under sections 146, 147 or 147A of the Licensing Act 2003 or section 7 of the Children and Young Persons Act 1933. It must also be shown the reasons why the requested activity is necessary in the circumstances of that particular case. Can you achieve the same end result without the surveillance?

If similar objectives could be achieved by methods other than covert surveillance, then those methods should be used before resorting to surveillance methods, unless it can be justified why they cannot or should not be used.

Then, if the activities are **necessary**, the person granting the authorisation must believe that they are **proportionate** to what is sought to be achieved by carrying them out. This involves balancing the intrusiveness of the activity on the subject and others who might be affected by it against the need for the activity in operational terms. The activity will not be proportionate if it is excessive in the circumstances of the case or if the information which is sought could reasonably be obtained by other less intrusive means. All such activity should be carefully managed to meet the objective in question and must not be arbitrary or unfair. The interference with the person's right should be no greater than that which is required to meet the aim and objectives.

The onus is on the Authorising Officer to ensure that the surveillance meets the tests of **necessity and proportionality**.

The codes provide guidance relating to proportionality which should be considered by both applicants and Authorising Officers:

- balancing the size and scope of the proposed activity against the gravity and extent of the perceived crime or offence;
- explaining how and why the methods to be adopted will cause the least possible intrusion on the subject and others;
- considering whether the activity is an appropriate use of the legislation and a reasonable way, having considered all reasonable alternatives, of obtaining the necessary result;
- evidencing, as far as reasonably practicable, what other methods had been considered and why they were not implemented.

It is important that the staff involved in the surveillance and the line manager manage the enquiry and operation, and constantly evaluate the need for the activity to continue.

Collateral intrusion

Collateral intrusion is an integral part of the decision making process and should be assessed and considered very carefully by both applicants and Authorising Officers.

The Revised Codes state Collateral Intrusion is intrusion into the privacy of persons other than those who are directly the subjects of the investigation or operation such as neighbours or other members of the subject's family. Where it is proposed to conduct surveillance activity specifically against individuals who are not suspected of direct or culpable involvement in the overall matter being investigated, interference with the privacy or property of such individuals should not be considered as collateral intrusion but rather as intended intrusion. Any such surveillance activity should be carefully considered against the necessity and proportionality criteria.

Intended intrusion could occur if it was necessary to follow a person not committing any offences but by following this person it would lead you to the person who is committing the offences.

Where such collateral intrusion is unavoidable, the activities may still be authorised, provided this intrusion is considered proportionate to what is sought to be achieved. The same proportionality tests apply to the likelihood of collateral intrusion as to intrusion into the privacy of the intended subject of the surveillance.

Prior to and during any authorised RIPA activity, a risk assessment should take place to identify the likely intrusion into the subject and any collateral intrusion. Officers should take continuing precautions to minimise the intrusion where possible. The collateral intrusion, the reason why it is unavoidable and your precautions to minimise it will have to be detailed on any relevant application forms. This will be considered by the Authorising Officer.

Before authorising surveillance the Authorising Officer should take into account the risk of collateral intrusion detailed on the relevant application forms as it has a direct bearing on the decision regarding proportionality.

The possibility of Collateral Intrusion does not mean that the authorisation should not be granted, but you should weigh up the importance of the activity to be carried out in operational terms on the one hand and the risk of collateral intrusion on the other hand.

Unexpected interference with third parties

When you are carrying out covert directed surveillance or using a CHIS, you should inform the Authorising Officer if the investigation unexpectedly interferes with the privacy of individuals who are not the original subjects of the investigation or covered by the authorisation in some other way. It will be appropriate in some circumstances to submit a review form and in other cases the original authorisation may not be sufficient and consideration should be given to whether a separate authorisation is required.

Confidential information

Confidential information consists of matters subject to legal privilege, confidential personal information or confidential journalistic material and applications where there is a likelihood of acquiring such information can only be authorised by the Chief Executive or the Executive Director of Services.

No authorisation should be given if there is any likelihood of obtaining legally privileged material without consulting the shared BDC/ RBC Legal Team.

Confidential personal information is information held in confidence relating to the physical or mental health or spiritual counselling concerning an individual (whether living or dead) who can be identified from it. Such information, which can include both oral and written communications, is held in confidence if it is held subject to an express or implied undertaking to hold it in confidence or it is subject to a restriction on disclosure or an obligation of confidentiality contained in existing legislation. Examples might include consultations between a health professional and a patient, or information from a patient's medical records. Journalistic material is also mentioned in the codes however it is highly unlikely that this will be obtained. The definition should it be required can be obtained from the Codes of Practice at Chapter 4.

The following general principles apply to confidential material acquired under authorisations:

- Those handling material from such operations should be alert to anything which may fall within the definition of confidential material. Where there is doubt as to whether the material is confidential, advice should be sought from the Head of Legal, Equalities and Democratic Services before further dissemination takes place;

- Confidential material should not be retained or copied unless it is necessary for specified purpose;

- Confidential material should be disseminated only where an appropriate officer (having sought advice from the Head of Legal and Democratic Services) is satisfied that it is necessary for a specific purpose;

- The retention or dissemination of such information should be accompanied by a clear warning of its confidential nature. It should be safeguarded by taking reasonable steps to ensure that there is no possibility of it becoming available, or its content being known, to any person whose possession of it might prejudice any criminal or civil proceedings related to the information;

- Confidential material should be destroyed as soon as it is no longer necessary to retain it for a specified purpose.

Use of CCTV

The use of the CCTV systems operated by the Council does not normally fall under the RIPA regulations. However it does fall under the Data Protection Act 1998 and the Councils CCTV

policy**.** However should there be a requirement for the CCTV cameras to be used for a specific purpose to conduct surveillance it is likely that the activity will fall under Directed Surveillance and therefore require an authorisation.

On the occasions when the CCTV cameras are to be used in a Directed Surveillance situation either by enforcement officers from relevant departments within the Council or outside Law Enforcement Agencies such as the Police, either the CCTV staff are to have a copy of the application form in a redacted format, or a copy of the authorisation page. It is important that the staff check the authority and only carry out what is authorised. A copy of the application or notes is also to be forwarded to the Information Management Team for filing. This will assist the Council to evaluate the authorisations and assist with oversight.

Operators of the Councils CCTV system need to be aware of the RIPA issues associated with using CCTV and that continued, prolonged systematic surveillance of an individual may require an authorisation.

Use of Social Media

This part of the policy covers the use of social media, including Social Networking Sites (SNS) such as Twitter and Facebook, and selling platforms such as eBay and Gumtree.

Guidance from the OSC (now Investigatory Powers Commissioner's Office, IPCO) on covert surveillance of SNS states that 'Repeat viewing of individual 'open source' sites for the purpose of intelligence gathering and data collation should be considered within the context of the protection that RIPA affords to such activity.'

The fact that digital investigation is routine or easy to conduct does not reduce the need for authorisation. Care must be taken to understand how the social networking site being used works. Authorising Officers must not be tempted to assume that one service provider is the same as another or that the services provided by a single provider are the same.

Whilst it is the responsibility of an individual to set privacy settings to protect unsolicited access to private information from their social media sites and, even though data may be deemed published and no longer under the control of the author, it is unwise to regard it as 'open source' or publicly available. The author has a reasonable expectation of privacy if access controls are applied.

Where privacy settings are available but not applied the data may be considered 'open source' and an authorisation is not usually required. However, repeat viewing of 'open source' sites may constitute directed surveillance on a case by case basis and officers need to be aware of this and seek advice about obtaining an authorisation. For example if someone is being monitored through, for example, their Facebook profile for a period of time and a record of the information is kept for later analysis, this is likely to require a RIPA authorisation for directed surveillance.

If it is necessary and proportionate for the Council to breach covertly access controls, the minimum requirement is an authorisation for directed surveillance.

Officers also need to be aware that if viewing of on-line information progresses to an officer establishing a relationship whether through a friend request or sending an email purporting to be interested in an item to purchase, then a CHIS authorisation will be required. In that scenario the officer themselves would be regarded as acting as a CHIS. Using a third party to contact the subject on behalf of the Council would also require authorisation of the third party as a CHIS.

It is not unlawful for a council officer to set up a false identity, but this should not be done for a covert purpose without significant management consideration and under the control of an authorisation. Using photographs of other persons without their permission to support the false identity infringes other laws.

Obtaining Communications Data

The Investigatory Powers Act 2016 governs the lawful obtaining of communications data by public authorities. The term communications data includes the 'who', 'when', 'where', and 'how' of a communication but not the content, that is, what was said or written. A local authority cannot make an application that requires the processing or disclosure of internet connection records for any purpose.

Communications data is generated, held or obtained in the provision, delivery and maintenance of communications services, that is, postal services or telecommunications services. All communications data held by a telecommunications operator or obtainable from a telecommunication system falls into two categories of entity data and events data.

Examples of entity data include:

- 'subscriber checks' such as "who is the subscriber of phone number 01234 567 890?", "who is the account holder of email account example@example.co.uk?" or "who is entitled to post to web space www.example.co.uk?"

- subscribers' or account holders' account information, including names and addresses for installation, and billing including payments method(s), details of payments;

- information about apparatus or devices used by, or made available to, the subscriber or account holder, including the manufacturer, model, serial numbers and apparatus codes.

Examples of events data include, but are not limited to:

- information tracing the origin or destination of a communication that is, or has been, in transmission (including incoming call records);

- information identifying the sender or recipient of a communication from data comprised in or attached to the communication;

- itemised timing and duration of service usage (calls and/or connections);

- information about amounts of data downloaded and/or uploaded;

Part 3 of IPA contains provisions relating to authorisations for obtaining communications data. This part of IPA is now in force but the acquisition of communications data was previously covered by RIPA. Under RIPA, local authorities were required to obtain judicial approval in order to acquire communications data. However, the position has now changed and from June 2019, all communication data applications must instead be authorised by the Office for Communications Data Authorisations ("the OCDA").

The Home Office issued 'Communications Data' Code of Practice in November 2018 and chapter 8 covers local authority procedures. A local authority must make a request to obtain communications data via a single point of contact (SPoC") at the National Anti-Fraud Network ("NAFN"). In addition to being considered by a NAFN SPoC, an officer within the local authority of the rank of service manager or above should be aware the application is being made before it is submitted to an authorising officer in the OCDA.

A serious crime threshold applies to the obtaining of some communications data. The Council can only submit an application to obtain events datta for the investigation of a criminal offence capable of attracting a sentence of 12 months or more. However, where the Council is looking to obtain entity data this can be done for any criminal investigation where it is necessary and proportionate to do so.

Joint agency surveillance

In cases where one agency is acting on behalf of another, it is usually for the tasking agency to obtain or provide the authorisation. For example, where surveillance is carried out by Council employees on behalf of the Police, authorisation would be sought by the police. If it is a joint operation involving both agencies the lead agency should seek authorisation.

Council staff involved with joint agency surveillance must ensure that all parties taking part are authorised on the authorisation page of the application to carry out the activity. When staff are operating on another organisations authorisation, they should obtain either a copy of the application form (redacted if necessary) or a copy of the authorisation containing the unique number. This will ensure they see what activity they are authorised to carry out. Their line manager should be made aware of the joint surveillance and a copy of the authorisation forwarded to the central register in order that a record can be retained. This will assist with oversight of the covert activities undertaken by Council staff.

Provisions should also be made regarding any disclosure implications under the Criminal Procedures Act (CPIA) and the management, storage and dissemination of any product obtained.

Documentation and central record

Authorising Officers or Managers of relevant enforcement departments may keep whatever records they see fit to administer and manage the RIPA application process. However this will

not replace the requirements under the Codes of Practice for the Council to hold a centrally held and retrievable record.

A centrally retrievable record of all authorisations will be held by the Information Management team and regularly updated whenever an authorisation is refused, granted, renewed or cancelled. The record will be made available to the relevant Commissioner or an Inspector from the Office of Surveillance Commissioners, upon request.

All original surveillance Authorisations and copies of judicial applications/order forms (whether authorised or refused), Review, Renewal and Cancellation documents will be forwarded to the Information Management team in a sealed envelope for security purposes. The Information Management team will be responsible for maintaining the Central Record of Authorisations and will ensure that all records are held securely with no unauthorised access. The only persons who will have access to these documents will be the Information Management team, the Senior Responsible Officer and the RIPA Co-ordinating Officer. The Head of Service of the shared Regulatory Service will have access to a read only copy of the Central Record of Authorisations.

The Information Management team can be contacted on extension 1661 (Nicola Brothwell) or extension 3871 (Julie Smout)

The documents contained in the centrally held register should be retained for at least three years from the ending of the authorisation or for the period stipulated by the Council's document retention policy, whichever is greater. The centrally held register should contain the following information:

- if refused, that the application was not authorised and a brief explanation of the reason why. The refused application should be retained as part of the Central Record of Authorisation.
- if granted, the type of authorisation and the date the authorisation was given and approved by the JP.
- name and rank/grade of the authorising officer.
- the unique reference number (URN) of the investigation or operation.
- the title of the investigation or operation, including a brief description and names of subjects, if known.
- whether the urgency provisions were used, and if so why.
- frequency and the result of each review of the authorisation.
- if the authorisation is renewed, when it was renewed and who authorised the renewal, including the name and rank/grade of the authorising officer and the date approved by the JP.
- whether the investigation or operation is likely to result in obtaining confidential information as defined in this code of practice.
- the date the authorisation was cancelled.

- authorisations by an Authorising Officer in urgent cases where they are directly involved in the investigation or operation (see Authorising Officer Responsibility page 17.) If this has taken place it must be brought to the attention of a Commissioner or Inspector during their next RIPA inspection.
- the date and time when any instruction was given by the Authorising Officer.

As well as the Central Record the Information Management Team will also retain:

the original of each application, review, renewal and cancellation, copy of the judicial application/order form, together with any supplementary documentation of the approval given by the Authorising Officer

- a record of the period over which the surveillance has taken place;

For CHIS applications

In addition, records or copies of the following, as appropriate, should be kept by the relevant authority:

- the original authorisation form, copy of the judicial application/order form, together with any supplementary documentation and notification of the approval given by the Authorising Officer;
- the original renewal of an authorisation, copy of the judicial application/order form, together with the supporting documentation submitted when the renewal was requested;
- the reason why the person renewing an authorisation considered it necessary to do so;
- any risk assessment made in relation to the source;
- the circumstances in which tasks were given to the source;
- the value of the source to the investigating authority;
- a record of the results of any reviews of the authorisation;
- the reasons, if any, for not renewing an authorisation;
- the reasons for cancelling an authorisation.
- the date and time when any instruction was given by the Authorising Officer to cease using a source.

The records kept by public authorities should be maintained in such a way as to preserve the confidentiality of the source and the information provided by that source. There should, at all times, be a designated person within the relevant public authority who will have responsibility for maintaining a record of the use made of the source.

Annual report to Investigatory Powers Commissioner's Office

The Council is required to provide statistics to the IPCO (was the OSC) every year in March for the purposes of the Annual Report. The Information Manager shall be responsible for completing the return and providing the statistics.

Storage and retention of material

All material obtained and associated with an application will be subject of the provisions of the Criminal Procedures Investigations Act 1996 (CPIA) Codes of Practice which state that relevant material in an investigation has to be recorded and retained and later disclosed to the prosecuting solicitor in certain circumstances. It is also likely that the material obtained as a result of a RIPA application will be classed as personal data for the purposes of the Data Protection Act. All officers involved within this process should make themselves aware of the provisions within this legislation and how it impacts on the whole RIPA process. Material obtained together with relevant associated paperwork should be held securely. Extra care needs to be taken if the application and material relates to a CHIS (see pages 12 and 14).

Material is required to be retained under CPIA should be retained until a decision is taken whether to institute proceedings against a person for an offence or if proceedings have been instituted, at least until the accused is acquitted or convicted or the prosecutor decides not to proceed with the case.

Where the accused is convicted, all material which may be relevant must be retained at least until the convicted person is released from custody, or six months from the date of conviction, in all other cases.

If the court imposes a custodial sentence and the convicted person is released from custody earlier than six months from the date of conviction, all material which may be relevant must be retained at least until six months from the date of conviction.

Each relevant service within the Council may have its own provisions under their Data Retention Policy which will also need to be consulted to ensure that the data is retained lawfully and for as long as is necessary

Training

There will be an on-going training programme for Council Officers who will need to be aware of the impact and operating procedures with regards to this legislation. The training officer will be required to retain a list of all those officers who have received training and when the training was delivered.

Authorising Officers must have received formal RIPA training before being allowed to consider applications for surveillance and CHIS.

Errors

There is now a requirement as set out in the OSC Procedures and Guidance 2011 to report all covert activity that was not properly authorised to the Investigatory Powers Commissioner's Office (IPCO, was the OSC) in writing as soon as the error is recognised. This includes activity which should have been authorised but wasn't or which was conducted beyond the directions provided by the authorising officer. It is therefore important that when an error has been identified it is brought to the attention of the SRO in order to comply with this guidance. The Council has a responsibility to report to the Inspector at the commencement of an inspection all activity which should have been authorised but wasn't. This is to confirm that any direction provided by the Commissioner has been followed. This will also assist with the oversight provisions of the Councils' RIPA activity.

This does not apply to covert activity which is deliberately not authorised because an authorising officer considers that it does not meet the legislative criteria, but allows it to continue. This would be surveillance outside of RIPA (see oversight section below).

Oversight

It is important that all staff involved in the RIPA application process take their responsibilities seriously. Careful management and adherence to policy and procedures will assist with maintaining oversight and reducing unnecessary errors. The policy and use of RIPA will be monitored on an on-going basis through the quarterly meetings referred to below.

Senior Responsible Officer and RIPA Co-ordinating officer

Overall oversight within the Council will fall within the responsibilities of the Senior Responsible Officer (SRO) for the Council. The Senior Responsible Officer is Jayne Pickering - Executive Director (Finance and Corporate Resources). To assist the SRO with monitoring, ensuring the policy is kept up to date, liaising with the Office of Surveillance Commissioner and organising training for staff, the Principal Solicitor has been identified as the RIPA Co-ordinating Officer. The SRO and the RIPA Co-ordinating Officer will meet on a quarterly basis to review the RIPA activity that has taken place, consider any changes to legislation or guidance and to review the policy and processes for RIPA and the training programme.

Reporting to members

Quarterly returns of all surveillance activity undertaken by Council staff including joint surveillance and Directed Surveillance using the CCTV system will be compiled by the Senior Responsible Officer and the RIPA Co–ordinating Officer and reported to the Portfolio Holder for Resources in line with the current advice in the Codes of Practice. It will be the role of the Portfolio Holder to report to the Cabinet any issues of concern arising out of the quarterly returns. Members will also receive an annual report to keep them updated as to the levels of RIPA activity, legislative changes, staff training and any issues regarding the RIPA policy.

Scrutiny and tribunal

Scrutiny will be provided by the Investigatory Powers Commissioner's Office or IPCO (formerly provided by the Office of the Surveillance Commissioner). The Commissioner will periodically inspect the records and procedures of the Authority to ensure the appropriate authorisations have been given, reviewed, cancelled, and recorded properly.

It is the duty of any person who uses these powers to comply with any request made by a Commissioner to disclose or provide any information the Office requires for the purpose of enabling them to carry out their functions.

A tribunal has been established to consider and determine complaints made under RIPA if it is the appropriate forum. Persons aggrieved by conduct, e.g. directed surveillance, can make complaints. The forum hears application on a judicial review basis. Claims should be brought within one year unless it is just and equitable to extend that period.

Complaints can be addressed to the following address:

Investigatory Powers Tribunal

PO Box 33220

London

SW1 H9ZQ

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Appendix 1

List of Authorising Officers for Bromsgrove District Council and Redditch Borough Council and authorising levels:

Name	Department	Contact Number	Level of Surveillance Authority		
			Juvenile or Vulnerable CHIS and/or Confidential Material from CHIS or Directed Surveillance	CHIS	Directed Surveillance
Kevin Dicks	Chief Executive	Ext 1487	Yes	No	No
Sue Hanley	Deputy Chief Executive / Executive Director for Leisure, Environment & Community Services	Ext 3601	Yes	Yes	Yes
Deborah Poole	E-Government & Customer Services	Ext 1256	No	Yes	Yes
Simon Wilkes	Head of Regulatory Services	01562 738088	No	No	Yes

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Appendix 2

This box is to be completed by police/BDC Authorising Officer, prior to attending CCTV room

OFFICER IN CASE: DATE:

AUTHORITY NUMBER: AUTHORISING SUPT/OFFICER:

DETAILS OF OPERATION i.e. dates/times and non sensitive information

This operation has received the necessary authority as required under RIPA legislation

Signature: Date:

To be completed by ..insert your council name……. Council Supervisor

Grounds on which this action is necessary, please circle:

1. Interest of National Security / Public Safety / Protecting Public Health / Economic well being of UK / Preventing or Detecting crime or preventing Disorder.

2. Is the use of the CCTV systems for the directed surveillance; proportionate to what it seeks to achieve?

YES / NO (please circle one)

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3. Have you discussed alternative methods of obtaining this private information and agreed the use of directed surveillance as the most appropriate method? YES / NO (please circle one) 4. Have you discussed collateral intrusion implications and methods to minimise the risk to other persons? YES / NO (please circle one) 5. Have you discussed the obtaining of private and confidential material through the use of the CCTV system and been assured of its future use and integrity? YES / NO (please circle one)
I hereby confirm that I believe the use of … insert your council name Council CCTV is necessary and proportionate for this operation and that RIPA and Human Rights considerations have been considered. The use of CCTV systems for the directed surveillance is granted. Signature of Council Supervisor Date: Name:
For Auditing & Monitoring Purposes by CCTV Control Room Police/BDC RIPA authority valid from dates …… to …… Police/BDC operation planned for dates …… to …… Police/BDC operation actually took place from dates ……to ……

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Appendix 3

Risk Assessment form for Surveillance

(to be completed by Investigating Officer)

Is target suitable for surveillance? Is target known to be surveillance aware?	
Has property/target been assessed for suitability?	**YES/NO**
Type of property, e.g. flats/house etc	
Number of property entrances/exits	
Is there any public transport nearby? If yes, what is it? Will subject be likely to use public transport? What measures are to be taken to account for this type of transport? Will surveillance task include following on public transport?	

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Please describe Locality. E.g. type of area/type of road, cul-de-sac etc/shops/neighbours/schools/lighting etc.	
Please describe any collateral intrusion and how it is to be minimized. E.g. Family/other occupants/neighbours/visitors/other buildings/correct use of camera or technical equipment to reduce etc.	
Is there likely to be any confidential information obtained?	
What risks were identified as part of this assessment?	
What actions can be taken to reduce risks to officer? E.g. position of officer/vehicle	
Can task be undertaken without compromise to Officer?	**YES/NO**
Is the area “safe” for Officer whilst	

undertaking such duties? Is it known to be a "difficult area" either by position or residents/passers-by/activities	**YES/NO**
Communications & Equipment: Have they been tested in the area to ensure they work, e.g. mobile phones vs black spots? What security has been put in place for equipment sited, e.g. static cameras?	
How many Officers are required to undertake task?	
If vehicles are required, are the vehicle(s) taxed, MOT'd and insured for such activities?	**YES/NO**
If undertaking mobile surveillance is it anticipated that the officer may travel further than 50 miles from the Council Offices? How far is the officer expecting to travel?	**YES/NO**
If yes, please provide justification for undertaking such extensive surveillance.	

Confirm that the Officer advised the Police of activity being undertaken, to confirm presence in area and ensure that any concerns by the public who contact them, are allayed? Incident number raised?	
Please note:	Copy of GIS map to be provided with this document and request for authorization, showing target of surveillance
Please note:	If surveillance is authorized: • Agree method of communication between Officer and Line Manager/office whilst out undertaking surveillance (e.g. phone/text/personal interaction) • Notify the Line Manager/Colleague who is monitoring Lone Working, of start and finish times • If undertaken prior to 9am and/or after 5pm, ensure Line Manager is aware of the activity • Provide Lone Working monitoring officer with details of address, start and finish times • Officer should contact monitoring officer both on arrival and on departure from task

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Investigating Officer Name: Signature:_____

Date:

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Appendix 4

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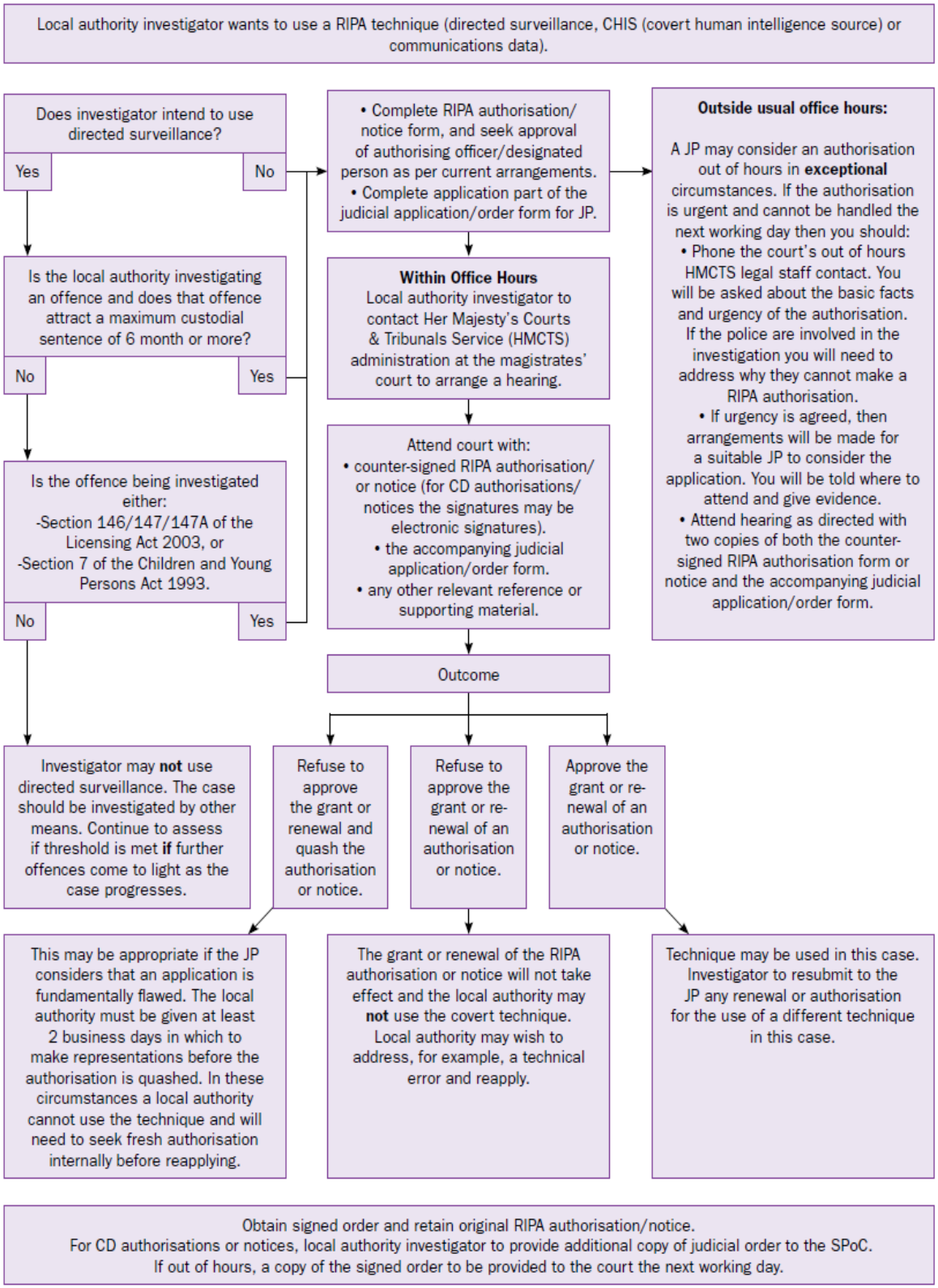
LOCAL AUTHORITY PROCEDURE: APPLICATION TO A JUSTICE OF THE PEACE SEEKING AN ORDER TO APPROVE THE GRANT OF A RIPA AUTHORISATION OR NOTICE



BROMSGROVE DISTRICT COUNCIL

AUDIT STANDARDS AND GOVERNANCE COMMITTEE **22nd July 2020**

BROMSGROVE DISTRICT COUNCIL AUDIT PLAN ADDENDUM - COVID 19

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder Consulted	-
Relevant Head of Service	Jayne Pickering – Exec Director Finance and Resources
Ward(s) Affected	All Wards
Ward Councillor(s) Consulted	No
Key Decision / Non-Key Decision	Non–Key Decision

1. SUMMARY OF PROPOSALS

To present Members with the Bromsgrove District Council Audit Plan Addendum - Covid 19 from the Council's External Auditors Grant Thornton.

2. RECOMMENDATIONS

2.1 **The Committee is asked to NOTE the report and the Bromsgrove District Council Audit Plan Addendum - Covid 19 as presented in the report and at Appendix 1.**

3. KEY ISSUES

3.1 The document provides an update to the planned scope and timing of the statutory audit in light of the impact of Covid and the increased risks that it has brought.

3.2 Legal Implications

None as a direct result of this report.

3.3 Service/Operational Implications

Timely and accurate financial monitoring ensures that services can be delivered as agreed within the financial budgets of the Council

4. Customer / Equalities and Diversity Implications

None, as a direct result of this report.

5. RISK MANAGEMENT

As part of all audit work the auditors undertake a risk assessment to ensure that adequate controls are in place within the Council so reliance can be placed on internal systems.

BROMSGROVE DISTRICT COUNCIL

AUDIT STANDARDS AND GOVERNANCE COMMITTEE **22nd July 2020**

6. APPENDICES

Appendix 1 – Bromsgrove District Council Audit Plan Addendum - Covid 19

7. BACKGROUND PAPERS

None

AUTHOR OF REPORT

Name: Chris Forrester – Head of Finance and Customer Services
Email: chris.forrester@bromsgroveandredditch.gov.uk
Tel: (01527) 881673

Grant Thornton

External Audit Plan update

Year ending 31 March 2020

Bromsgrove District Council

28 April 2020

Introduction & headlines

Purpose

This document provides an update to the planned scope and timing of the statutory audit of Bromsgrove District Council ('the Authority') as reported in our Audit Plan dated 5 March 2020, for those charged with governance.

The current environment

In addition to the audit risks communicated to those charged with governance in our Audit Plan on 5 March 2020, recent events have led us to update our planning risk assessment and reconsider our audit and value for money (VfM) approach to reflect the unprecedented global response to the Covid-19 pandemic. The significance of the situation cannot be underestimated and the implications for individuals, organisations and communities remains highly uncertain. For our public sector audited bodies, we appreciate the significant responsibility and burden your staff have to ensure vital public services are provided. As far we can, our aim is to work with you in these unprecedented times, ensuring up to date communication and flexibility where possible in our audit procedures.

Impact on our audit and VfM work

Management and those charged with governance are still required to prepare financial statements in accordance with the relevant accounting standards and the Code of Audit Practice, albeit to an extended deadline for the preparation of the financial statements up to 31 August 2020 and the date for audited financials statements to 30 November 2020. We will liaise with management to agree appropriate timescales. We continue to be responsible for forming and expressing an opinion on the Authority and group's financial statements and VfM arrangements.

In order to fulfil our responsibilities under International Auditing Standards (ISA's (UK)) we have revisited our planning risk assessment. We may also need to consider implementing changes to the procedures we had planned and reported in our Audit Plan to reflect current restrictions to working practices, such as the application of technology to allow remote working. Additionally, it has been confirmed since our Audit Plan was issued that the implementation of IFRS 16 has been delayed for the public sector until 2020/21.

Changes to our audit approach

To date we have:

- identified a new significant financial statement risk, as described overleaf; and
- reviewed the materiality levels we determined for the audit. We did not identify any changes to our materiality assessment as a result of the risk identified due to Covid-19.

Changes to our VfM approach

We have updated our VfM risk assessment to document our understanding of your arrangements to ensure critical business continuity in the current environment. We have not identified any new VfM risks in relation to Covid-19.

Conclusion

We will ensure any further changes in our audit and VfM approach and procedures are communicated with management and reported in our Audit Findings Report. We wish to thank management for their timely collaboration in this difficult time.

Significant risks identified – Covid – 19 pandemic

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Covid – 19	The global outbreak of the Covid-19 virus pandemic has led to unprecedented uncertainty for all organisations, requiring urgent business continuity arrangements to be implemented. We expect current circumstances will have an impact on the production and audit of the financial statements for the year ended 31 March 2020, including and not limited to; • remote working arrangements and redeployment of staff to critical front line duties may impact on the quality and timing of the production of the financial statements, and the evidence we can obtain through physical observation; • volatility of financial and property markets will increase the uncertainty of assumptions applied by management to asset valuation and receivable recovery estimates, and the reliability of evidence we can obtain to corroborate management estimates; • financial uncertainty will require management to reconsider financial forecasts supporting their going concern assessment and whether material uncertainties for a period of at least 12 months from the anticipated date of approval of the audited financial statements have arisen; and • disclosures within the financial statements will require significant revision to reflect the unprecedented situation and its impact on the preparation of the financial statements as at 31 March 2020 in accordance with IAS1, particularly in relation to material uncertainties. We therefore identified the global outbreak of the Covid-19 virus as a significant risk.	We will: • work with management to understand the implications the response to the Covid-19 pandemic has on the organisation's ability to prepare the financial statements and update financial forecasts and assess the implications on our audit approach; • liaise with other audit suppliers, regulators and government departments to co-ordinate practical cross sector responses to issues as and when they arise; • evaluate the adequacy of the disclosures in the financial statements in light of the Covid-19 pandemic; • evaluate whether sufficient audit evidence using alternative approaches can be obtained for the purposes of our audit whilst working remotely; • evaluate whether sufficient audit evidence can be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances; • evaluate management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment; and • discuss with management any potential implications for our audit report if we have been unable to obtain sufficient audit evidence.

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

THE INTERNAL AUDIT PROGRESS REPORT OF THE HEAD OF THE INTERNAL AUDIT SHARED SERVICE ~ WORCESTERSHIRE INTERNAL AUDIT SHARED SERVICE.

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder Consulted	Yes
Relevant Head of Service	Chris Forrester, Financial and Customer Services
Ward(s) Affected	All Wards
Ward Councillor(s) Consulted	No
Key Decision / Non-Key Decision	Non–Key Decision

1. SUMMARY OF PROPOSALS

1.1 To present:

- the monitoring report of internal audit work for 2020/21 and residual 2019/20 work.

2. RECOMMENDATIONS

2.1 **The Committee is asked to note the report.**

3. KEY ISSUES

Financial Implications

3.1 There are no direct financial implications arising out of this report.

Legal Implications

3.2 The Council is required under Regulation 6 of the Accounts and Audit Regulations 2018 to "maintain in accordance with proper practices an adequate and effective system of internal audit of its accounting records and of its system of internal control".

Service / Operational Implications

3.3 The involvement of Members in progress monitoring is considered to be an important facet of good corporate governance, contributing to the internal control assurance given in the Council's Annual Governance Statement.

3.4 This section of the report provides commentary on Internal Audit's performance for the period 01st April 2020 to 30th June 2020 against the performance indicators agreed for the service.

3.5 Summary Dashboard:

Total reviews planned for 2020/21:	13 minimum	
Reviews finalised to date for 2020/21:	0	
Assurance of 'moderate' or below:	0	
Reviews currently awaiting final sign off:	1	
Reviews ongoing:	3	
Reviews to be commenced (Q2 to 4):	14	
Number of 'High' Priority recommendations reported to date:		0
Satisfied 'High' priority recommendations to date:		0
Productivity:	50% (against targeted 74%)	
Overall plan delivery to date:	10% (against target >90%)	

2019/20 AUDIT REPORTS ISSUED/COMPLETED SINCE THE LAST PROGRESS REPORT (5th March 2020):

3.6 In summary they are:

- Safeguarding
- Debtors
- Creditors
- NNDR
- Main Ledger
- Health & Safety (Hybrid follow up)
- Worcestershire Regulatory Services
- Benefits (Draft)
- IT (Draft)
- Business Continuity (Draft)

Reports finalised	7
'High' priority recommendations reported	1
'Medium' priority recommendations reported	8
'Low' priority recommendation reported	3
'Moderate' or above assurances	6
'Limited' or below assurances	Nil

Full reports are contained at Appendix 3. Health and Safety Hybrid findings have already been reported to Committee and are not included in the above figures.

All 'limited' assurance reviews go before CMT for full consideration.

3.7 2020/21 AUDITS ONGOING AS AT 30th June 2020

Audits progressing through clearance or draft report awaiting management sign off stage include:

- Orb

Audits progressing through testing stage included:

- Health and Safety
- Use of Agency and Consultants
- Creditors (rolling review)

The summary outcome of the above reviews will be reported to Committee in due course when they have been completed and management have confirmed an action plan.

A rolling testing programme on Debtors and Creditors is undertaken during quarters 1 to 3 inclusive. The rolling testing programme results will be amalgamated as at the end of quarter 3 and formal audit reports issued during quarter 4.

The 2020/21 plan will reflect the delayed start and certain lesser risk reviews may need to be rolled to next years plan. Priority will be given to potentially higher risk areas e.g. limited assurance audits. As we return to the new normal the impact of restrictions of the COVID-19 lockdown on the plan will be closely managed as the year progresses. The plan for 2020/21 will therefore remain very flexible but the core financial areas of the business will be considered and reported on and there is sufficient coverage for the Head of Internal Audit to provide an overall opinion. Committee will be regularly informed of developments throughout the year and any variations to the plan will be overseen by the Executive Director and s151 Officer.

3.8 AUDIT DAYS

Appendix 1 shows that progress continues to be made towards delivering the Internal Audit Plan and achieving the targets set for the year. As at 30th June 2020 a total of 24 days had been delivered against a target of 230 days for 2020/21.

Appendix 2 shows the performance indicators for the service. These indicators were agreed by the Audit, Standards and Governance Committee on the 5th March 2020 for 2020/21.

Appendix 3 provides copies of the reports that have been completed and final reports issued.

Appendix 4 provides the Committee with 'Follow Up' reports that have been undertaken to monitor audit recommendation implementation progress by management.

3.9 OTHER KEY AUDIT WORK

Much internal audit work is carried out "behind the scenes" but is not always the subject of a formal report. Productive audit time is accurately recorded against the service or function as appropriate. Examples include:

- Governance for example assisting with the Annual Government Statement

- Risk management
- Transformation review providing support as a critical review
- Dissemination of information regarding potential fraud cases likely to affect the Council
- Drawing managers' attention to specific audit or risk issues
- Audit advice and commentary
- Internal audit recommendations: follow up review to analyse progress
- Day to day audit support and advice for example control implications, etc.
- Networking with audit colleagues in other Councils on professional points of practice
- National Fraud Initiative over view.
- Investigations

3.10 **National Fraud Initiative**

There has been on going work undertaken in regard to the National Fraud Initiative. This year is the 2 yearly cycle of data extraction and uploading to enable matches to be reported. Worcestershire Internal Audit Shared Service (WIASS) has a coordinating role in regard to this investigative exercise in Bromsgrove District Council. The data requirements were uploaded during October and December 2018 with any queries dealt with accordingly. Potential matches have been returned to the Authority for investigation. A further upload of Council Tax single person data and Elections was completed in January 2020. WIASS have a watching brief in regards to these uploads. A further substantial upload of data is due to take place in December 2020.

3.11 **Monitoring**

To ensure the delivery of the 2020/21 plan and any revision required there is close and continual monitoring of the plan delivery, forecasted requirements of resource – v – actual delivery, and where necessary, additional resource will be secured to assist with the overall Service demands. The Head of Internal Audit Shared Service remains confident his team will be able to provide the required coverage for the year over the authority's core financial systems, as well as the revised plan for other systems which have been deemed to be 'high' and 'medium' risk. Due to changing circumstances and the impact of the COVID-19 pandemic a variation in the plan will be required. This will be agreed on a risk priority basis with the s151 Officer as the year progresses. With any adjustment to the plan there will remain comprehensive audit coverage for 2020/21.

3.12 **Quality Assurance Improvement Plan**

3.13 WIASS delivers the audit programme in conformance with the International Standards for the Professional Practice of Internal Auditing (ISPPIA) as published by the Institute of Internal Auditors. Further improvements may be identified through the self assessment process which is due to be carried out by the end of August 2020 and will be reported to Committee.

3.14 **Customer / Equalities and Diversity Implications**

There are no implications arising out of this report.

3.15 WIASS is committed to providing an audit function which conforms to the Public Sector Internal Audit Standards (as amended). WIASS recognise there are other review functions providing other sources of assurance (both internally and externally) over aspects of the Council's operations. Where possible we will seek to place reliance on such work thus reducing the internal audit coverage as required.

3.16 WIASS confirms it acts independently in its role and provision of internal audit.

4. RISK MANAGEMENT

The main risks associated with the details included in this report are:

- failure to complete the planned programme of audit work for the financial year; and,
- the continuous provision of an internal audit service is not maintained.

5. APPENDICES

Appendix 1 ~ Internal Audit Plan delivery 2020/21
Appendix 2 ~ Plan position and key performance indicators 2020/21
Appendix 3 ~ Finalised audit reports including definitions
Appendix 4 ~ Finalised 'follow-up' reports.

6. BACKGROUND PAPERS

Individual internal audit reports are held by Internal Audit.

7. KEY

N/a

AUTHOR OF REPORT

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Head of Internal Audit Shared Service,
Worcestershire Internal Audit Shared Service
Tel: 01905 722051
E Mail: andy.bromage@worcester.gov.uk

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 1

Delivery against Internal Audit Plan for 2020/21
1st April 2020 to 30th June 2020

Audit Area	2020/21 Total Planned Days	Forecasted days to the 30th September 2020	Actual Days Used to the 30th June 2020
Core Financial Systems (see note 1)	60	6	4
Corporate Audits	66	28	13
Other Systems Audits (see note 2)	68	35	2
SUB TOTAL	**194**	**69**	**19**
Audit Management Meetings	15	8	3
Corporate Meetings / Reading	5	3	1
Annual Plans, Reports and Committee Support	16	8	1
Other chargeable (see note 3)			
SUB TOTAL	**36**	**19**	**5**
TOTAL	**230**	**88**	**24**

Notes:

Audit days used are rounded to the nearest whole.

Note 1: Core Financial Systems are audited predominantly in quarters 3 and 4 in order to maximise the assurance provided for Annual Governance Statement and Statement of Accounts but not interfere with year end. A rolling programme has also been introduced for Debtors and Creditors to maximise coverage and sample size. The results will be reported during Q4.

Note 2: A number of the budgets in this section are 'on demand' (e.g. consultancy, investigations) so the demand can fluctuate throughout the quarters.

Note 3: 'Other chargeable' days equate to times where there has been, for example, significant disruption to the IT provision resulting in lost productivity.

* Where the forecasted days are less than the planned days for the year this reflects the adjustments that have been made to the plan during the year.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 2

Audit Plan Position as at the 30th June 2020

Audit Area	Planned days 2020/21	Proposed Review	Current Position and indicative delivery date		Assurance
Accountancy & Finance Systems					
Debtors	9	Full	To commence	Q3/4	
Main Ledger/Budget monitoring/bank rec	10	Full	To commence	Q3/4	
Creditors	9	Full	Rolling review commenced	Q3/4	
Treasury Management	6	Full	To commence	Q2	
Council Tax	8	Full	To commence	Q3/4	
Benefits	10	Full	To commence	Q3/4	
NNDR	8	Full	To commence	Q3/4	
SUB TOTAL	**60**				
Corporate					
IT	8	Full	To commence	Q4	
Risk Management	6	Critical Friend Support	To commence	Q1/ 4	
Health and Safety	7	Limited Focus	Testing commenced	Q1/ 2	
Procurement	8	Full	To commence	Q4	
GDPR	8	Limited Focus	To commence	Q4	
Orb	9	Full	Clearance	Q1	
Use of Agency & Consultants	9	Full	Planning	Q2	
Projects	11	Critical Friend	To commence	Q4	
SUB TOTAL	**66**				
System / Management Arrangements					
Refuse Service Scalability	6	Limited Scope	To commence	Q4	
Markets	10	Limited Scope	To commence	Q2	
Worcester Regulatory Services	10	Limited Scope	To commence	Q4	
Advisory and Consultancy	10	Pull Down Budget	Q1 – Q4		N/a
Fraud and Investigations inc. NFI	10	Pull Down Budget	Q1 – Q4		N/a
Completion of prior years work	8	Pull Down Budget	Q1 – Q4		N/a
Report follow up	10	Pull Down Budget	Q1 – Q4		N/a
Statement of Internal Control	4	Pull Down Budget	Q1 – Q4		N/a
SUB TOTAL	**68**				

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

General				
Audit Management Meetings	15	Pull Down Budget	Q1 – Q4	N/a
Corporate Meetings/Reading	5	Pull Down Budget	Q1 – Q4	N/a
Reports, Annual Plans and Committee Support	16	Pull Down Budget	Q1 – Q4	N/a
SUB TOTAL	**36**			
PLAN TOTAL	**230**			

Performance against Key Performance Indicators 2020-2021

The success or otherwise of the Internal Audit Shared Service will be measured against some of the following key performance indicators for 2020/21. Other key performance indicators link to overall governance requirements of Bromsgrove District Council e.g. KPI 4. The position will be reported on a cumulative basis throughout the year.

	KPI	Trend/Target requirement	2020/21 Position (as at 30th June 2020)		Frequency of Reporting
Operational					
1	No. of audits achieved during the year	Per target	Target = Minimum 13 Delivered = Nil to date	😐	When Audit Committee convene
2	Percentage of Plan delivered	>90% of agreed annual plan	10%	😟	When Audit Committee convene
3	Service productivity	Positive direction year on year (Annual target 74%)	50%	😟	When Audit Committee convene
Monitoring & Governance					
4	No. of 'high' priority recommendations	Downward (minimal)	0 (2019/20 = 9)	😐	When Audit Committee convene
5	No. of moderate or below assurances	Downward (minimal)	0 (2019/20 = 7)	😐	When Audit Committee convene
6	'Follow Up' results	Management action plan implementation date exceeded (nil)	Nil to report	🙂	When Audit Committee convene
Customer Satisfaction					
7	No. of customers who assess the service as 'excellent'	Upward (increasing)	Nil returns to date	😐	When Audit Committee convene

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

APPENDIX 3

2019/20 Residual Audit Reports.

Appendices A & B are indicated below and are applied to all reports. To save duplication these have been produced once, listed below and removed from the reports.

APPENDIX A

Definition of Audit Opinion Levels of Assurance

Opinion	Definition
Full Assurance	The system of internal control meets the organisation's objectives; all of the expected system controls tested are in place and are operating effectively. No specific follow up review will be undertaken; follow up will be undertaken as part of the next planned review of the system.
Significant Assurance	There is a generally sound system of internal control in place designed to meet the organisation's objectives. However isolated weaknesses in the design of controls or inconsistent application of controls in a small number of areas put the achievement of a limited number of system objectives at risk. Follow up of medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Moderate Assurance	The system of control is generally sound however some of the expected controls are not in place and / or are not operating effectively therefore increasing the risk that the system will not meet it's objectives. Assurance can only be given over the effectiveness of controls within some areas of the system. Follow up of high and medium priority recommendations only will be undertaken after 3 to 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Limited Assurance	Weaknesses in the design and / or inconsistent application of controls put the achievement of the organisation's objectives at risk in many of the areas reviewed. Assurance is limited to the few areas of the system where controls are in place and are operating effectively. Follow up of high and medium priority recommendations only will be undertaken after 3 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
No Assurance	No assurance can be given on the system of internal control as significant weaknesses in the design and / or operation of key controls could result or have resulted in failure to achieve the organisation's objectives in the area reviewed. Follow up of high and medium priority recommendations only will be undertaken after 3 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

APPENDIX B

Definition of Priority of Recommendations

Priority	Definition
H	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. Immediate implementation of the agreed recommendation is essential in order to provide satisfactory control of the serious risk(s) the system is exposed to.
M	Control weakness that has or is likely to have a medium impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation within 3 to 6 months is important in order to provide satisfactory control of the risk(s) the system is exposed to.
L	Control weakness that has a low impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation is desirable as it will improve overall control within the system.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Safeguarding - Children 2019/20
(Evidence to Support the Section 11 Audit Return)

5th March 2020

Distribution:

To: Head of Community and Housing Services
Head of Transformation, Organisational Development and Digital Services
Human Resources & Development Manager
Cc: Chief Executive
Executive Director and Deputy Chief Executive
Executive Director and Section 151 Officer

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1. The audit of the safeguarding of children was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved at the Audit, Governance and Standards Committee and the Audit, Standards and Governance Committee on 29th July 2019 and 18th July 2019 respectively. The audit was a risk based systems audit of the safeguarding of children as operated by Redditch Borough Council and Bromsgrove District Council.

1.2. The strategic purpose that this Underpins is Keep my Place Safe and Looking Good

1.3 There are no risks recorded on the corporate register in relation to this review.

The following entries on the service risk register are relevant to this review:

- COM 3 – Safeguarding – Inadequate child and adult protection systems/process

1.4 Statutory guidance included within the Working Together to Safeguard Children (2013) document requires local Safeguarding Children's Boards to gather data to assess whether partners are fulfilling their statutory obligations under section 11 of the Children Act 2004. The Worcestershire Safeguarding Children's Board, (now known as the Worcestershire Safeguarding Children's Partnership), requires that such a self-assessment should be made every two years. The section 11 'audit' for Redditch Borough Council and Bromsgrove District Council was last completed and submitted to the Worcestershire Safeguarding Children Board by the Head of Community Services on behalf of both Councils in February 2018.

1.5 This review was undertaken during the months of September and October 2019. .

2. Audit Scope and objective

2.1. This review has been undertaken to provide assurance that;

- The evidence stated in support of the last Section 11 audit response return is relevant, reliable and up to date.
- Critically review the procedures relating to the recruitment of staff and volunteers for those related to DBS (Disclosure and Barring Service) please place in full requirements including the renewal process and the decision making as to when DBS are appropriate and at what level. (**See Section 5 below**)

2.2. The scope covered:

- The most recent Section 11 assessment undertaken.
- Policy and procedures for DBS checks and renewals in relation to safeguarding.

2.3. This reviewed covered the last completed Section 11 assessment and DBS check procedures in place at the time of the audit and incorporated a critical friend review of the procedures relating to the recruitment of staff and volunteers for those related to DBS requirements including the renewal process and the decision making as to when DBS are appropriate and at what level.

2.4 This review did not provide sufficient evidence to give absolute assurance that the Council is meeting its Legislative and Regulatory duties and responsibilities in relation to safeguarding.

3. Audit Opinion and Executive Summary

3.1. From the audit work carried out we have given an opinion of **moderate assurance** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

3.2. We have given an opinion of **moderate assurance** in this area because there is a sound system of control in place but that some of the expected controls are not in place and / or are not operating effectively therefore assurance can only be given over the effectiveness of controls within some areas of the system.

3.3. The review found the following areas of the system were working well:

- The Council has formally documented its Safeguarding Policy and procedures and these are made accessible to office based staff and Members via the Orb. The Safeguarding Policy includes named designated Safeguarding Advisers to act as safeguarding leads.
- Experienced Safeguarding Leads.
- Knowledge, pro-activeness and involvement of the Community Safety Team in educating children and advising where they can seek help in relation to maltreatment and abuse.
- The safeguarding awareness, knowledge and procedures within the Family Support Service.

3.4 The audit has identified through the last Section 11 Return, areas for improvement which include the need to retain evidence which should be retained in an easy accessible file. This will assist with future completion of the Section 11 Audit Response and will allow it to be presented within a timely manner if requested by Worcestershire County Council or as part of a serious case review.

Due to the number of employees, members, volunteers and agency workers within Bromsgrove District Council and Redditch Borough Council, it would be advisable to review the number of safeguarding leads to ensure there is sufficient availability, knowledge and presence within both authorities. The Safeguard Lead has responded to this advising that it is felt that there are sufficient safeguarding leads for BDC and RBC. The primary role of the safeguard lead within RBC and BDC is to discuss, provide advice/guidance and support referrals as appropriate to children's services. All leads are shared managers so whilst their primary offices are in RBC they do work from Parkside and are accessible at all times by phone. The 3 Leads operate a rota for cover so one Lead is always on duty plus the Deputy Chief Executive is the strategic lead.

Due to the consequences to a child of child neglect the authority must not become complacent and must ensure they have robust processes in place including training records to deliver, co-ordinate, monitor and record safeguarding training to staff. A good awareness of safeguarding concerns within all service areas of Bromsgrove and Redditch is important in order to identify trends and implement or change policy when required.

3.5 The review found the following areas of the system where controls could be strengthened:

	Priority (see Appendix B)	**Section 4 Recommendation number**
Safeguarding Training & Monitoring of the Training	**High**	**1**
Commissioned Services	**Medium**	**2**
Safeguarding Policy April 2019	**Medium**	**3**
Whistleblowing	**Medium**	**4**
Literature	**Low**	**5**
Knowledge Sharing	**Low**	**6**

3.6 There were some areas of the system that audit have challenged Management on:

Challenge	Section 5 Challenge number
DBS Checks	1

4 Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
New Matters Arising – From the review of the evidence supporting the Section 11 Audit - Return Completed February 2018					
1	H	**Training and Monitoring** The manual safeguarding training records held and referred to within the section 11 was incomplete. Therefore there was no up to date record that evidenced staff that do not receive the net consent training including operational staff, agency staff and volunteers, had been trained. The training record shows that staff have been reminded that their safeguarding training is outstanding. However	Lack of Co-ordination and recording of training could result in staff not completing training and lead to incorrect procedures being followed. Resulting in vulnerable children not been given the correct and necessary help, which has the potential to lead to reputational damage for the authorities.	To ensure there is a clear Corporate Safeguarding training plan in place for each year. A review of the safeguarding training record and establish a protocol to ensure that where mandatory training is required its completion is monitored and timely	**Responsible Manager** Head of Community and Housing Services **Action** To review and improve the training record to ensure it is up to date with the ability to set up reminders including escalation to Managers

		there is no evidence that this has been addressed and no feedback from Managers are received. The results from the net consent training identified that 43% of staff incorrectly answered the question 'Which one of the following is not one of our safeguard leads'. A further report showed that the read time for this training took 50.23% of staff less than 1 minute. The training provided by Worcestershire Safeguarding Children's Board which provided more in depth training for those staff with more regular contact with children was withdrawn in March 2019 and no suitable alternative training has been identified. No evidence of specific training in relation to Safer Recruitment. There is no mention of safeguarding in the Bromsgrove Induction Policy or Guidelines for Managers dated 2005 found on the Orb. However, a new Corporate Induction handbook is		reminders are issued and followed up for non-completion. Procedures for the provision of regular fresher training should be established. Send out a communication to staff reminding them of who the safe guard leads within Redditch Borough Council and Bromsgrove District Council are. If feasible, request that the consent the staff agree to which confirms they have understood the safeguarding training is moved to the end of the training so that the presentation has to be read and test completed before they can agree their understanding. Source and implement suitable training for those staff dealing with vulnerable children on a regular basis. Review the purpose and process of the Safeguard log as it is not capturing referrals across all services including housing and no output is	**Implementation Date** 31st October 2020 **Action** To identify replacement training resources for staff who are in regular contact with children. **Implementation Date** 31st May 2020 **Action** If possible to make changes to Net consent as recommended. **Implementation Date** 31st May 2020 **Action** Re-run the results of the net consent safeguarding testing to determine if staff are still getting the question relating to who the safeguarding leads are wrong and if so, appropriate action to be taken. **Implementation Date**

		in the process of being developed for both authorities.		being recorded. Review what Safer Recruitment training is in place and if this training is being rolled out and effective. Liaise with Human Resources as to when the induction handbook is likely to be finalised and published.	30th September 2020 **Action** To review the safeguarding log and determine an appropriate process for recording referrals from all services including the housing service. **Implementation Date** 31st July 2020 **Management Response / Action** New Induction booklet on track to be launched Spring 2020. New starters have access to the system currently and will continue to trigger the launch of the safeguarding awareness training via Netconsent. **Responsible Manager** Human Resources and Development Manager **Implementation Date** 30th June 2020

					Action Explore options for safer recruitment training **Responsible Manager** Head of Community & Housing Services / Human Resources and Development Manager **Implementation Date** 30th June 2020
2	M	**Commissioned Services** The audit identified a lack of evidence to support the responses within the Section 11 Audit return with regards to commissioned services which states that safeguarding requirements built into commissioned services, tenders and specifications. **(**RBC) At the time of the audit the Rubicon Leisure safeguarding policy for safeguarding Children is still in draft stage and waiting approval. However, the Senior Safeguard Lead advised that as staff are RBC employees they were all following the RBC policy	Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such responses could be misplaced or not found if the senior safeguarding lead is not present.	Ensure that an agreed and approved safeguarding policy for Rubicon for safeguarding children is in place and that both leisure safeguarding contracts are being monitored on a regular basis. Review the procedure for new contracts in relation to safeguarding requirements. To retain evidence for the responses given in the Section 11 that can be accessed within an organised folder or	**Responsible Manager** Head of Community & Housing Services / Business Development Manager **Management Response** Rubicon Safeguarding Policy in place and safeguarding included on contract monitoring agendas **Implementation Date** Action completed 30th November 2019 **Action**

		whilst their own policy was being developed as part of the mobilisation plan. (BDC) No written evidence provided that the Bromsgrove Sports and Leisure Centre Contract has been monitored over the last year. However, a safeguarding agenda item has been added to agenda's from 15th November 2019 and monitoring of this contract is now taking place with evidence that a current issue is being monitored.		hyperlinked to the documents and produced within a timely manner if requested.	Agree a process with the procurement team to ensure that safeguarding requirements are included within relevant contracts. **Implementation Date** 30th April 2020 **Action** Evidence for future Section 11 audits to recorded electronically **Implementation date** to be determined by date of next S11 audit
3	M	**Safeguarding Policy April 2019** The response within the last Section 11 return suggests that the policy is promoted to all staff via the in house safeguarding group. The Orb and team brief. From the evidence received. It appears that the last in house safeguarding meeting was held in September 2018. There is still an old version of the safeguarding policy displayed on	Due to 2 policies showing on the Orb. Staff could refer to the out of date policy which has the potential to follow an incorrect procedure. Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such	Update the old version on the Orb or remove. Ensure that any changes to the Safeguard Policy are communicated within a timely manner to staff and evidenced. To retain evidence for the responses given in the Section 11 that can be	**Responsible Manager** Head of Community & Housing Services **Action** 1. Policy listed under the Corporate section of the Orb removed 2. Annual update to the

		the Orb under the Corporate Policy Section. The Section 11 completed Feb 18 states the policy as evidence that there is a named senior board member. However there is no mention to the board member within the policy. Other documentation could have been referred to in order to evidence this standard.	responses could be misplaced or not found especially if the senior safeguarding lead is not present. .	accessed within an organised folder or hyperlinked to the documents and produced within a timely manner if requested.	Safeguarding Policy promoted on Team Brief 3. Evidence quoted for future Section 11 audits to be cross referenced for accuracy and recorded electronically. **Implementation Date** Action point 1 completed November 2019 Action point 2 – 31st May 2020 Action Point 3 – to be determined by date of next S11 audit
4	M	**Whistleblowing** There is no mention of whistle blowing within the training on Net Consent. The Joint Whistleblowing policy dated June 2017 for Bromsgrove District Council and Redditch Borough Council is not on the Orb for staff to refer to.	Risk of potential reputational risk if the authority is unable to evidence the response within the Section 11 Self-Assessment.	Review the content of the basic safeguarding awareness training on net consent and include a reference to the Whistleblowing Policy. Make available on the Orb the June 2017 Whistleblowing Policy for both Bromsgrove & Redditch staff to refer to.	**Responsible Manager** Head of Community & Housing Services **Management Response / Action** The training on whistleblowing in the S11 audit refers to corporate training rather than it being included within the safeguarding training.

					A copy of the Joint Whistleblowing Policy 2017 to put on the Orb for staff to refer to **Implementation Date** 31st March 2020
5	L	**Literature** Safeguarding literature found on notice boards at both Redditch and Bromsgrove displayed out of date information. The up to date literature was available on the Orb.	By displaying out of date literature. There is a potential risk that staff may not follow the correct procedure which could delay vulnerable children not been given the correct and necessary help, which has the potential to lead to reputational damage for the authorities.	Remove all out of date posters, leaflets on notice boards within the Town Hall and Parkside (and anywhere else they may be used such as the depots, children centres, locality offices). Replace with up to date literature.	**Responsible Manager** Head of Community & Housing Services **Management Response / Action Plan** Literature updated at all sites **Implementation Date** Completed end of January 2020
6	L	**Knowledge sharing** The safeguard log held and assessed by the safeguarding leads shows 2 safeguarding issues were raised in 2018 and 6 have been recorded in 2019. No output has been recorded against these.	That knowledge sharing and lessons learnt are not formally shared across the organisation potentially leading to missed opportunities of better staff awareness and action.	The discussion of the Internal Safeguarding Group should be formally documented and include reference to reporting lines. Consider if there is sufficient	**Responsible Manager** Head of Community & Housing Service **Action Plan** Safeguarding Log themes and

		Lack of evidence as to what safeguarding communication has been sent to staff.	Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such responses could be misplaced or not found especially if the senior safeguarding lead is not present.	safeguard leads within both authorities.	lessons learnt to be discussed at Safeguarding Group. Key representatives from the Internal Safeguarding Group to act as additional communication links between the staff and Safeguarding Leads. **Implementation Date** 31st March 2020

5 Critical Review Challenge

The challenges identified during the review have been set out in the table below along with the related risks and management action plan.

Ref.	Current Position	Challenge	Risk	Management Response and Action Plan
1	**DBS Checks** There is awareness by management within Bromsgrove District Council and Redditch Borough Council that DBS checks are required for staff that regularly come into contact with vulnerable families and children and the DBS check is carried out during the recruitment process. The application form also asks if the candidate has any	**Renewal of DBS Checks** It is the responsibility of the employer/volunteering organisation (bearing in mind their legal and other regulatory obligations) to determine if a DBS check is needed, what level of check and workforce(s) may be applicable, and how frequently checks are updated on their staff and volunteers. If an employer / organisation require their employees to have their Disclosure Certificates renewed after a set number of years that is their decision.	Current Staff may have undisclosed convictions which may put vulnerable people at risk of harm, leading to reputational damage.	**Responsible Manager** Human Resources and Development Manager **Management Response / Action** Service Managers to work with HR to determine level of risk relating to post requiring DBS check and appropriateness of renewal HR Adviser to work with service areas to support **30th September 2020**

	unspent convictions. No records have been provided which detail which posts require DBS checks and records with volunteer's certificates and information. Each post will have documentation to support the job vacancy and any additional requirements such as DBS checks. There is no process in place for renewing DBS checks. However, mangers will ask staff in periodic meetings if there have been any changes in their DBS Status. Mangers can refer to HR for any guidance and support if a potential safeguarding issue arises and it is likely that an action plan will be put in place for the employee if there is cause for concern. There is a cost associated with DBS checks. **Recruitment and Selection Procedures**	The authorities need to consider the risk for not carrying out DBC checks during the recruitment process for roles that have contact with Vulnerable Adults, Families and children and ensure any reasons clearly documented for any decisions to not carry out the DBS check. The risk should also be considered whether a further check after a set number of years is required bearing in mind that DBS Disclosure Certificate carries no fixed period of validity and is only valid on the date of issue. The authority should ensure that there are robust procedures in place to mitigate any risk should there be a change to the employee's circumstance that would have an impact on their job role and potentially put an adult or child at risk of harm and reputational damage to the authorities.	Potential for reputational damage if the authority cannot evidence the justification to what is stated on the Section 11	

	There is no reference within the Recruitment, Selection and Employment Policy for Bromsgrove District Council regarding DBS checks (policy on the Orb not dated). The date on the Recruitment and Selection policy for RBC is November 2012 and there is no evidence that this has been reviewed or updated and refers to CBS check which was superseded by DBS checks. The HR policies do not make reference for staff to refer to the safeguarding policy recruitment section which contains the Safer Recruiting Policy and Procedures and no evidence that staff who are involved in the recruitment process have received training. Therefore there is lack of evidence that safer recruitment has been embedded via HR policy and Procedures.	Retain evidence that the Safer Recruiting Process is embedded within the recruitment process for both authorities.		

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Overall Conclusion (Critical Friend)

This shared service is delivered by Redditch Borough Council and is a statutory requirement.

Managers are responsible for identifying if DBS checks are required for the vacant post and this is discussed and agreed with HR.

The Authorities need to ensure that their recruitment policies are reviewed and updated regularly to include the policy for DBS checks and ensure that the policy makes reference to the Safeguarding Policy which refers to Safer Recruiting Procedures. A decision needs to be made by the authority as to whether to carry out any renewals of DBS checks and any policy decisions should be documented and retained for future reference on a shared drive.

There is still a potential risk for the authorities even if a DBS is carried out. Therefore there needs to be robust procedures in place to manage any change in employee circumstance that could impact on their job role or that could be a risk to others or themselves.

6. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms with the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Internal Audit Shared Service

Final Internal Audit Report

Sundry Debtors 2019/20

10th March 2020

Distribution:

To: Financial Support Manager

CC: Executive Director Finance and Resources (S151 officer)

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1. A light touch review of Sundry Debtors was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Bromsgrove District Council for 2019/20 as approved at the Audit, Standards and Governance Committee on 30th July 2019.

1.2. This review does not relate directly to the Councils Strategic Purposes but does underpin them as the system is used for the raising of invoices for the collection of Sundry Income.

1.3. There were no risks on the corporate or Service risk register relevant to this review.

1.4. The testing in relation to this review was undertaken during the months of April 2019 to December 2019 and reviewed during January 2020.

2. Reasoning for Light Touch Audit

2.1. There has been no recent or planned change in the system used or the key responsible officer for this area.

2.2. The last three years audits have given the following assurance:

Year	Assurance (Please see Appendix A)
2018/19	Significant
2017/18	Significant
2016/17	Significant

3. Audit Scope

3.1. Testing of 90 Debtors invoices randomly selected across the period was undertaken to ensure that:

- Invoices were raised for items that are reasonable for the council to charge for

- Invoice clearly states the name and contact details in case of query
- Invoices clearly stated the Debtors name and reference, goods/services supplied, charge and VAT amounts
- The charges applied are in accordance with the Council's scale of fees and charges

3.2. The five highest gross value aged debtors where selected in bias and tested to ensure that the debts had been chased in line with the Council's Debt Management Policy. It was found that debts where being chased where appropriate (a number of these debts are in line with Housing Benefits and as such can be sensitive) however the chasing was not always systematic.

3.3. Debtor Write Off was tested to ensure appropriate authorisation had been given. Papers for April, May and June where provided with authorisation, however the authorised papers for July to December had been misplaced. A total of £11218.78 debt has been written off in the period.

4. Audit Opinion and Executive Summary

4.1. If any major control/risk issues had been highlighted during the testing this would have been reported at the time. An interim report was issued in August 2019 in regard to incorrect charges for naming and numbering of new premises. Further testing in this area found that the charges had been corrected going forward. The missing authorised papers for debtor write off were reported verbally to CMT on the 14th January 2020.

4.2. From the audit work carried out we have given an opinion of **significant assurance** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

4.3. We have given an opinion of **significant assurance** in this area because there is a reasonably sound system of internal control in place and our testing in relation to the controls at 3.1 above found that incorrect charges had been used in relation to the Naming and Numbering of New Premises (as per the interim report of August 2019), and that in relation to the controls at 3.3 above found that records of authorisation of Debtor Write Off is have been misplaced.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

5. Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
1	M	**Debtor Write Off** The electronic sheets of debts to be written off are printed and manually authorised. Manual authorisation sheets for July-Dec 2019 have been misplaced.	Potential for financial loss.	If the current process of debt write off is to continue then the manual authorisation sheets are to be scanned and held electronically. Going forward, any new system to consider system authorisation of write offs.	All records of write offs are now scanned and held electronically so evidence of write off authorisation will be fully available **Responsible Manager:** Financial Support Manager **Implementation date:** Implemented

6. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms to the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Creditors 2019/20

26th February 2020

Distribution:

To: Financial Services Manager
Senior Payments Officer

CC: Executive Director Finance and Resources (S151 officer)
Senior Accounting Technician

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1 The audit of the Creditors system was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved by the Audit and Governance Committee on 29th July 2019 and the Audit, Standards and Governance Committee on 30th July 2019.

1.2 This review does not relate directly to the Councils Strategic Purposes but does underpin them as the system is used for the purchasing of goods/services.

1.3 There were no risks on the corporate or service risk registers relevant to this review.

1.4 Performance Indicators for this area are:

- The average percentage of Standard suppliers' payments (30 days).
  - As at November 2019 Bromsgrove District Council was 84.1%

1.5 The testing in relation to this review was undertaken during the months of April 2019 to December 2019 and was reviewed in January 2020.

2. Reasoning for the Light Touch Review

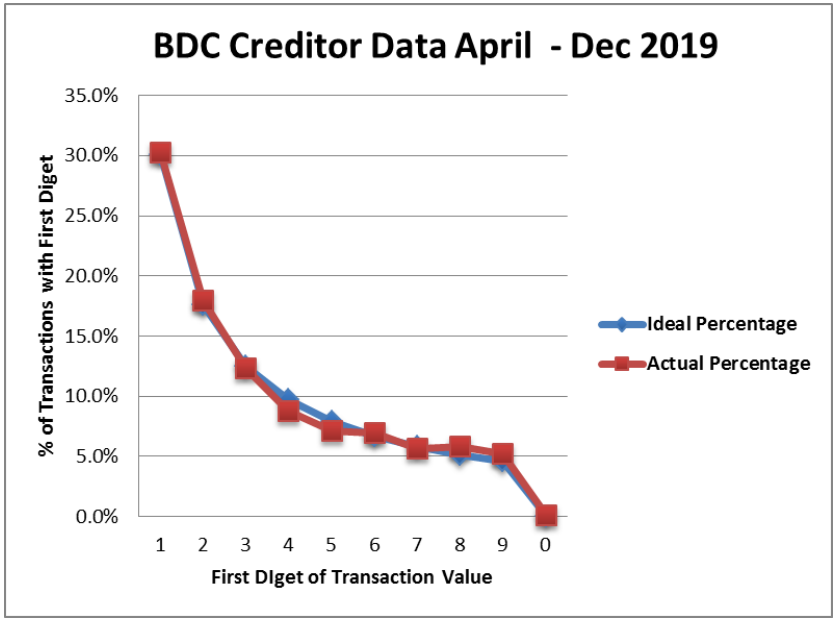
2.1 There has been no recent or planned change in the system used or the key responsible officer for this area.

2.2 The last three years audits have given the following assurance:

Bromsgrove District Council;

Year	Assurance (Please see Appendix A)
2018/19	Significant
2017/18	Significant
2016/17	Moderate This was due to a specific control of orders not being raised prior to the goods being ordered and therefore this control was included in this review.

2.3 There were no significant issues highlighted by using Benford's Law to analyse the Creditors data. **(Appendix B)**



NB: Within the data 33 transactions were for £100,000 or more, which represented 43% of the total value.

3. Audit Scope

3.1 Testing was undertaken to ensure that:

- Invoices were addressed to the Council
- The goods/services were in line with that expected for use by the Council
- The Purchase Order has been raised prior to the supply of the goods/services
- The payment has been made within 30 days of the Tax Point
- There was segregation of duties between the officer raising and authorising the order
- Authorisation levels had been adhered to
- Where applicable the VAT number is valid

3.2 The review covered the period from 1st April 2019 to 31st December 2019.

3.3 90 creditors' transactions for Bromsgrove District Council were selected across this period. The sample was biased to ensure that items over £100,000 were included and then the remainder were randomly selected using a random number generator.

4. Audit Opinion and Executive Summary

4.1 If any major control/risk issues had been highlighted during the testing this would have been reported at the time.

4.2 From the audit work carried out we have given an opinion of **significant assurance for both Councils** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit in respect of the specific audit scope as stated in 3.1 above.

4.3 We have given an opinion of **significant assurance** in this area because there is a reasonably sound system of internal control in place and our testing in relation to the controls at 3.1 above found that in one of the transactions tested it was authorised by a person without the necessary authorisation level. Please see 5 below for recommendation.

5. Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix C.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
New matters arising					
1	M	**Authorisation of transaction** One transaction for Bromsgrove District Council was not authorised by a person of appropriate level.	Potential for financial loss.	With the current system, to implement procedures that ensure that incorrect authorisation of invoices cannot occur. Within the new system, to ensure that system parameters will not allow the incorrect authorisation of invoices	**Responsible Manager:** Senior Payments Officer **Management action:** Efin has now been updated to prevent this occurring in the future **Implementation date:** 26/02/2020

6. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms to the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Internal Audit Report

NNDR 2019/20

11th March 2020

Distribution:

To: Financial Support Services Manager
Assistant Financial Support Manager
Cc: Executive Director, Finance & Resources and Section 151 Officer
Chief Executive

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

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AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1 The audit of the NNDR system was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved by the Audit, Governance and Standards Committee and the Audit, Standards and Governance Committee at the meeting held on 29th July 2019 and 30th July 2019 respectively. The audit was a risk based systems audit of the NNDR system as operated by Redditch Borough Council and Bromsgrove District Council.

1.2 The audit relates to the following from the Corporate Plan for each Authority:

- Bromsgrove District Council Key Priorities 2017-20 – Financial Stability, with the Strategic Purpose “Help me to be financially independent”
- Redditch Borough Council Strategic Purposes - "Help me to be financially independent" and “Help me run a successful business”

1.3 The following entries on the Corporate Risk Register for Redditch Borough Council and Bromsgrove District Council are relevant to this review:

- Lack of robust financial accounting and monitoring arrangements
- IT systems and infrastructure has a major failure

The following entries on the service risk register are relevant to this review:

- CUS 20: RBC Data Protection
- CUS 21: BDC Data Protection
- CUS 23: RBC Failure to meet audit requirements
- CUS 24: BDC Failure to meet audit requirements 2017/18
- CUS 25: RBC Failure to meet audit requirements

1.4 This review was undertaken during the months of December 2019 and January 2020.

2. Audit Scope and objective

2.1 The audit provided assurance that the NNDR process is maximising all income using appropriate and timely recovery methods where necessary and that bad debt is being closely managed.

2.2 The scope covered the following:

- A review of the updated position in relation to the 2018/19 audit recommendations.
- Debt recovery procedures are followed in a timely manner to ensure that income is maximised.
- The correct protocol is being followed with regards to first and any subsequent reminders and appropriate suppression is being managed.
- Collection rates and recovery success are monitored and are within acceptable levels.
- Write Offs are being administered and appropriate procedures are followed when identified.
- There is regular performance monitoring and reporting.

2.3 This review did not cover:

- Registration processes
- Identification of new dwellings

3. Audit Opinion and Executive Summary

3.1 From the audit work carried out we have given an opinion of **significant assurance** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

3.2 We have given an opinion of **significant assurance** in this area because there is a generally sound system of internal control in place but that our testing has identified isolated weaknesses in the design of controls and / or inconsistent application of controls in a small number of areas. There are three areas that were highlighted during the previous audit relating to website pages, forms and relief and

exemption reviews. Audit notes that there is ongoing work in each of these areas and implementation dates have not yet been reached therefore they will be revisited at the next review.

3.3 The review found the following areas of the system were working well:

- Debt recovery processes for current year NNDR debt are followed in an accurate and timely manner, ensuring that income is maximised.
- Write Offs are being correctly administered and all of the appropriate procedures are being followed.

3.4 It was highlighted during testing that the performance measures available via the dashboard could be re-purposed to improve on their output, relevance and usefulness. Discussions are taking place to this effect with the aim of having a new set of performance measures by the start of 2020/21 to provide management information with which the service can develop.

3.5 The review found the following areas of the system where controls could be strengthened:

	Priority (see Appendix B)	Section 4 Recommendation number
Recovery of Prior Year and Aged NNDR Debt	**Medium**	**1**

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

4. Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
New matters arising					
1	M	**Recovery of Prior Year and Aged NNDR Debt** Audit testing on random accounts with varying recovery stages showed that current year recovery was prompt, accurate and reasonable with the appropriate costs added where necessary. Testing identified that although recovery relating to previous years was being undertaken - and new attempts to recover aged debt were evidenced in the majority of cases reviewed - there were delays found in recovery being moved to the next stage including following the return of debt from the bailiff due to the resource to pursue further recovery attempts or to establish write offs being limited, leading to debt stagnation.	Adverse collection rates and loss of potential income to the authority due to limited recovery on aged debt leading to reputational damage and financial hardship.	An options paper and clear policy is formulated as to how the Councils will handle aged NNDR debt and the way it is managed going forward to maximise income and enable timely action.	**Management Response:** A review of resources for recovery of Council Tax and Non-Domestic rates will be completed within the first 6 months of 2020. As part of this review there will be a challenge to the existing Recovery Policy and Debt Collection strategies. This review will ensure that more thorough guidance is provided to teams in relation to actions for collection of debt, methods of enforcement and where applicable write off. **Responsible Manager:** Financial Services Support Manager

					Implementation Date: 30 September 2020

5. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms to the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Bromsgrove District Council
www.bromsgrove.gov.uk

Final Internal Audit Report

Worcestershire Regulatory Services (Stray Dog Service) - 2019/20

14th April 2020

Distribution:

To: Technical Services Manager
Head of Regulatory Services
Executive Director (S151 Officer)

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1 The audit of the Stray Dog Service was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Bromsgrove District Council for 2019/20 as approved at the Audit, Standards and Governance Committee on 18th July 2019. The audit was a risk based systems audit of the Stray Dog Service as operated by Bromsgrove District Council.

1.2 There were no strategic risks appropriate to this review.

1.3 The following Service Risks were relevant to this review:

- Issues with the Worcestershire Regulatory Services database system

1.4 This review was under taken by Matt Wooldridge during the month of February. .

2. Audit Scope and objective

2.1 This review has been undertaken to provide assurance that the process surrounding the management and recharging of costs associated with stray dogs are well documented, transparent and accurate.

2.2 The scope covered:

- Stray dog information is accurately recorded
- Fees are accurately calculated and recharged
- Reconciliations for the kennels/contractors used and payments made
- Potential continuity issues and conflicts of interest have been considered and documented.

2.3 This reviewed covered the period from April 2019 to February 2020.

2.4 This review did not cover:

- An independent review of the contracts in place
- The geographical logistics of the dog warden service.

3. Audit Opinion and Executive Summary

3.1 From the audit work carried out we have given an opinion of **significant assurance** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

3.2 We have given an opinion of **significant assurance** in this area because there is a generally sound system of internal control in place designed to meet the organisation's objectives. However isolated weaknesses in the design of controls or inconsistent application of controls in a small number of areas put the achievement of a limited number of system objectives at risk.

3.3 The review found the following areas of the system were working well:

- The Idox Solutions Database contained reportable information for the evidencing of key performance indicators
- There was an understanding of the trajectory of the service and the issues faced
- Evidence of the development requirements of the Idox Solutions Software
- Financial procedures in place including reconciliations for the recording and payment/receipt of the Worcestershire Partners and additional contracts for Authorities outside of Worcestershire.

3.4 There is an emerging risk of which there is awareness by the Technical Services Manager in regard to a potential conflict of interests if Dog Wardens were to licence kennels used for the kennelling of stray dogs. This is not currently an active conflict as licensing of the kennels currently used for the housing of stray dogs is completed by an Officer outside of the stray dog process, however this may become an issue following Dog Wardens acquiring the relevant qualifications under the new legislation that comes into force during 2021, it is advised therefore that appropriate procedures are documented to allow the avoidance of any conflict of interest to continue in future.

3.5 Additionally there is an ongoing system issue that does not allow a time to be input to the Idox Solutions system when recording stray dog cases however this has been raised with the vendor prior to the audit and therefore is included for note only.

3.6 The review found the following areas of the system where controls could be strengthened:

	Priority (see Appendix B)	**Section 4 Recommendation number**
Contract Continuity	**Medium**	**1**
Contractor Reconciliations	**Medium**	**2**
Idox Solutions Narrative	**Low**	**3**

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

4. Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Ref.	Priority	Finding	Risk	Recommendation	Clearance meeting discussion points
New matters arising					
1	M	**Contract Continuity** Testing identified that all kennels used had a contract in place. However a number of contracts had expired and are operating under a month extension (that had been accepted by all contractors at the time of audit) whilst procurement for new contracts continued. There is potential for there to be a further requirement to extend again on a month by month basis until the procurement process is completed.	Service continuity is affected if a contractor refuses an additional extension prior to successful procurement of new contracts.	It is accepted that a number of charitable organisations and commercial businesses exists in relation to stray dogs and there is a number which could be used during a continuity issue. However continuity could be further improved by ensuring the procurement process is actioned and completed in preparation for the end dates of any current contracts. Additionally any other kennels that could potentially be used in a continuity event are documented as part of service continuity arrangements.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** The recommendation to commence the procurement process in good time is accepted and will be actioned when the contracts are next due to be tendered. In relation to maintaining a list of potential kennels, this is not considered of value. Geographical remit of WRS changes and businesses willing to work with us change depending on date and reason. With the vast number of potential kennelling facilities that are available within our current operating range, it would be a

					considerable task that would not be useful at the time we required the information collated. There is no intention to undertake this part of the recommendation. **Implementation Date:** October 2022 (ahead of expiry of contract February 2023)
2	M	**Contractor Reconciliations** Reconciliations are performed for costs and charges for all stray dog cases for the contracts undertaken on behalf of Authorities outside of Worcestershire. In addition to this charges are verified for veterinary services received by the Senior Dog Warden prior to invoices being passed for payment. However there is no periodic reconciliation for charges received in relation to stray dogs from within Worcestershire for kennelling and out of hour collections. It is understood there is some mitigation of risk in place in the form of the reconciliations completed for the external contracts as mentioned above as the contractor used for kennelling dogs and the out of hours service	Errors/fraud not identified on contractor invoices prior to being passed for payment.	Periodic/random reconciliations are performed on charges received in relation to Worcestershire stray dogs so that potential discrepancies are identified and reported back to the relevant contractor.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** The recommendation is accepted and periodic random checks will be made on charges received. **Implementation Date:** 1st June 2020 (to enable new processes and contracts to bed down and account for issues raised by COVID-19)

		is the same for all stray dogs regardless of location and therefore discrepancies may be picked up on invoices in relation to these external contract charges.			
3	L	**Idox Solutions Narrative** Testing showed that all relevant information was recorded on the account to allow the discharging off the service and both Dog Wardens and the Technical Service Manager were aware of ongoing cases including difficulties within more complex cases. However an increase in the amount and quality of narrative and therefore justification of decisions made would be beneficial when reviewing individual stray dog cases and to justify decisions if challenged.	Unable to justify decisions if challenged due to lack of descriptive narrative on the database (transparency). Lack of clear audit trail.	Staff are reminded of the importance of including all relevant information that does not conform to a defined field within the narrative box to allow easier review and justification of decisions made.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** It is accepted that an improvement in the quality of the information recorded would benefit the service. A reminder to all staff to ensure appropriate level of detail is provided on case records. This will be audited with a view to identify training requirements or action. **Implementation Date:** 1st April 2020

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

5. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms with the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Appendix 4

Finalised 'Follow-Up' Reports

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Health and Safety Follow Up 2019/20

17th February 2020

Distribution:
To: Director of Finance and Resources
Head of Transformation
Human Resources and Development Manager

CC: Senior Health and Safety Advisor
Chief Executive

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1 The Health & Safety follow-up was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council for 2019/20 as approved by the Audit and Governance Committee on 20th March 2019. The audit was a follow up of the Health & Safety Audit 2018/19.

1.2 This area is fundamental in the achievement of all 5 themes contained in the Worcester City Plan 2016-2021.

1.3 The following entries on the corporate risk register were relevant to the original review:

- COR19 – Non Compliance with Health and Safety legislation

The following entries on the service risk register were relevant to the original review:

- COR19 – Non Compliance with Health and Safety legislation

1.4 This follow up was undertaken during the months of January and February 2020.

2. Audit Scope and objective

2.1 The original review gave **Limited Assurance** over the control environment and covered:

- Review of action plan
- Financial Analysis and Review of the training budget
- Health and Safety Documents
- Planning and development
- Training
- Communication of Health and Safety information
- Risk Assessments and Risk Management
- Fire Safety Risk Assessment and Risk Management
- Active and Re-active Monitoring and review of Health and Safety Statistics and information
- Corporate Health and Safety advice and support

2.2 This follow up has concentrated on the actions taken by management to address the findings of the 2018/19 audit.

3. Executive Summary

3.1 The original review gave **Limited Assurance** and found that controls could be strengthened in the following areas:

	Priority (see Appendix B)
Policies	High
Manager IOSH training	High
Fire Risk Assessments Action Plan	High
Fire Alarms and Drills	High
Action Plan update	Medium
Financial Analysis and Training budget:	Medium
Induction Process	Medium
Bespoke health and safety training	Medium
Risk Assessments	Medium

3.2. This follow-up has sought evidence, explanations and information in order to assess the progress against the Management action plan in relation to the above control areas. The results of this follow up can be seen in Section 5.

4. Conclusion - Current Position statement

Health and Safety have made good progress in addressing the recommendations made during the Health & Safety 2018/19 Internal Audit. Bespoke in house training has been developed for health and safety including risk assessment training for managers with scope to expand this to include a Health and Safety Induction and Manual handling.

There remains an outstanding risk as the Fire Risk Assessments throughout the council need to be fully completed however there is a programme in place for the completion of these. In addition there is no evidence that regular fire alarm testing is taking place and a full

programme of fire drills has not been completed. Whilst we are aware that there is a programme in place for alarm testing and fire drills, work needs to be undertaken to ensure these are being completed and completion is documented.

5. Detailed Findings, Recommendations and Updated Position

The issues identified during the 2018/19 Health and Safety audit have been set out in the table below along with the related recommendations, management responses and action plan and actions taken up to the time of the follow-up. The issues identified were prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
1 High	**Policies** **The Orb** Testing of the policies on the orb found that: - • There are policies missing i.e. the Fire Safety Policy. • There is no version control on the policies from a version/review date perspective. • There is no evidence to show if the documents on the orb is the same	**The Orb** Effective working practice is established to ensure policies are uniform and are uploaded on the orb in a timely manner for both Councils at the same time to prevent any knowledge gaps. All policies must have a version control associated and a review date prominently displayed.	**Responsible Manager:** **HR Manager** Approval process is currently under review which will potentially change the delegation which will stream line the process and the activation and communication of policies. **Implementation date:** April 2019		**In Progress** Health and Safety statement of intent and Health and Safety Manual have been developed, both documents have been approved by the both Council Leaders and have been published on the Orb. The policies detail version control and the date of publishing. The Health and Safety statement of intent details the Councils' commitment to a 'Plan Do check Act' approach to health and Safety. The Health and Safety Manual is an all-

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	document that was written in 2011. • Using the Orb it is easy to access Health and Safety policies but regarding fire procedures, training and other areas it is more difficult to navigate through.	There must be an established forum e.g. Orb, notice board, providing ease of use and access to information.	Review of notice boards will be undertaken including review of electronic notice boards Section was cleared down in Sept/Oct 18 April 2019		encompassing manual which details: - Organisation structure and responsibilities, - Health and Safety Management Governance. - Specific Health and Safety Arrangements including fire precautions, first aid at work and lone working. Noticeboards are still in place however information held on these has been reduced. No funding is currently available for rolling screens however information is updated to Orb to ensure staff are aware of changes to policies/procedures. Council wide decision taken to continue with the orange high vis, some areas have introduced green for first aiders. Details of first aiders are held centrally and courses are made available to them. Further work to be undertaken to display first aider notice to include photos and locations.
2 High	**Manager IOSH training** The findings indicate that: • There is no review date. • There is no expiry date. • Managers may not have attended the allocated training slot.	Establish a mandatory requirement for IOSH training and issue reminders when completed training is set to expire.	**Responsible Manager: Health and Safety Officer / HR** Accepts taking on part of the risk, as does not believe need to commit to IOSH Managing Safely as a mandatory course, as there are alternative routes that could be taken.		**Complete** There is no requirement to make IOSH a mandatory course. CMT have given approval for internal risk assessment training to be delivered by the Senior Health and Safety advisor. The training will be delivered to frontline managers, however IOSH training will be provided where required.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			Suggestions to improve include: - • Identify the right people who would require the training (likely front line managers) • Develop an in-house course, which could take one day, which delivers: 1.) Broad introduction to health and safety law and how it applies to both councils 2.) Accident and incident investigation 3.) Risk assessment • To go down the route of getting approval / endorsement from IOSH • This would not require IOSH to be paid to come in and present each time Regarding ensuring this detail is tracked and reviewed, that is not difficult to achieve. I would then		

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			suggest refresher on a three year basis. **Implementation date:** February 2019		
3 High	**Fire Risk Assessments Action Plan** The findings are that: - • According to the 2014 action plan there are a number of items incomplete especially regarding housing. • There are no public buildings such as Parkside in Bromsgrove and Town Hall in Redditch mentioned within the 2014 action plan. • There is a sheet being filled in by housing and a sheet being filled in by place partnership. • There is a high risk item set in 2016 which was not complete as of 11th June 2018. Review date stated mentions 2019. • Risk assessments are not being completed frequently.	To update the 2014 action plan to include all public buildings for both councils and to ensure that it is up to date to mirror the actual fire risk assessments that have been filled in. It is recommended to have regular meetings regarding the process on the action plan to ensure controls are in place and to create an audit trail through the minutes. To ensure 'high risk' items are updated and dealt with in as a priority and it a timely manner.	**Responsible Manager: Senior Contracts Manager** An IT system has been sourced and will be part of the asset management system implementation that Senior Contracts Manager is leading on and will enable better maintenance of records and data. Public buildings will be managed centrally. Budget bid for dedicated system linking to PPL transfer in-house. **HR& OD Manager** **Facilities Management** - **Property Services** - **Place Partnership** - **Housing** **Implementation date:** Bromsgrove to review in October/November 2019.		**In Progress** Ridge have now been contracted to complete the Council's Fire Risk Assessments. There is a programme in place to complete baseline assessments across the council; once these are completed the plan will change to a risk based approach.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			Place Partnership will no longer be carrying out this work post 31st march 2019. It is therefore intended that processes and procedures will be established as part of the Officer in Charge process to ensure that all fire safety checks are carried out in a timely and compliant way by the transfer date. It is also intended that all officers with responsibility for FRAs will review risk assessment and action plans and training will be delivered where required. Health checks are currently being carried out in the Housing Schemes and new FRAs being developed for High Risk Housing		
4 High	**Fire Alarms** There is no consistency in how often the test is carried out. In August 2017 for instance it	To ensure a control is in place at both councils to carry out a weekly fire	**Responsible Manager: Facilities Management** - Property Management – BDC		**In Progress** Weekly tests are being completed.

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Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	was noticeable that the test was only carried out once; there is also other occasion during the year of 2017 where tests have been infrequent. **Fire Drills : - Bromsgrove District Council** For the Bromsgrove District Council Depot evidence suggests that the latest fire drill was completed on 23/5/2014. The follow up should have been completed in November 2014. This did not occur and is non-compliant. At the Parkside site the evidence provided shows that the last live fire drill was performed in October 2017. This should have been followed up in April 2018. This is now non-compliant.	alarm test and record it to comply within British Standards 5839. If a test is not completed on a weekly basis then there needs to be justification to support why it was not carried out in case a fire officer visits the site and questions it. Redditch Borough Council and Bromsgrove District Council need to establish a requirement to complete a fire test regularly to remain within compliance for fire safety regulations. It is recommended that both depots start to commence fire drills within a 6 month window to ensure that they are compliant and regiment the evacuation process for any fire Marshalls. A process to be established where a designated fire warden is	- Place Partnership – RBC **Implementation date:** BDC – Implemented RBC – April 2019 To create a sub group to work through recommendations and give a clear plan by April 2019. Group to feature Health and Safety Advisor, Facilities and be supported by Claire Felton and Guy Revans. This group will also review officer behaviour through fire drills to ensure compliance. To deliver fire drills at all sites in Dec-18.		Fire evacuation drills will happen over a phased period across all locations once completed these will take place on a risk basis, i.e. some locations may only complete one a year however other such as children's centres will have these more frequently. Fire wardens are made aware of their responsibilities during training. Evacuation procedures are being reviewed by RIDGE as part of their Fire Risk Assessments and local site management is then required to establish plans based upon recommendations therein. Contractors are provided with a site induction on arrival.

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Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
		located next to one of the fire exits to ensure no unauthorised personnel re-enter the building until safe to do so. Better planning to ensure that the fire alarms are tested on time and that the key is available and not moved. A process is established to ensure all contractors sign a register when coming to work on site and that they have basic induction training to know where the fire evacuation point is. It is recommended to have a systematic approach to ensuring all documentation is up-to-date at all times so that if departments change locations this does not impact on obtaining an assurance that everyone has left the building.	To provide audit trail moving forwards, to be implemented immediately.		

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
5 Medium	**Action Plan Update** Testing of the health and safety action plan found: - • There is no version control within the action plan to state when it was last edited or modified. • There is a lot of information which has a narrative as 'Out Of date' and no comments as to why the action is out of date or what has been put in its place. • The target deadline date has been not been adhered to since the end of 2014. • There are target dates in place but none of the targets set have been completed. • The recommendations from the fire risk assessment and management perspective have not been completed according to the action plan. • There is no tab specifically for 'Planning and Development'. There is no evidence of a planning and development within the action plan scope for the	The action plan should be treated as a key management tool driving the development of H&S and must be regularly updated with a systematic approach to enable a clear indication of progress. A version control must also be included and priorities need to be established e.g. fire risk assessments and management perspective. To focus on getting any work 'Out of date' completed and to include a new tab saying 'Planning and development' as well as to include High/Medium/Low priority to assist the planning structure.	**Responsible Manager: HR Manager** Work will be actioned to combine all H&S Audits into a definitive action plan **Implementation date: April 2019** Whilst a large amount of work has been taken from the 2014 action plan. An ambulation of plans will take place and used to go forward from April 2019.		**Complete** Action plan is regularly reviewed and monitored; progress towards implementation is reported to the Health, Safety and Wellbeing Committee and the Audit and Governance Committee.

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Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	technological and innovative factors of the business.				
6 Medium	**Financial Analysis and Training budget:** • There is no centralised finance code dedicated for Health and Safety. • There is no system in place for showing value for money is being achieved on spend. • The budget was overspent on a couple of occasions at both Bromsgrove District Council and Redditch Borough Council.	To improve overview of the training budget use. To consider using cost centres for the training budget and Health and Safety to improve corporate oversight of expenditure.	**Responsible Manager: HR Manager in conjunction with Finance Director.** There is a current review of corporate training budgets and the separation of H&S training in readiness for 2019/20. **Implementation date: April 2019**		**Complete** Review of budgets completed, a decision has been taken to provide bespoke in house training in most instances. External training courses will only be provided where there is a specific need.
7 Medium	**Induction Process** The findings from the testing showed that: - • No corporate training has been completed on a scheduled basis and there is evidence to show that even under the presumption that training was being carried out on a monthly basis there is no evidence that can prove this. • Inductions have not been completed for a while; there	**Training** Design into the new HR training system to leaver's dates, start dates and a review date to enable local monitoring regarding the training from both a corporate and service level perspective leading to better communication between local departments and Human Resources.	**Responsible Manager: HR Manager** **Implementation date:** Looking at corporate induction process and currently under review. Consideration being given to hard copy and interactive learning. Full review to be undertaken which is		**In Progress** A review of the corporate induction process is currently being undertaken

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	is no review date or location included to state Redditch Borough Council or Bromsgrove District Council. • There are blank entries and 'n' showing in the attendance of the training throughout the training document with no comments as to what was done to get staff on the training. • No training has happened since 2017 due to limited resources. • There is no information being passed on to Human Resources from local teams to confirm what training that has been completed.	To establish exception reporting to ensure comment are included in any fields that are blank or show 'n' on the training attendance. The frequency of induction training to be established. Introduce self-serve training systems through e-learning and ensure all new employees complete mandatory induction training within 30 days. Probationary periods should not be signed off if mandatory training has not been satisfactorily completed. Existing staff to have mandatory training requirements identified for their roles and reported on an exceptions basis.	currently underway. **July 2019**		
8 Medium	**Bespoke health and safety training** • There is no systematic approach in reference to how the training is being recorded.	**Be-Spoke training** To develop further the 2014 action plan to ensure all training is completed and recorded in a timely manner.	**Responsible Manager: HR Manager** Continue to review and explore how training can be monitored and recorded on		**In Progress** A new system is being introduced later this year which will encompass the HR system, functionality of this may allow for training to be recorded and allow for prompts highlighting that

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	• There are dates in place for training for both supervisors and team leaders, but there is no evidence that training took place or who attended the training sessions. • There is no review date in place for any training that was completed. • There is no information that the employee in question still currently works for the Council.	Consider what the new system can provide in order to establish record integrity in regards to the current workforce training requirements, how it is reported and how potential training gaps can be identified.	the HR 21 system. By the end of the first financial quarter we will have a better understanding of the budgets allocation and the spend on training and training records. **Implementation date: July 2019**		training needs are to be reviewed after a given time period.

6. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms to the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Andy Bromage
Head of Internal Audit Shared Services

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

2019/20 INTERNAL AUDIT ANNUAL REPORT AND AUDIT OPINION

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder Consulted	No
Relevant Head of Service	Chris Forrester, Financial and Customer Services
Ward(s) Affected	All Wards
Ward Councillor(s) Consulted	No
Key Decision / Non-Key Decision	Non–Key Decision

1. SUMMARY OF PROPOSALS

1.1 To present:

- The 2019/20 Internal Audit Annual Report for the period 1st April 2019 to 31st March 2020 along with the Audit Opinion and Commentary.

2. RECOMMENDATION

2.1 **The Committee is asked to RESOLVE that the report is noted.**

3. KEY ISSUES

Financial Implications

3.1 None as a direct result of this report.

Legal Implications

3.2 The Council is required under Regulation 6 of the Accounts and Audit Regulations 2018 to "undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control".

Service / Operational Implications

3.3 **Appendix 1** provides a summary of allocation in respect of the 207 audit days delivered against the 230 budgeted.

3.4 **Appendix 2** provides a breakdown of the audits completed including the overall assurance as well as confirmation of follow up audits undertaken during the year

3.5 **Appendix 3** provides the 2019-20 audit opinion and commentary.

3.6 **Appendix 4** provides a copy of the Internal Audit Charter for WIASS.

3.7 **Appendix 5** provides a copy of the quality assurance improvement programme (QAIP).

3.8 **Dashboard:**

Target total of reviews for delivery 2019/20:	13 (minimum)
Actual reviews delivered:	19
Reviews finalised to date for 2019/20:	16
Reviews currently awaiting final sign off:	3
Assurance of 'moderate' or above:	13
Assurance of 'limited' or below:	2
Reviews requiring audit work completion:	0
Number of 'High' Priority recommendations reported for year:	9
Productivity:	81% (against targeted 74%)
Overall plan delivery:	90% (against target >90%)
Feedback for Service	Good

3.9 The Worcestershire Internal Audit Shared Service (WIASS) has achieved and delivered the 2019/2020 internal audit plan with minor revisions.

3.10 The Internal Audit Plan for 2019/2020 was risk based (assessing audit and assurance factors, materiality risk, impact of failure, system risk, resource risk, fraud risk, and external risk) and reported to the Audit, Standards and Governance Committee on the 30th July 2019. It included:

- a number of core systems which were designed to suitably assist the external auditor to reach their 'opinion' and other corporate systems for example governance and
- a number of operational systems, for example planning, safeguarding and markets were looked at to maintain and improve its control systems

and risk management processes or reinforce its oversight of such systems.

3.11 In accordance with best practice the plan is subject to review each year to ensure that identified changes, for example, external influences, risk assessment and process re-engineering are taken into consideration within the annual plan.

3.12 The purpose of the 2019/20 Annual Plan was to aid the effectiveness of the Internal Audit function and ensure that:

- Internal Audit assisted the Authority in meeting its corporate purposes by reviewing the high risk areas, systems and processes,
- Audit plan delivery was monitored, appropriate action taken and performance reports issued on a regular basis,
- The key financial systems are reviewed annually, enabling the Authority's external auditors to inform their opinion using the work completed by Internal Audit,
- An opinion can be formed on the adequacy of the Authority's system of internal control, which feeds into the Annual Governance Statement which is presented with the statement of accounts.

3.13 The Service carefully managed its resource and worked with partners to deliver the revised audit programme for Bromsgrove District Council for 2019/20 with regular updates of progress reported before Committee. The s151 Officer was kept fully briefed during the year in regard to overall progress and was instrumental in the plan variance along with enhancing the process to achieve quicker management sign off. There was also regular reporting to both SMT and CMT.

3.14 During 2019/20, audit reviews totalled 19. Summaries of the audit reports, plus the Auditors opinion on the effectiveness of the controls operating within those areas and an action plan containing recommendations to address the identified control weakness, have either been reported before the Audit, Standards and Governance Committee on an on-going basis throughout the year or will be reported on finalisation.

3.15 Based on the audits performed in accordance with the audit plan the Worcestershire Internal Audit Shared Services Manager has concluded that, on the whole, the internal control arrangements during 2019/20 effectively managed the principal risks identified in the revised audit plan but there continues to be pockets of risk within the organisation where mitigation work is continuing.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

Annual Governance Statement ~ Assurance Checklist Statements 2019/20

3.16 It is the responsibility of management to maintain the Authority's internal control framework and ensure that controls are being complied with.

3.17 In order to ascertain management's view on this and in order to identify any areas where current or emerging risks in relation to internal controls may exist, all Fourth Tier Managers were asked to complete an internal control checklist covering Strategic and Operational, Human Resources, Corporate Procedure Documents, Service Specific Procedures, Risk Management and Anti Fraud, Performance Management and Data Quality, Inventories and independent recommendations from outside bodies including audit.

3.18 Officers were required to acknowledge their responsibilities for establishing and maintaining adequate and effective systems of internal control in the services for which they are responsible and confirmed that those controls were operating effectively except where reported otherwise.

3.19 A review of the returned statements indicates that although work continues there are several areas where work is required to strengthen some control requirements. It is considered that those areas identified do not present a significant and material risk at this time. The areas identified in the statements will be considered as part of the audit programme. A reoccurring theme identified a lack of resources as a current or emerging area of risk.

Work of interest to the External Auditor

3.20 To try to reduce duplication of effort we understand the importance of working with the External Auditors. The audit plan is shared with the external auditors for information. The result of the work that WIASS has performed on seven systems audits was of direct interest to External Audit. However, all audit reports are passed to the external auditor on request for their information.

External Work

3.21 The work to deliver the ICT work for Worcestershire County Council audit contract was completed during 2019/20. This contract has been extended for a further three years.

Follow Up Audits

3.22 A summary of audit follow ups for the year is provided as part of Appendix 2. This area of work is undertaken to ensure that potential risks to the authority are mitigated. The outcome of this work is reported on an exceptions basis. There have been no exceptions reported to the Committee during 2019/20. Follow ups, and any exceptions, will continue to be reported but the number of additional visits to ensure points are satisfied is continuing to decrease compared with the previous years. From April 2020 onwards the full report is planned to be presented before Committee rather than a summary position.

Quality Measures

3.23 Managers are asked to provide feedback in regard to systems audits that have taken place by completing a questionnaire. At the conclusion of each audit a feedback questionnaire is sent to the Responsible Manager and an analysis of those returned along with anecdotal evidence during the year shows very high satisfaction with the audit product – see **Appendix 2.**

3.24 To further assist the Committee with their assurance of the overall delivery and that Worcestershire Internal Audit Shared Service conforms to the Public Sector Internal Audit Standards (as amended). All staff work to a given methodology and have access to the internal audit reference material and charter which are updated regularly to reflect the requirements of the standards and the changing environment that WIASS is auditing in. A copy of the Audit Charter is included at **Appendix 4** for information.

Independence and Safeguards

3.25 Worcestershire Internal Audit Shared Service Internal Audit activity is organisationally independent. Internal Audit reports to the s151 Officer but has a direct and unrestricted access to senior management and the Chair of the Audit, Standards and Governance Committee.

3.26 Further quality control measures embedded in the service include individual audit reviews and regular Client Officer feedback. Staff work to a given methodology and have access to the internal audit reference material and Charter which have been updated to reflect the requirements of the standards. The Charter is included as part of this report at **Appendix 4**. Where WIASS provide assistance with the preparation of areas of work such as risk management there are clear safeguards in place to ensure independence is not compromised. Safeguards include review within the audit service by an independent person to those who have completed the work as well as independent scrutiny by the Executive Director – Finance and Resources of the authority. Audit Committee can also challenge the reported findings and the minutes would record this.

3.27 The Client Officer Group which is the management board for the Service is made up of partner s151 Officers. They meet on a regular basis and consider the performance of the Shared Service including progress against the Service Plan as well as actively promoting the continuous improvement of the Service. Further improvement has been identified through the self assessment process which was carried out in April 2019 and a quality assurance improvement plan (QAIP) was formulated and implemented during the year. This is reported for information at **Appendix 5**.

Risk Management

3.28 Heads of Service periodically provide Risk Management updates before the Audit Committee for consideration along with verbal updates from the Financial Services Manager to provide assurance. Development of the risk management system continues under the Directorship of the Executive Director – Finance and Resources.

Assurance Sources

3.29 We recognise there are other review functions providing other sources of assurance (both internally and externally) over aspects of the Council's operations. Where possible we will seek to place reliance on such work thus reducing the internal audit coverage as required.

Other Operational Work

3.30 Work is continuing in respect of the National Fraud Initiative (NFI) exercise. Appropriate action is being taken and work is progressing to identify any potential fraudulent activity for example overpayment for housing benefits, income support, etc. The last significant data extract was during 2018/19 and the results continue to be worked on. A further data upload took place in December 2019 for single person discount and Election data. A further significant upload of data is scheduled for December 2020.

COVID-19 Pandemic Impact 2019/20

3.31 The majority of the revised 2019/20 plan was completed prior to the COVID-19 pandemic lockdown in March 2020. Loose ends were completed and some draft and final reports were issued during the lockdown period. Three 2019/20 reviews that did not take place were Risk Management, Procurement and Waste – Scalability of Service. All feature in the 2020/21 plan.

Customer / Equalities and Diversity Implications

3.31 There are no implications arising out of this report.

4. RISK MANAGEMENT

The main risks associated with the details included in this report are.

- Non-compliance with statutory requirements.

5. APPENDICES

Appendix 1 ~ Delivery against plan 2019/20
Appendix 2 ~ Audits completed with assurance for 2019/20 and audit follow up work
Appendix 3 ~ Audit Opinion and Commentary
Appendix 4 ~ Internal Audit Charter
Appendix 5 ~ Quality Assurance Improvement Programme (QAIP)

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

6. BACKGROUND PAPERS

None.

7. Key

N/a

AUTHOR OF REPORT

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 1

Delivery against Internal Audit Plan for 2019/20
1st April 2019 to 31st March 2020

Audit Area	2019/20 PLANNED DAYS	2019/20 DAYS USED
Core Financial Systems (see note 1)	52	52
Corporate Audits (see note 4)	50	41
Other Systems Audits (see note 2 and 4)	92	81
TOTAL	**194**	**174**
Audit Management Meetings	15	16
Corporate Meetings / Reading	5	5
Annual Plans, Reports and Audit Committee support	16	12
Other chargeable (see note 3)		
TOTAL	**36**	**33**
TOTAL (see note 4)	**230**	**207**

Note:

Days are rounded to the nearest whole.

Note 1: Core Financial Systems were audited using a rolling programme throughout the year in order to provide a larger sample to maximise the assurance provided for Annual Governance Statement and Statement of Accounts.

Note 2: Budgets contained in this area include draw down/contingency budgets which by their nature may or may not be used e.g. fraud and special investigations, consultancy and advisory.

Note 3: 'Other chargeable' days equate to times where there has been significant disruption to the ICT provision resulting in lost productivity.

Note 4: The small variation in planned days to actual days was due to a combination of factors including theCovid-19 lockdown.

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Date: 22nd July 2020

Performance against Key Performance Indicators 2019-2020

The success or otherwise of the Internal Audit Shared Service will be measured against some of the following key performance indicators for 2019/20. Other key performance indicators link to overall governance requirements of Bromsgrove District Council e.g. KPI 4 to KPI 6.

	KPI	Trend/Target requirement	2018/19 Year End Position	2019/20 Year End Position		Frequency of Reporting
Operational						
1	No. of audits achieved during the year	Per target	Target = 13 (minimum) Delivered = 17	Target = 13 (minimum) Delivered = 19 (incl. 3 in draft)	🙂	When Audit Committee convene
2	Percentage of Plan delivered	>90% of agreed annual plan	98%	90%	😐	When Audit Committee convene
3	Service productivity	Positive direction year on year (Annual target 74%)	67%	81%	🙂	When Audit Committee convene
Monitoring & Governance						
4	No. of 'high' priority recommendations	Downward (minimal)	16	8	🙂	When Audit Committee convene
5	No. of moderate or below assurances	Downward (minimal)	10	7	🙂	When Audit Committee convene
6	'Follow Up' results (Using 2017/18 reviews onward)	Management action plan implementation date exceeded (nil)	1	0	🙂	When Audit Committee convene
Customer Satisfaction						
7	No. of customers who assess the service as 'excellent'	Upward (increasing)	4x issued 3x returned 'excellent' 1x awaited	6x issued 4x returned 'excellent' 2 awaited	🙂	When Audit Committee convene

WIASS conforms to the Public Sector Internal Audit Standards as amended.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

Appendix 2

Audit Opinion Summary Analysis ~ Audits completed during financial year 2019/2020:

Audit Report / Title	Final Report issued	Assurance
Worcestershire Regulatory Services	14th April 2020	Significant
National Non Domestic Rates	11th March 2020	Significant
Debtors	10th March 2020	Significant
Creditors	26th February 2020	Significant
Council Tax	6th February 2020	Significant
Bereavement Services	24th September 2019	Significant
Planning Application Process: Planning Applications S106 Contributions	4th February 2020	Significant / Moderate
Main Ledger	11th March 2020	Moderate
Safeguarding	5th March 2020	Moderate
SLM	7th January 2020	Moderate
Compliments and Complaints	6th December 2019	Moderate
Treasury Management	18th October 2020	Moderate
Document Retention Policies	5th November 2019	Limited
Markets	6th September 2019	Limited
Bulky Waste	1st July 2020	Critical Review
Health and Safety (Hybrid)	17th February 2020	Follow Up Hybrid
Business Continuity	20th April 2020(D)	Moderate (D)
Benefits (Hybrid)	25th March 2020(D)	Follow Up Hybrid (D)
ICT	4th March 2020(D)	Critical Review (D)

Note: (D) = draft report but no variance expected.

Follow Up Audits:

Audit Area	Latest Date for Follow Up	Position
Equality and Diversity 2014/15	September 2018	Satisfied
On /Off Street Parking 2018/19	December 2019	Ongoing
Health and Safety	February 2020	Satisfied
All core financial audits		

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

Summary of 2019/20 Audit Assurance Levels from 19 audits.

Number of Audits	Assurance	Overall % (rounded)
0	Full	0%
7	Significant	37%
6	Moderate	32%
2	Limited	10%
0	No	0%
0	To be confirmed	0%
4	Critical Friend/Hybrid	21%

Client Feedback Analysis ~ IA Reporting

Feedback is sought after the issue of the final audit report via a feedback questionnaire. Sometimes this is reported back verbally rather than in the written form. The feedback is used to assess the effectiveness of internal audit and to help improve and enhance the internal audit function. Feedback during the 2019/20 financial year has been received indicating that:

- the auditee was happy with the process and format of the audits. This continues to be further developed.
- anecdotal evidence indicates a high satisfaction rate with the audit product from the data received.

Comments received included:

- [The Auditor] was able to grasp the processes and complexities very quickly.
- [The Auditor] was able to carry on with little assistance from me in accessing things.
- Common sense was used and practicality considered.

Overall Conclusions:

- The 2019/20 Internal Audit Plan as agreed by the Audit Committee on the 30th July 2019 along with any subsequent revisions has been delivered.
- 69% of the audits undertaken for 2019/20 which have received an assurance allocated returned an assurance of 'moderate' or above.
- Clients are satisfied with the audit process and service from the data received.

- Independent assurance has been brought before the Committee for consideration in respect of the finalised audits throughout 2019/20 and one exception was reported in regard to 'follow up' audit work.
- To assist the Committee to draw further assurance from the work that Internal Audit undertakes clear reference is contained in the final audit report to identify whether a direct link exists to corporate priorities and the risk register entry in connection with the audited service provision. This information has been, and will continue to be, reported to the Committee as part of the summary reporting in 2020/21.
- On-going dialogue will be maintained with the s151 Officer and the Client Officer Group. The Client Officer Group for the Internal Audit Shared Service comprises all the partners' s151 Officers whom actively encourage the on-going development of the service.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 3

Audit Opinion and Commentary 2019/20

1. Overall Conclusion

1.1 Based on the audits performed in accordance with the approved plan, the Head of Internal Audit Shared Service has concluded that the internal control arrangements during 2019/20 effectively managed the principal risks in a number of areas, but not all, and can be reasonably relied upon to ensure that the Council's corporate objectives have been met in the main. Close monitoring of deployed measures are set to continue but the need to reduce the overall risk and work towards a better approach beyond 2019/20 will be critical to create better transparency, expectation and accountability. This will be necessary in order to ensure the District manages risk management effectively, and, ensure other areas which attracted a 'limited' assurance develop and deploy a sound control environment where there is the potential for emerging risk.

2. Risk Management Conclusion

2.1 The Head of Internal Audit can confirm the development of the formal risk management system is set to continue in the organisation under the Direction of the Executive Director - Finance and Resources with a view to achieving a better embedded approach in the future.

3. Audit Opinion

3.1 The internal audit of Bromsgrove District Council's systems and operations during 2019/20 was conducted in accordance with the Internal Audit Annual plan which was approved by the Audit, Standards and Governance Committee on 30th July 2019 and any subsequent revision.

3.2 The Internal Audit function was set up as a shared service in 2010/11 and hosted by Worcester City Council for 5 district councils and increased to 6 partners with the inclusion of Hereford and Worcester Fire and Rescue Authority from April 2016. The shared service conforms with CIPFA guidance and the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and objectively reviews on a continuous basis the extent to which the internal control environment supports and promotes the achievement of the Council's objectives and contributes to the proper, economic and effective use of resources.

3.3 The Internal Audit Plan for 2019/20 was risk based (assessing audit and assurance factors, materiality risk, impact of failure, system risk, resource risk fraud risk, and external risk). It included:

- a number of core systems which were designed to suitably assist the external auditor to reach their 'opinion' and other corporate systems for example governance, and,
- a number of operational systems, for example, compliments and complaints, safeguarding, markets were looked at to maintain and improve control systems and risk management processes or reinforce oversight of such systems.

3.4 The 2019/20 internal audit plan and any revision thereto was delivered providing sufficient coverage for the s151 and the Head of Internal Audit Shared Service to form an overall opinion.

3.5 At the time of writing this opinion in regard to the 19 reviews that have been undertaken, 16 have been finalised and 3 at draft report stage. Areas that returned an assurance level of 'limited' included markets and document retention policies.

3.6 A clear management action plan has been formulated to address the issues identified in all the other audit areas along with discussion at the Corporate Management Team where 'limited' assurance was identified to mitigate the risk. Where audits are to be finalised a comprehensive management action plan will be required and agreed by the s151 Officer.

3.7 As part of the process of assessing the Council's control environment, senior officers within the Council are required to complete an annual "Internal Control Assurance Statement" to confirm that the controls in the areas for which they are responsible are operating effectively. Officers were required to acknowledge their responsibilities for establishing and maintaining adequate and effective systems of internal control in the services for which they are responsible and confirming that those controls were operating effectively except where reported otherwise. There were some key themes identified in some of the returns which will be picked up directly with management. A reoccurring theme reported across several Services was the impact of staff shortages. No areas of significant risk have been identified in addition to those already identified in the audit work completed.

3.8 13 of the completed audits have been allocated an audit assurance of either 'moderate' or above meaning that there is generally a sound system of internal control in place, no significant control issues have been encountered and no material losses have been identified. However, there were 2 audits allocated a 'limited' assurance which indicates weaknesses in the design and / or inconsistent application of controls potentially putting the achievement of the organisation's objectives at risk in those areas reviewed. Any assurance provided is limited to the few areas of the system where controls are in place and are operating effectively. The two critical friend reviews that were undertaken did not provide an overall assurance but did report on potential lessons learnt. Although there remained some areas where the overall assurance fell short of 'moderate' assurance or above 2019/20 saw a slightly improved corporate picture based on the previous year results where 11 audits were 'moderate' or above and there were 6 'limited' assurance audits reported.

3.9 WIASS can conclude that no system of control can provide absolute assurance against material misstatement or loss, nor can Internal Audit give that assurance. This statement is intended to provide reasonable assurance based on the audits performed in accordance with the approved plan and the scoping therein.

Andy Bromage
Head of Internal Audit Shared Service
Worcestershire Internal Audit Shared Service
July 2020

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE
Date: 22nd July 2020

APPENDIX 4

Worcestershire Internal Audit Shared Service (WIASS)

Internal Audit Charter

Bromsgrove District Council

Definitions

1. Management refers to the Chief Executive, Executive Directors, Heads of Service and Service Managers

2. Board refers to the Audit, Standards & Governance Committee

This Charter was last reviewed April 2017 and was approved by the Audit Standards & Governance Committee on 11th October 2018.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

1. Introduction

Purpose

1.1 The purpose of this charter is to define what Internal Audit is and explain its purpose, role and responsibilities.

Provision of Internal Audit Services

1.2 WIASS covers five district authorities Wychavon, Malvern Hills, Bromsgrove, Redditch and Worcester and one Fire Service, Hereford and Worcester Fire and Rescue Authority. WIASS will provide internal audit services to third parties under contractual arrangements.

Worcester City Council hosts the Shared Service provision under an on-going Administrative Collaborative Agreement. It is governed by a Client Officer Group (COG) which is made up of the district and Fire Service s151 officers each having an 'equal say'. The Client Officer Group meets approximately 4 times a year.

1.3 For line management matters internal audit will report to the Corporate Director of Resources (s151 Officer within Worcester City Council) and the Monitoring Officer in their prolonged absence.

2. Mission and Definition

2.1 Mission:

"To enhance and protect organisational value by providing risk-based and objective assurance, advice and insight".

Additional information can be found on the local intranet site:

https://staffroom.worcester.gov.uk/internal-audit

2.2 Definition:

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

3. Scope and Authority of Internal Audit Work

3.1 Under the Accounts and Audit Regulations 2015 No. 234 Part 2 Regulation 5:

(1) A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.

(2) Any officer or member of a relevant authority must, if required to do so for the purposes of the internal audit—

(a) make available such documents and records; and

(b) supply such information and explanations;

as are considered necessary by those conducting the internal audit.

(3) In this regulation "documents and records" includes information recorded in an electronic form.

To aid compliance with Regulation 5 of the Accounts and Audit Regulations 2015, the CIPFA Code of Practice for Internal Audit in Local Government in the United Kingdom 2006 details that "Internal Audit should work in partnership with management to improve the control environment and assist the organisation in achieving its objectives".

Internal Audit work should be planned, controlled and recorded in order to determine priorities, establish and achieve objectives.

3.2 In the course of their reviews internal audit staff, under the direction of the Head of Service, shall have authority in all partner organisations to:-

- at all reasonable times after taking account of audit requirements, enter on any partners' premises or land;
- have access to, and where internal audit deem necessary take into their possession, any records, documents and correspondence relating to any matter that is the subject of an audit;
- require and receive such explanations as may be considered necessary from any officer of the Partner regardless of their position;
- require any officer of the Partner to produce forthwith cash, stores or any other property under their control.

for the Partner in which the internal audit service is being provided.

3.3 Internal Audit work will normally include, but is not restricted to:

- review and assess the soundness, adequacy, integrity and reliability of financial and non-financial management and performance systems, and quality of data;
- reviewing the means of safeguarding assets;
- examine, evaluate and report on compliance with legislation, plans, policies, procedures, laws and regulations;
- promote and assist the Partner in the effective use of resources
- examine, evaluate and report on the adequacy and effectiveness of internal control and risk management across the Partner and recommend arrangements to address weaknesses as appropriate;
- advise upon the control and risk implications of new systems or other organisational changes.
- provide a 'critical friend' to assist services to achieve value for money
- undertake independent investigations into allegations of fraud and irregularity in accordance with the Partner's policies and procedures and relevant legislation
- at the specific request of management[1], internal audit may provide consultancy services provided:

  - the internal auditors independence is not compromised
  - the internal audit service has the necessary skills to carry out the assignment, or can obtain skills without undue cost or delay
  - the scope of the consultancy assignment is clearly defined and management[1] have made proper provision for resources within the annual plan
  - management understands that the work being undertaken is not internal audit work.

3.4 IA's remit extends across the entire control environment of the organisation and is not limited to certain aspects or elements.

4. Responsibility of Management[1] and of Internal Audit.

4.1 At all times internal audit will operate in accordance with the partner's Constitution and legal requirements and all internal audit staff will adhere to recognised Professional Standards and Codes of Conduct and Ethics e.g. the Institute of Internal Auditors' and/or CIPFA as well as the Partner's Codes of Conduct and Anti-Fraud and Corruption Policies.

4.2 It is the responsibility of Management to put in place adequate controls to ensure systems meet their objectives and that they are notified without delay of any instances where systems are failing to operate properly. However, where there has been, or there are grounds to suspect that there is risk of a

serious breakdown in a significant system, the Head of Service should be informed of the problem and any counter measures already in hand or proposed, as quickly as possible, in order that the Head of Internal Audit Shared Service can decide whether audit involvement is needed.

4.3 Similarly, it is the responsibility of Management to put in place adequate controls to prevent and detect fraud, irregularities, waste of resource, etc. Internal Audit will assist Management to effectively manage these risks. However, no level of controls can guarantee that fraud and the like will not occur even when the controls are performed diligently with due professional care. As a consequence all cases of actual or suspected fraud should be reported to the Head of Internal Audit Shared Service forthwith. The Head of Internal Audit Shared Service will then decide the course of action to be taken with due regard to the Partner's Constitution, e.g. Whistleblower's Charter, Stopping Fraud and Corruption Strategy, etc.

4.4 Any officer of a partner organisation who has genuine concerns at raising a suspected instance of fraud or malpractice through their normal reporting channels can raise the matter under the Partner's Whistleblower's Charter directly with any of the persons named in the policy document, including the Head of Internal Audit Shared Service. Head of Internal Audit Shared Service will then pursue the matter in accordance with the provisions of the policy document.

4.5 Internal audit is not responsible for any of the activities which it audits. WIASS will not assume responsibility for the design, installation, operation or control of procedures. However should any partner/client contract for specialist services within an area then the WIASS staff member assigned will not be asked to review any aspect of the work undertaken until two years have passed from the completion of the assignment.

4.6 The Head of Internal Audit Shared Service will ensure that the relevant Head of Service and/or Section 151 Officer is briefed on any matter coming to the attention of internal audit, either through a review or otherwise, that could have a material impact on the finances, create an unacceptable risk or be fraudulent for the Partner as quickly as possible, and will ensure the appropriate Officer of the Authority e.g. Director, Monitoring Officer is regularly briefed on the progress of audits having a corporate aspect. Matters involving fraud or malpractice are to be reported in line with the anti-fraud and corruption policy. The most appropriate action/engagement of the relevant Head of Service will be determined by the HoWIASS depending on the circumstances.

4.7 In order to (1) maintain a broad skills base within Internal Audit and (2) maximise the ability of the team to offset the cost of providing the internal audit function to the Partner, the strategic plan will include a commitment that internal audit obtains income to the Partner from external work either from partnership working and/or selling its expertise. Such activities will be governed by targets set out in the Collaborative Administrative Agreement and will be approved and reported on to the Client Officer Group.

5. Planning and Reporting

5.1 To meet the objectives above, the Head of Internal Audit Shared Service shall:-

a) prior to the beginning of each financial year, following consultation with Management[1] and after taking into account comments from Members arising from the reporting process set out below, provide the Committee with:

- a risk based audit plan forecasting which of the Partner's activities are due to receive audit attention in the next 12 months. The risk based plan will take into consideration a number of risk factors including corporate risk register, service risk register, local knowledge, corporate promises or objectives, key strategic documents e.g. five year plan and any external audit guidance. Where there is a potential difference between strategy/plan and resource this is reported to the Board[2];

- a detailed operational plan using a risk based assessment methodology showing how/what resources will be required/allocated in the coming financial year in order to meet the requirements of the Partners strategic plans. The Plans will be flexible and include a small contingency contained as part of the consultancy budget to allow for changes in priorities, emerging risks, ad hoc projects, fraud and irregularity, etc. The Head of Internal Audit Shared Service will bring to the attention of the s151 Officer if this budget is depleted so an additional contingency can be agreed. 'Consultancy', for the purposes of WIASS activity, is defined as work that is of a specialist nature and commissioned/requested in regard to an area of work activity within a service area that is in addition to the agreed partners audit plan. The work can be financial or governance based and the output will provide management[1] with challenges to consider

depending on its nature. The approach to the assignment can be flexible but follow a similar path in regard to the methodology.

b) during the course and at the close of each financial year provide the Board[2] with:

- quarterly progress reports on actual progress compared to the plan and performance indicators. Such reports to highlight serious problems, either affecting the implementation of the plan, or, in the take up of audit recommendations;

- an annual report summarising the overall results for the year compared to the plan and pointing out any matters that will impact on internal audit's ability to meet the requirements in the strategic plan;

c) during the course and close of each full systems/risk audit provide the client manager[1] with:

- a copy of an audit brief and audit information request setting out the objectives and scope of the audit prior to commencement of the audit and a confirmation of resource requirements for the audit.

- draft recommendations, which will be discussed with the responsible manager[1] prior to sending the draft audit report. The manager[1] is responsible for confirming the accuracy of the audit findings and is invited to discuss the report during the 'clearance' meeting prior to the issue of the draft report.

- an audit report containing an overview of the quality of the control system, an opinion as to the level of system assurance and detailed findings and recommendations including priority. 'Assurance', for WIASS purposes, is defined as the determination of an overall outcome against a predetermined criteria leading to an applied level giving an overall summary for the work audited.

d) shortly after the close of each financial year provide for the purposes of the Annual Governance Statement:

- an annual audit opinion of the Partner's system of controls based on the audit work performed during the year in accordance with the plans at 5.1(a) above and reported in accordance with 5.1(b) and (c) above and on the assurance methodology adopted, and, a statement of conformance with the Public Sector Internal Audit Standards and the results of quality assurance and improvement programme.

5.2 Expectations of Clients:

Managers and staff should co-operate with the Auditors, and responses should be made to draft reports as outlined at 3 above. Responses should include an action plan, dates for action and responsibility where actions are delegated. The final 'High' and 'Medium' recommendations will be reported to the Board[2].

5.3 Audit reports will be drawn up following the internal audit report framework. A matrix type report displaying audit findings, risks and recommendations along with a column for management comments, as per 5.1(c), will be provided to management[1]. The report will also contain an introduction and priority categories for each of the recommendations. A covering report will be attached to the matrix providing details of the partner organisation, circulation, audit scope and objectives, an audit opinion, an executive summary and an audit assurance rating as well as a clear indication of what action is required by management.

5.4 Upon completion of audits, the audit exceptions will be discussed with the relevant line manager and will form the basis of the draft audit reports. The draft audit reports are issued to the relevant line managers for them to confirm the accuracy of the audit findings and content. Managers are invited to contact the Auditor if they wish to discuss the report and asked to show their response in the form of an action plan to each recommendation on the draft report. For accepted recommendations, dates for action or implementation are recorded. The managers' responses are recorded in the final reports that are issued to the appropriate Management[1] officers as deemed relevant for the audit.

5.5 In accordance with professional standards, after three/six months from the date of issue of the final report, follow-up audits are undertaken to ensure that the agreed recommendations and action plans have been implemented, or, are in the process of being implemented. A formal follow up procedure / methodology is used to follow up audit reports and reported on an exceptions basis.

5.6 Internal Audit works to the reporting quality standards of:

- draft audit reports to be issued within 5 working days of the clearance meeting;
- management responses received within 10 working days;
- final audit reports to be issued within 5 working days of the final discussions of the draft audit report and receipt of management responses;

- final reports to be followed-up initially within 3 to 6 months of the date issue of the final audit report depending on the recommendation priority and residual risk, to ensure that the accepted recommendations due for implementation have been established.

5.7 Escalation for late or non return of audit reports will be instigated when after two requests the reports have not been provided by management. The escalation will commence with the s151 Officer being informed of the late return. If the report remains outstanding then the Board[2] will be informed of the inaction with a view to them calling in the Officer to justify the late return.

6. 7 Principles of Public Life and how WIASS interprets and applies them.

1. Selflessness - protecting the public purse and ensuring all actions taken are solely in the public interest.

2. Integrity - completely independent and above undue bias or influence in the work that we do.

3. Objectivity – demonstrate impartiality and fairness in all aspects of our work and when reporting uses only the best evidence without discrimination or bias.

4. Accountability – provide transparency and assurance holding people to account in regard to decisions and actions and provide assurance to those in governance roles.

5. Openness – to promote and ensure through good governance that decisions are taken in an open and transparent manner and no information is withheld from the public unless there are clear and lawful reasons for so doing

6. Honesty – to provide independent assurance to those in governance of confirmation of truthfulness

7. Leadership – through the audit work actively promotes and robustly supports the principles and shows a willingness to challenge poor behaviour wherever it occurs.

For further information on the principles of public life:

https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

7. Core Principles for Professional Practice and how WIASS interprets and applies them.

1. Demonstrates integrity:
   WIASS works independently, without influence or undue bias. The audit plan is created so that there are no conflicts of interest between the officer and the audit. Potential conflicts of interest are formally checked annually with all members of the WIASS team. Areas of risk for WIASS are identified and mitigated. Potential areas of risk include, but are not limited to, auditors re-auditing Risk Management, NFI, and Regulatory Services in consecutive years and Services that they have transferred from. Officers that have conflicts of interest, or if they are / have been working in the area of audit, will not undertake any audits in the conflicting area for a minimum of three years, safeguarding the officers and WIASS' integrity. Further protection is in place by using randomly selected testing samples and a series of independent review stages. All audit working papers, reports and findings are reviewed and if necessary challenged before being issued to the client by either the Head of Service or Team Leader.

2. Demonstrates competence and due professional care:
   All reports are reviewed and signed off by either the WIASS Head of Service or Team Leader both of which are highly qualified and governed by professional institution standards. Regular 1-2-1 meetings are held with each officer to ensure progress and personal development. An "open door" culture is adopted throughout WIASS allowing all team members to ask for assistance advice and support at any time. Training (both in-house and external) is available and is provided should it be deemed relevant and appropriate by Head of Worcestershire Internal Audit Shared Service (HoWIASS) / Team Leader.

3. Is objective and free from undue influence:
   Independence and safeguarding is a key element of internal audit provision. All WIASS staff are vetted via the Basic Disclosure Check, as well as making a Declaration of Interest on an annual basis declaring any potential conflicts of interest with upcoming audit programme and the partners that WIASS work with. No auditor, who has transferred from a Service, will audit that Service for a minimum of three years. The Service is organisationally independent for all Partners. Although the HoWIASS reports directly to the s151 Officers of the Partner organisations the role has direct and unrestricted access to the senior management team and Committee Chair. The Client Officer Group, who governs the Service, meets on a quarterly basis and is made up of the Partner s151 Officers. They each have an equal vote and consider the strategic

direction of the Service as well as progress and performance. Further independence and safeguard checks are reported throughout this Charter in the form of checks, actions and process.

4. Aligns with the strategies, objectives, and risks of the organisation:
   The audit plan and it's content is discussed with Management[1]and s151 Officers to ensure that risks are identified; appropriate processes, systems and strategies are tested and that areas of risk are monitored and mitigated. Corporate and service risk registers are used along with corporate knowledge and the promises and objectives. Five year plans are also considered as part of the risk profiling and plan definition.

5. Is appropriately positioned and adequately resourced:
   As a shared service, WIASS is hosted by Worcester City Council, but audit allocations ensure a presence in all authorities that it serves across the year. Resources are monitored and tracked throughout the annual audit plan, with forecasting used as often as possible to prevent resources becoming too stretched resulting in reduced coverage. WIASS is governed by a Client Officer Group made up from the Partner s151 Officers but also has direct access to Management[1] and the Board[2] Chairs. Delegated powers are used should there be any resourcing issues.

6. Demonstrates quality and continuous improvement:
   Continuous monitoring of the teams performance via trackers is conducted. Quarterly and annual reports are issued to committee and board members demonstrating trends in productivity and value. Individual reviews via 1-2-1 meetings are held monthly with the Team Leader, and include personal development plans for all team members. Improvements and changes will also be made using external assessment as well as internally generated client feedback forms. A self assessment will be completed each municipal year to further provide assurance of quality and improvement. The Service is working with partners to ensure that it continues to provide a 'fit for purpose' Service by developing techniques that will complement requirements, continue to add value and work in a changing environment e.g. critical friend reviews. There is a continuous desire to ensure that the Service changes and adopts best practice methods as identified by the professional institutions e.g. IIA, CIPFA.

7. Communicates effectively
   Various forms of communication are adopted (verbal, written, diagram / graph) throughout the review process by all members of the WIASS team. Continued monitoring and improvements to the methodology are conducted,

making the report and testing documents clearer for all users. Findings are discussed verbally with management[1] prior to the issue of a formal report. Reports are issued to Officers and Committee[1] on a regular basis.

8. Provides risk-based assurance
   The audit plans are risk based with reviews being classified from high to low risk. The review scope is risk based which drives the review without creating restrictions on the areas covered. All findings are rated high, medium or low risk. Risks associated with the findings are linked directly to the recommendation and the management action to mitigate it. The review risk is combined to create the overall assurance level of the audit, which will be presented to the client with explanation and reasoning in the form of a report.

9. Is insightful, proactive and future-focused
   Insightful – where possible WIASS officers with relevant background experience will be assigned to conduct audits in similar fields. Continued monitoring of current "audit and fraud affairs" is distributed to all WIASS team members. A sharing of knowledge is encouraged in the Service and pre engagement research. Identification of best practice is shared amongst the authorities. Reports identify areas that are working well as well as those that require improvement. Reviews look for efficiencies and better ways of working.
   Proactive – scoping meetings are held for all audits allowing for changes to the audit scope in line with changes in service delivery and legislation between annual planning and audits starting. There is also an ability to vary the plan should an emerging risk present itself using delegated powers so the audit service can be proactive is providing assurance to those in governance. Consultancy days are built into the plans to allow for pre implementation of new system/process advice.
   Future-focused – The Service will scan the horizon for risks and issues that are emerging. Networking using, for example, the Midlands Audit Group is used to help inform the audit plans and consultancy assignments to provide information to the partners before it becomes a potential issue for them. Monitoring of the next generation initiatives from Central Government and having a team of auditors aware of the potential risks and impact along with environmental control issues will assist in adding value for our partners.

10. Promotes organisational improvement
    Ethics and culture are key aspects to organisation improvement. WIASS reviews consider ethical and cultural aspects and the potential impact and associated risk. Liaison with s151 Officers, Senior Management Teams and governance boards where applicable to promote continuous organisational

development. Audit Reports are issued to management[1] to ensure oversight of the organisation and areas of concern including common themes are looked at and improved on. High and Medium priority findings are followed up after a 3 or 6 month period respectively using an established methodology to ensure that potential risks are being mitigated and there is continuous improvement. Findings will be followed up until such time that they are satisfied. Follow up on findings will be documented and reported to Management, Heads of Service and or the appropriate s151 to give assurance of action and risk mitigation.

For further information please reference:
https://na.theiia.org/standards-guidance/mandatory-guidance/Pages/Core-Principles-for-the-Professional-Practice-of-Internal-Auditing.aspx

8. External Relationships

8.1 The main contacts are with:

- Institute of Internal Auditors
- External Auditors
- Local Authorities in the Worcestershire area
- Local Authorities in the Midlands area
- Organisations within the Exeter Benchmarking Group
- CIPFA (publishers of the systems based auditing control matrices written by Exeter IA section)
- National Fraud Initiative via DCLG and Cabinet Office

But may include other external parties as necessary.

8.2 Assurance will be accepted and reported from 3rd parties as long as WIASS can rely on their work and they are suitably qualified to carry out the assessment. The relevance of the work will also be a consideration in using a 3rd party certification e.g. IT integrity testing.

8.3 Where work is undertaken on a contractual basis assurance will be provided to 3rd parties outside of the partnership as appropriately agreed. The methodology applied to audit 3rd party organisations will be the same as the methodology used for the members of the partnership. All of the safeguards used to protect the integrity of the audits carried out for the partnership will

be extended to 3rd parties as well and appropriate reporting protocols established as part of any contractual agreement. These will be established as part of the engagement with a clearly identified engagement officer and requirements. No contract will be entered into if it is considered that the independence or integrity of the Service will be compromised. If, during the delivery of a contract, it becomes apparent that there is undue influence being brought to bare and/or that the actions of the client is undermining the ethos of internal audit the HoWIASS will inform the Client Officer Group without delay so a strategic decision can be made to avoid any potential reputational damage or compromised independence. Any assurances provided to 3rd Parties will be based on the established internal methodology and the defined definitions of the different levels and priorities.

Notes

a) In the absence of the Head of Internal Audit Shared Service all provisions relating to him/her above will apply to the relevant Team Leader in accordance with the duties allocated by the Head of Internal Audit Shared Service.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

Version Control:	Date of Change	Action	Updated by
1.0	2nd March 2012	Charter for WIASS	AB
2.0	9th August 2012	Update to Charter	AB
3.0	23rd April 2013	Update to Charter re. International Standards	AB
4.0	21st Janaury2016	Update to Charter re. legislative requirements & title changes	AB
5.0	1st July 2016	Update re. titles and definition of 'consultancy' and 'assurance'.	AB
6.0	April 2017	Full review in line with Standards	HT
7.0	May 2017	COG suggestion: Update of H&WFRS name to reflect legal entity & 'Council's' to 'Partners'.	HT
8.0	June/July 2018	External Assessment recommendations: Update to Mission & Definition Inclusion of 3.4, IA remit Update to 4.6 regarding HIASS responsibility on briefing Inclusion of 5.7, escalation for late and non return audit reports Inclusion of 6 – Principle of Public Life Inclusion of 7 – Core Principles of Public Practice Inclusion of 8.2, assurance from 3rd Parties Inclusion of 8.3, assurance to 3rd Parties	HG, AB, HT

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

Appendix 5

Quality Assurance Improvement Plan for 2019/20.

Action No.	Area to be actioned	Outcome required	Action	To be undertaken by:	Targeted date to be completed	Position as at 31st March 2020
1	1112 - Safeguarding Independence	Formal reporting to Client Officer Group (COG) confirming if there are, or are not, any conflicts of interest with the plan. This is to be done on an annual basis following the annual 'Declaration of Interest' (DOI) from WIASS Staff	Inform COG of DOI on the 2019/20 Plan	Head of Internal Audit	4th July 2019 due to postponed COG meeting in June 2019.	Completed September 2019
2	1320 - Inclusion of QAIP in Annual Reports	Following the development of the QAIP, this needs to be added to the annual reports for all partners	Update annual reports to include QAIP	Head of Internal Audit	Approx. August 2019 (dependent on Partner Committee date)	Completed September 2019
3	2240 - Approving Work prior to starting	Develop a process where by we can QA the testing programme prior to testing being undertaken, and to ensure that a formal sign off has taken place by either Head of Internal Audit or Team Leader	Engage with staff via Team Meetings to agree a process and to adjust the methodology to reflect the initial sign off prior to the testing commencing.	Audit Team Leader	Dec-19	Completed March 2020
4	2420 - Timely Completion of Stages	To make improvements in line with completing all stages of audits in a timely manner.	Stage monitoring will be picked up via 1-2-1's and the report monitoring will be picked up with the Audit Tracker "Response" tab (and discussed in 1-2-1's).	Audit Team Leader	Immediate implementation with ongoing monitoring throughout the year	Completed March 2020
5	2430 / 2450 – Use of 'Conducted in Conformance with International Standards for the Professional Practice of Internal Auditing (ISPPIA).	Include the QAIP in the annual report for all patterns, which will then allow us to quote the conformance to ISPPIA.	Include the QAIP in the partner annual reports.	Head of Internal Audit	Approx. August 2019 (dependent on Partner committee dates)	Completed September 2019

BROMSGROVE DISTRICT COUNCIL

AUDIT STANDARDS AND GOVERNANCE COMMITTEE **22nd July 2020**

SEPTEMBER – DECEMBER FINANCIAL SAVINGS MONITORING REPORT 2019/20

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder Consulted	-
Relevant Head of Service	Jayne Pickering – Exec Director Finance and Resources
Ward(s) Affected	All Wards
Ward Councillor(s) Consulted	No
Key Decision / Non-Key Decision	Non–Key Decision

1. SUMMARY OF PROPOSALS

To report to the Committee the monitoring of the savings for September - December 2019/20. This report presents the savings delivered for the third quarter against those identified in the medium term financial plan (MTFP)

2. RECOMMENDATIONS

2.1 That the Committee note the final financial position for savings as presented in the report and at Appendix 1.

3. KEY ISSUES

3.1 This report provides a statement to show the savings the period September – December 2019/20 as detailed in the MTFP and approved by Council in February 2019.

3.2 The medium term financial plan included £332k of savings identified to be delivered during 2019/20 the breakdown of these savings is attached at appendix 1. £166k of these identified savings are in relation to estimated vacancies.

3.3 To quarter 3 £272k of the savings have been realised against the budgeted April 2019 to December 2019 savings of £249k.

In addition to the above officers have been required to find further savings throughout the financial year 2019/20. At quarter 1 and 2 savings were found of £558k, £166k of these were allocated to the vacancy factor target. The remainder £392k have therefore been returned to balances. At quarter 3 officers have found another £4k these will be also be vired off the relevant services to be returned to working balances by the end of the financial year.

3.3 The External Auditors, Grant Thornton, have recommended that the delivery of savings be monitored more closely to ensure that the Council is meeting savings in the way that was expected when the budget was set. This monitoring was recommended to be undertaken by this Committee and Grant Thornton further advised that the savings monitoring should be against the Medium Term Financial Plan.

3.4 As members may be aware during the budget process, heads of service propose savings that are to be delivered during future financial years. The budget allocation is then reduced to reflect the proposed saving and officers meet on a monthly basis to ensure that all estimated reductions to budget are being delivered.

3.5 **Legal Implications**

None as a direct result of this report.

3.6 **Service/Operational Implications**

Timely and accurate financial monitoring ensures that services can be delivered as agreed within the financial budgets of the Council

4. Customer / Equalities and Diversity Implications

None, as a direct result of this report.

5. RISK MANAGEMENT

Effective financial management is included in the Corporate Risk Register.

6. APPENDICES

Appendix 1 – Saving monitoring September – December 2019/20

7. BACKGROUND PAPERS

Available from Financial Services

AUTHOR OF REPORT

Name: Chris Forrester – Financial Services Manager (Deputy S151)
Email: chris.forrester@bromsgroveandredditch.gov.uk
Tel: (01527) 881673

BROMSGROVE - SAVINGS & ADDITIONAL INCOME FROM 19-20 BUDGET ROUND

APPENDIX 1

						Quarter 3			
Department	**Strategic Purpose**	**Description of saving**	**2019-20 £'000**	**April - Dec 19/20**	**Comments**	On target Y/N	**Additional (add to to in yr savings) £'000**	**below target Y/N**	**Pressure £'000**
Community Services	Help me to live my life independently	Additiional Income from new contract with Cannock Chase Council	-60	-45	New SLA with Cannock	Y			
Community Services	Help me to live my life independently	Additiional Income from new contract with Cannock Chase Council - SLA with Cannock	-20	-15	New SLA with Cannock	Y			
Corporate Services	Enabling	New Print Contract	-29	-22	Savings realised on procurement of new print contract	Y			
Corporate Services	Enabling	Car Mileage	-2	-2	Reduction in Car Mileage	Y			
Corporate Services	Enabling	Community Group Funding	-5	-4	Budget has decreased due to the impact of the New Homes Bonus scheme reducing	Y			
Environmental Services	Keep my place safe & looking good	Review of budget allocations	-15	-11	Reductions in various materials, equipment & vehicle R&M budgets	Y			
Legal & Democratic	Help me find somewhere to live in my locality	Review of budget allocations within Land charges	-2	-2	Budget no longer required	Y			
Legal & Democratic	Enabling	Additional income on external legal work	-7	-5		Y			
Customer Services & Financial Support	Enabling	Reduction in operational budgets	-26	-20		Y			
Corporate Services	Enabling	Vacancy Management	-166	-125	2% on any employee that does not require agency cover	Y	-23		
			-332	**-249**			0		0

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS & GOVERNANCE COMMITTEE

WORK PROGRAMME 2020/21

22 July 2020

- Monitoring Officer's Report
- Model Code of Conduct
- RIPA Report
- External Audit - Bromsgrove District Council Audit Plan Addendum – Covid 19
- Internal Audit – Progress Report 2019/20 & 2020/21
- Internal Audit Annual Report incl. Audit Opinion 2019/20
- Financial Savings September to December 2019
- Risk Champion's Update Report

8 October 2020

- Monitoring Officer's Report
- External Audit – Progress / Sector Update Report
- External Audit – Audit Findings Report
- Internal Audit – Progress Report
- Financial Savings December 2019 – March 2020
- Benefits and Compliance Report
- Risk Champion's Update Report
- Work Programme

Virtual Meetings 2020

- Annual Appointment of Risk Management Champion for the Committee
- ASG Work Programme
- Dispensations Report
- Final Statement of Accounts
- Treasury, Capital, and Investments Strategy
- Treasury Report Update (6 monthly)

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