Public Document Pack

West Northamptonshire Council

Audit and Governance Committee

A meeting of the Audit and Governance Committee will be held at the The Jeffrey Room - The Guildhall, Northampton, NN1 1DE on Wednesday 27 March 2024 at 6.00 pm

Agenda

1.	**Apologies for Absence and Notification of Substitute Members**
2.	**Declarations of Interest** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
3.	**Minutes** (Pages 5 - 14) To confirm the Minutes of the meeting of the Committee held on 21st November 2023.
4.	**Chair's Announcements** To receive communications from the Chair.
5.	**Urgent Business** The Chair to advise whether they have agreed to any items of urgent business being admitted to the agenda.
6.	**Internal Audit Plan 2024-25** (Pages 15 - 26)
7.	**Internal Audit Progress** (Pages 27 - 70)
8.	**Public Sector Internal Audit Standards - Self Assessment** (Pages 71 - 92)

9.	**CIPFA Position Statement on Audit Committees** (Pages 93 - 110)
10.	**Risk Management Strategy and Strategic Risk Register** (Pages 111 - 142)
11.	**External Audit - progress report** (Pages 143 - 156)
12.	**Grant Thornton Audit Plan for Northamptonshire Pension Fund 2023-24** (Pages 157 - 182)
13.	**Update Report - Regulation of Investigatory Powers Act 2000 (as amended)** (Pages 183 - 204)
14.	**Update on Governance** (Pages 205 - 224)
15.	**Update on Budget Setting and Revenue and Capital Medium Term Capital Programme** Verbal Update
16.	**Review of Committee Work Programme** (Pages 225 - 228) To review and note the Committee Work Programme.

Catherine Whitehead
Proper Officer
19 March 2024

Audit and Governance Committee Members:

Councillor Cecile Irving-Swift (Chair)
Councillor Charles Manners (Vice-Chair)

Councillor Jamal Alwahabi
Councillor Alan Chantler
Councillor Stephen Clarke
Councillor Keith Holland-Delamere
Councillor Mark Hughes
Councillor Rosie Humphreys
Councillor Sam Rumens

Information about this Agenda

Apologies for Absence

Apologies for absence and the appointment of substitute Members should be notified to

democraticservices@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
Members are reminded that any member who is two months in arrears with Council Tax must declare that fact and may speak but not vote on any decision which involves budget setting, extending or agreeing contracts or incurring expenditure not provided for in the agreed budget for a given year and could affect calculations on the level of Council Tax.

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Email: democraticservices@westnorthants.gov.uk

Or by writing to:

West Northamptonshire Council
The Guildhall
St Giles Street
Northampton
NN1 1DE

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West Northamptonshire Council

Audit and Governance Committee

Minutes of a meeting of the Audit and Governance Committee held at The Jeffrey Room - The Guildhall, Northampton, NN1 1DE on Tuesday 21 November 2023 at 6.00 pm.

Present:
Councillor Cecile Irving-Swift (Chair)
Councillor Charles Manners (Vice-Chair)
Councillor Jamal Alwahabi
Councillor Alan Chantler
Councillor Keith Holland-Delamere
Councillor Rosie Humphreys
Councillor Sam Rumens

Substitute Members:
Councillor Nigel Hinch

Also Present:
Councillor Mike Hallam, Cabinet Member for Corporate and HR

Apologies for Absence:
Councillor Stephen Clarke
Councillor Mark Hughes

Officers:
Sarah Hall, Deputy Monitoring Officer
Martin Henry, Executive Director - Finance (Section 151 Officer)
Audra Statham, the Interim Head of Audit and Risk Management
Adrian Ward, Head of Audit and Risk Management
Scott Peasland, Audit Manager
Fiona Coates, Pensions Service Financial Manager
Alison Golding, Assistant Director HR
Clare Young, Head of Organisational Development, Design and Change
Maisie McInnes, Democratic Services Officer

Janet Dawson, Ernst Young (EY) – Remote
William Howard, Grant Thornton (GT) – Remote
Mark Stocks, Grant Thornton (GT) – Remote
Grant Patterson, Grant Thornton (GT) – Remote

155. **Declarations of Interest**

Councillor Nigel Hinch declared an interest as a member of Northamptonshire Partnership Homes (NPH).

156. **Minutes**

RESOLVED: That the minutes of the previous meeting held on 26 July 2023 were agreed and signed by the Chair as an accurate record of the meeting.

157. **Chair's Announcements**

The Chair welcomed everyone to the meeting and introduced the Head of Audit and Risk Management, Adrian Ward and Mark Stocks, Head of Public Sector Assurance at Grant Thornton.

The Chair thanked Audra Statham, Assistant Director Finance (Accountancy) for her hard work and taking over the mantle for the last few months prior to the Head of Audit and Risk Management joining West Northamptonshire Council.

158. **Urgent Business**

There were no items of urgent business.

159. **Update on Workforce Skills and Capacity**

The Assistant Director HR delivered a presentation to the committee on Workforce Skills and Capacity Risk E04. The Assistant Director HR gave

Members heard and observed the presentation and asked questions:

- Members queried the increase in headcount across WNC and the Cabinet Member for HR and Corporate Services explained that many positions had been brought in-house, for example in the legal team which had contributed to the headcount number.
- Members questioned the reasoning for the length of vacant posts in the Chief Executive office. The Assistant Director HR responded that this was due to new positions being created as there had been a restructure and as this was a small area the statistics appeared higher in the presentation.
- Members expressed concern at the amount of staff receiving a salary of less than £25,000 in a cost of living crisis. The Cabinet Member for HR and Corporate explained that pay negotiations were underway for next year and the Council paid a fair wage and was committed to this, and staff had received a 30% payrise since vesting day. Members highlighted the new national living wage of £12ph and importance of supporting staff.
- Members raised questions surrounding the number of voluntary leavers by recruitment status and asked for retirement figures to be included in these statistics. The Assistant Director HR explained that exit interviews were conducted to ascertain areas for improvement and there was a commitment to improving culture and regular polls to obtain staff feedback. There were plans in place to capture more information from managers and succession planning to forward plan for those near to retirement.
- Members asked for a follow up on the capacity issues in the planning department as it had been 18 months since the last update, and the Assistant Director explained there was a recruitment campaign to fill the vacancies as

detailed in the presentation. The Cabinet Member for HR and Corporate added that colleagues from the Corporate Directorate were also assisting with the workload by offering customer service support for the planning department in the interim.

- Members asked a question surrounding the volume of applications received and how these were handled. The Assistant Director explained the new ATS system aided the application process, and this made it easier for people to apply which increased the volume of applications. There was a manager self-service process for shortlisting applications.
- Members discussed the level of sickness in the council and asked if there was more that could be done to support staff and gave an example for those experiencing back and neck related injuries or pain. The Assistant Director HR offered to add the health and safety statistics for these sicknesses and whether they were internal or external related illnesses. The Council promoted wellbeing and there were a number of initiatives to promote a creation of wellbeing, such as the creation of mental health first aiders within the council.
- Members suggested that more contextual information be provided alongside the data at future meetings so that members can understand the story and rationale behind the figures.

Members discussed the current employment market and highlighted the risk areas which provided challenge to the council in recruiting and retaining staff. The Assistant Director HR emphasised the power of social media and sites such as LinkedIn for helping promote visibility of job vacancies to encourage people to apply. She explained that with the wide breadth of skill sets and specialisms needed to work across the council, there was a risk in the ability to recruit to pressure roles and the council was working on their branding as well as their training and development offer and other benefits for people working in the council. The Cabinet Member for HR and Corporate explained the market trends, with there being an expectation for people to move to new roles rather than stay with one company for the entirety of their working lifetime. There was a competitive job market in terms of pay and benefits and the accessibility of sites such as LinkedIn and Glassdoor providing reviews of workplaces. He was proud to share the council had a positive rating on Glassdoor and the team were committed to making West Northamptonshire Council a place to thrive.

160. **Northamptonshire Pension Fund Final Audit Results Report 2020-21**

At the Chair's invitation, Janet Dawson EY presented the Final report of the Northamptonshire Local Government Pension Scheme for 2020/21 report and highlighted the following salient points:

- The external auditor was ready to provide an unqualified opinion on the concluded audit subject to a letter from the organisation and other disclosures.
- In terms of the audit planning materiality there had been adjustments to custodian and EY asset values and asset values had been reclassed from level 2 to level 3 investments.
- There was a risk of verifying information produced by the entity (IPE) and reports using pension systems for completeness of the audit process, but the

teams were able to overcome this by using the Teams facility to use screen sharing to evidence this.

RESOLVED: That the Committee considered the external Final Audit Results report and recommendations.

161. **Pension Fund Annual Report and Statement of Accounts 2022-23**

The Executive Finance Director gave context to the committee that at the last Audit and Governance committee, members received a draft version of the report and the final report had been brought back to the committee following approval from the Pensions Fund Committee. There were no significant changes to the report for members to consider.

The Pension Services Financial Manager shared that the Pensions team had also delivered Accounts training to Audit and Governance committee in October which would enhance their understanding of the report. She confirmed that the two recommendations received from the external auditors had been actioned and handed over to Grant Thornton to present the report.

Grant Patterson, GT introduced himself as he had succeeded Ciaran McLaughlin in overseeing the Pension fund audits. William Howard, GT then presented the report and highlighted the following points:

- The audit was complete subject to testing, finalisation of IT work and a review of financial statements.
- There was one adjustment misstatement of £7.6m that had been made in relation to the level 3 investments, but this was not a material matter.
- The audit fees were highlighted on page 255 of the agenda pack, and the cost of letters were to be confirmed.

The Executive Director Finance summarised that there were no major issues with the audit, and the external auditors were finalising their audit with an unqualified opinion. Both teams had worked efficiently in closing the audits quickly and accurately and overall, a positive audit report.

The Chair thanked Grant Thornton members discussed the report.

RESOLVED: That the Audit and Governance Committee:
a) Approved the Statement of Accounts and notes the Annual Report of the Pension Fund for the 2022-23 financial year.
b) Considered the findings of external audit documented in the ISA260.

162. **Internal Audit Progress Report**

The Interim Head of Audit and Risk Management shared that the new Head of Audit and Risk Management Adrian Ward had joined WNC and would be taking the mantle and presenting the report going forward. She had thoroughly enjoyed putting together the comprehensive view of the report and working in the interim and expressed how internal audit were a great team to work with. She highlighted the key points from the report:

- In terms of vacancies, the positions had been filled and there was a new member of the team joining in December. There was also a member of the team who had returned from long term sickness. She was pleased to report the team was back to full capacity.
- There were two audit plan changes with the payroll and pension fund administration audits being passed over to the partner authority audit team to conduct.
- The internal audit team were making positive progress with the limited assurance reports and some actions were still outstanding.
- There was lots of activity ongoing in the counter fraud team such as checking of blue badges, and other in-house projects.

Members discussed the report and expressed concern at the audit actions. The Interim Head of Audit and Risk Management shared that the team were responsible for picking up the actions and helping with implementation of these. The was an updated system for actions and these were actively monitored by the team.

Adrian Ward, the new Head of Audit and Risk Management addressed the committee and shared his wealth of experience working in local government and internal audit specialism. He shared he was looking forward to starting at West Northamptonshire Council. The Chair requested a skills analysis for the committee and tailor made training for members to keep up to date with knowledge and understanding of audit requirements.

The Chair thanked the Interim Head of Audit and Risk Management for her comprehensive report.

RESOLVED: That the Audit and Governance committee reviewed and endorsed the Internal Audit Progress report.

163. **Update on Financial Statements**

The Interim Head of Audit and Risk presented the update on financial statements and explained that the National Audit Office (NAO) and the Department for Levelling Up, Housing and Communities (DLUHC) were planning to introduce a backstop to resolve the backlog of unaudited accounts and create a fresh start for local government. Since vesting day, WNC had managed to close ten of the outstanding legacy audits, which was a substantial amount of work for the team and a huge achievement. As it was not possible to start the WNC statements until these had been concluded, the statements for 2021/22 and 2022/23 had been delayed. The government were proposing that audits not completed by 31 March 2024 would be given a disclaimed audit opinion. The report was seeking approval from the Audit and Governance Committee to pause the 2021-2022 audit in line with the government statutory guidance. This would stand the council in good stead for producing the 2022/23 and 2023/24 accounts.

Members expressed concerns regarding the risk of public perception and conveying the news of the 2021/2022 audits being paused and potentially disclaimed. Members urged officers to consider how they would deliver communications. The Executive Director Finance emphasised that this was a unique position and collectively with his experience and the Interim Head of Risk and Audit, this had never been a similar position. They advised members to be realistic and pragmatic in their approach and a statement would be prepared for communications for the press and public.

Members asked for the opinion of the external auditor.
Mark Stocks, Grant Thornton responded that it was a difficult position, but WNC were not alone as this was a national issue affecting a number of councils. It was the best approach for WNC to pause to allow time for the government's announcement and at this moment it was not definitive. The government would need to issue a consultation, make changes to the legislation and audit code of practice. The council would continue to work closely with the external auditor in light of this news.

Members asked if a letter could be produced from the external auditor detailing this advice to members. The Executive Director Finance shared that a letter had been addressed to officers with this advice and they could circulate this to members outside of the meeting. He added that this course of action would also deliver a cost-saving to the council on audit fees.

Members requested a revision to the recommendation to reflect the audit would be paused in light of the statutory guidance, and not ceased. The Executive Director Finance reconfirmed that the recommendation was asking the external audit to step down and if the situation changed the audit would recommence.

RESOLVED: That the Audit and Governance committee agreed to pause the 2021/22 audit in advance of the government announcement, in order to be able to prepare the 2022/23 and 2023/24 statement of accounts.

164. **Northamptonshire County Council 2020-21 - Final Audit Results Report**

Janet Dawson, EY presented the Northamptonshire County Council 2020-21 final audit results report and highlighted the following salient points:

- The audit work was complete subject to a subsequent events review, agreement of the final set of financial statements, receipt of signed management representation letter and final manager and engagement partner reviews.
- One of the audit approaches focused on reviewing the Council's progress to address the weaknesses in Children's Services as part of the value for money audits following the Ofsted report in 2021.
- Another key area was Covid-19 grants and there were significant control weaknesses relating to grant recipients confirming the use of the grants and to repay any owing monies.

- In terms of the evaluation of One Angel Square, the accounts reflect the revised evaluation. Correcting the evaluation methodology increased the value by £4.3 million.

Members discussed the report and the Executive Director Finance shared that the Children's Trust had contributed to the improvement journey of Children's Services and the Council was continuing to support them and had a better grip on finance. In terms of risk management, the strategic risk register was in place and there was better reporting processes to the Audit and Governance Committee.

RESOLVED: That the Audit and Governance Committee considered and accepted the External Auditors Final Audit Report and recommendations.

165. **External Audit Progress Report (Ernst & Young)**

Janet Dawson EY gave a verbal update to the committee and expressed that she was looking forward to signing off and handing over to Grant Thornton. She passed on her immense thanks on behalf of EY to the Interim Head of Audit and Risk Management and the team for their hard work completing the predecessor audit accounts.

RESOLVED: That members received a verbal update on the audit progress from EY.

166. **External Audit Progress Report (Grant Thornton)**

GT presented the report and explained that a progress report would be brought to the next committee with a focus area on understanding finances. There was ongoing work with the value for money audits for 2022/23 and focussed work in the areas of sustainability and governance.

Members discussed the verbal update.

RESOLVED: That the Audit and Governance Committee accepted the External Audit progress update from Grant Thornton and were looking forward to the progress update at the next committee meeting.

167. **Update on Governance**

The Deputy Director Law and Governance delivered the update on governance and explained that the new Head of Audit and Risk Management had been working with the Deputy Director and Monitoring Officer on how to make further improvements to strengthen governance in WNC. There was an emphasis of risk reporting through ELT which had monthly meetings with statutory officer oversight, as well as any issues being flagged to the Monitoring Officer. They would be bringing a report to the committee for assurance on ongoing governance work across the council.

The Deputy Director Law and Governance highlighted the following points in relation to governance:

- There were no RIPA (Regulation of Investigatory Powers 2000) and further training was being organised to support understanding of this and more detail would be brought to a future meeting of the committee.
- In terms of data requests, they were preparing a report on a new system supporting the team processing the increasing number of data requests and freedom of information requests.
- There was more support being provided to officers to increase awareness of data protection across the council and a new structure for the team to provide support and data retention. There was a manager vacancy in the team currently being recruited to.
- There was a project ongoing to establish the companies that the council had working relationships with an those that had been inherited as part of the reorganisation. Once information had been pulled together, a report would be brought to ELT and the committee along with guidance from other authorities.
- The Democracy and Standards committee was responsible for conduct for members and the code of conduct for member complaints was being revised and would be going to a future full council meeting for approval.
- Finally in relation to training, this year training concentrated on overview and scrutiny and planning committee members. The training had been well received and there was more to be delivered in the programme for next year to emphasise the need for good governance.

The Chair thanked the Deputy Director Law and Governance for the update and encouraged members to come forward with any future training needs.

RESOLVED: That the committee received the update on governance and would receive further reports on improvements to strengthen governance and member training at a future meeting.

168. **Verbal Update on Budget Setting**

The Executive Director of Finance gave an update on the budget setting process and explained the financial plan and budget had been refreshed over the summer and budget star chamber meetings were underway. There was regular updates at ELT and discussions on how issues could be addressed. There was a budget gap due to pressures in the Children's Trust and Adult Social Care, costs for temporary accommodation and home to school transport. He recognised there were similar issues in local government nationally but was extremely pleased to report that they had worked hard to close the gap and a balanced budget was being delivered for 2024/25.

Corporate Overview and Scrutiny committee had received information relating to the budget earlier than in previous years, and a confidential briefing on the budget process had taken place for their understanding on the starting position for the budget process and the journey to a balanced budget. There was another confidential budget briefing with Corporate Overview and Scrutiny members planned for next week to demonstrate rationale and a draft budget would be formulated on 4 December. This would follow a 6 week budget process and the final budget proposals would be presented to Cabinet on 22 February 2024.

The Chair thanked the Executive Director Finance for the informative update on the budget setting process and looked forward to receiving the budget for 2024/25. She shared that the Chair and Executive Director Finance attended the Overview and Scrutiny Triangulation Group which focussed on forward planning to eliminate duplication and improve productivity by working with Cabinet members on upcoming work across the council.

RESOLVED: That the Audit and Governance committee received the update on the budget setting process and looked forward to receiving the balanced budget.

169. **Review of Committee Work Programme**

The Chair invited members to review the committee work programme and consider any items to be added. Members agreed there were no new items to be added to the work programme.

RESOLVED: That the Audit and Governance Committee reviewed the work programme.

The meeting closed at 8.30 pm

Chair: _____

Date: _____

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West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL
AUDIT & GOVERNANCE COMMITTEE

27 MARCH 2024

Report Title	**Internal Audit Plan 2024-25**
Report Author	**Adrian Ward – Head of Audit & Risk Management** **adrian.ward@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
S151 Officer	Martin Henry	15/03/2024

List of Appendices

Appendix A – Internal Audit Plan 2024-25
Appendix B – Summary Audit Universe

1. Purpose of Report

1.1. To allow the Committee to consider and approve the proposed Internal Audit Plan for 2024-25.

2. Executive Summary

2.1 The Internal Audit service provides assurance that organisational controls are effective and adequately mitigating risk and is one of the significant sources of assurance to senior management and the Audit & Governance Committee on the effectiveness of the Council's internal control arrangements.

3. Recommendation

3.1 It is recommended that the Audit & Governance Committee consider and approve the Internal Audit Plan for 2024-25 (Appendix A) and endorse the proposal to source additional external specialist computer audit expertise as set out in this report.

4. Reason for Recommendation

4.1 To ensure compliance with the practice and principles for audit committees set out in the CIPFA Position Statement for Audit Committees, which include responsibilities for overseeing and supporting the internal audit function and approving a risk-based audit plan.

5. Report Background

5.1 The proposed Internal Audit Plan for 2024-25 (Appendix A) has been developed by applying a risk-based approach and following the relevant principles set out in the Public Sector Internal Audit Standards (PSIAS).

5.2 As part of that process, an 'audit universe' has been developed, which seeks to identify the significant areas of the Council's operations which could be subject to internal audit review. A summary of the audit universe is attached as Appendix B, with those areas included in the proposed Internal Audit Plan for 2024-25 highlighted.

6. Issues and Choices

6.1 The areas included in the proposed Internal Audit Plan for 2024-25 have been derived from the audit universe following a risk-based approach, which included:

- An assessment of gross financial impact (ie. budgeted expenditure and income)
- Inherent risk (ie. complexity, public interest, potential reputations damage etc)
- Cumulative audit knowledge (ie. whether or not the area has been subject to previous internal audit review, and if so what the assurance ratings were)
- Other inspection or assurance work relevant to the area
- Consultation with senior management.

6.2 Areas within the audit universe which are not included in the proposed Plan for 2024-25 will be re-assessed again during future audit planning processes, with the intention of ensuring that all auditable areas are reviewed periodically within a frequency dependent upon their assessed risk ratings.

6.3 The planned work for quarters 3 and 4 is shown as indicative because it is proposed to undertake a review prior to the half-year stage to ensure that the Plan remains relevant in light of any emerging risks or issues that may arise in the first 6 months of the year. If any amendments to

the Plan are required as a result of the half-year review, this would be reported to the Audit & Governance Committee.

6.4 The available productive audit days included within the Plan are calculated as follows:

DETAILS	**DAYS**
Total days (for 6 audit staff)	1,569
Less: Annual Leave Allowance for sickness (5 days per staff member) Public Holidays Other (eg. medical appointments, training etc) Team Meetings, Corporate Briefings, Admin, 1-to-1s Team Management Service Improvements & Professional Networking Planning	 (203) (30) (42) (34) (130) (42) (42) (28)
TOTAL AVAILABLE AUDIT DAYS	1,018
Less: Northamptonshire Childrens Trust Audit Days	 (145)
COUNCIL AVAILABLE AUDIT DAYS	873

6.3 In relation to audit assurance for the Digital, Technology and Innovation (DTI) service, computer audit is a specialist area of internal audit where a significant level of relevant expertise and experience is required in order to ensure that audit work is targeted effectively and to provide sufficient assurance that relevant threats and risks are being mitigated appropriately and effectively.

6.4 The in-house internal audit team do not have the required technical knowledge and experience to undertake this role with maximum effectiveness. Whilst they can undertake general computer related audit work, without the required technical expertise it is more difficult to ensure that computer audit assignments are directed in an effective manner to review technical processes and activities, and to ensure that the Council is identifying and responding to emerging IT related risks and threats.

6.5 It is therefore proposed to undertake a procurement process for a 3 year contract to appoint a specialist computer audit provider, either via a suitable framework contract or by open competition. This proposed approach is supported by the relevant senior managers.

6.6 It is anticipated that the first work undertaken in Year 1 would be to conduct an IT audit 'needs assessment' which would establish an indicative IT audit plan for the remainder of Year 1, and for Years 2 and 3.

6.7 The needs assessment would be subject to an annual review in Years 2 and 3 to ensure it remains relevant and takes account of any emerging IT / digital related risks or threats that the Council may face.

6.8 A number of 'reserve audits' are listed at the end of the Plan. These are reviews that could replace audits included in the Plan if circumstances change for any reason.

7. Implications (including financial implications)

7.1 Resources and Financial

7.1.1 The proposal to obtain specialist computer audit resources will require an additional budget of up to £25,000 per annum, which it is anticipated will be met from underspends within existing resources.

7.2 Legal

7.2.1 As a relevant authority under the Accounts & Audit Regulations 2015, the Council 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.

7.3 Risk

7.3.1 There are no significant risks arising from the proposed recommendations in this report.

7.4 Consultation

7.4.1 The Executive Leadership Team (ELT) and other relevant senior managers have been consulted in drafting the proposed Internal Audit Plan.

7.5 Climate Impact

7.5.1 None identified.

7.6 Community Impact

7.6.1 None identified.

7.7 Communications

7.7.1 None identified.

8. Background Papers

8.1 Public Sector Internal Audit Standards: Public sector internal audit standards PSIAS | CIPFA

DIRECTORATE & AUDIT DETAILS	AUDIT DAYS *(NB. Q3 & Q4 are indicative)*				CORPORATE PLAN LINK (PRIMARY)	STRATEGIC RISK REGISTER LINKS
	Q1	Q2	*Q3*	*Q4*		
PEOPLE						
Public Health – Substance Misuse	15				Improved Life Chances	
Adult Social Care – Establishment Audits (2 x 15 days)	15			*15*	Robust Resource Management	
Adult Social Care – Direct Payments & Pre-paid Cards	25				Robust Resource Management	SR03
Adult Social Care – Commissioning & Monitoring of Providers				*15*	Robust Resource Management	SR03
Call Care				*12*	Robust Resource Management	
School Audits (3 x 15 days)	15	15		*15*	Robust Resource Management	
Early Years		20			Improved life Chances	
Northamptonshire Childrens Trust – Oversight & Monitoring		15			Improved Life Chances	SR09, SR10
Out of Area / Independent School Placements			*20*		Robust Resource Management	
PLACE						
Waste & Recycling (Norse Joint Venture)	20				Robust Resource Management	
Commercial & Investment Properties	15				Robust Resource Management	

DIRECTORATE & AUDIT DETAILS	AUDIT DAYS *(NB. Q3 & Q4 are indicative)*				CORPORATE PLAN LINK (PRIMARY)	STRATEGIC RISK REGISTER LINKS
	Q1	Q2	*Q3*	*Q4*		
Development Management	15				Robust Resource Management	
Highways Maintenance (Revenue)		20			Robust Resource Management	
Property & Land – Ownership, Transfers & Disposals		15			Robust Resource Management	
Social Care & Health Transport			*15*		Robust Resource Management	
Building Control			*15*		Robust Resource Management	
Property Management & Maintenance (WNC Assets)				*15*	Robust Resource Management	SR05
Section 106 Planning Agreements				*15*	Robust Resource Management	
COMMUNITIES & OPPORTUNITIES						
Travellers Site - Monitoring	10				Robust Resource Management	
Northampton Partnership Homes – Oversight & Monitoring		15			Robust Resource Management	SR02
Disabled Facilities Grants – Application Process		20			Robust Resource Management	
Homelessness – Temporary Accommodation			20		Robust Resource Management	SR04

DIRECTORATE & AUDIT DETAILS	AUDIT DAYS *(NB. Q3 & Q4 are indicative)*				CORPORATE PLAN LINK (PRIMARY)	STRATEGIC RISK REGISTER LINKS
	Q1	Q2	*Q3*	*Q4*		
CORPORATE SERVICES						
Customer Services / Contact Centre / One Stop Shop		20			Robust Resource Management	
Members Allowances		12			Robust Resource Management	
Business Continuity			15		Robust Resource Management	SR01
Digital, Technology & Innovation – EXTERNALLY RESOURCED					Robust Resource Management	SR01
FINANCE						
Capital Programme – Management & Monitoring	15				Robust Resource Management	
Insurance		12			Robust Resource Management	
Housing Revenue Account - Accounting		15			Robust Resource Management	
General Ledger – Control & Suspense Accounts			*15*		Robust Resource Management	
Housing Benefits			*30*		Robust Resource Management	
CROSS-CUTTING AUDITS						
Programme & Project Management			*20*		Robust Resource Management	
Capital Programme – Individual Schemes				*30*	Robust Resource Management	

DIRECTORATE & AUDIT DETAILS	AUDIT DAYS *(NB. Q3 & Q4 are indicative)*				CORPORATE PLAN LINK (PRIMARY)	STRATEGIC RISK REGISTER LINKS
	Q1	Q2	*Q3*	*Q4*		
Lead Authority Audits (to be determined)			*30*	*67*	Robust Resource Management	
Grant Certifications	8	8	*8*	*8*	Robust Resource Management	
Follow-up of Recommendations	15	15	*15*	*15*		
Allowance to Complete 2023/24 Audits	35					
Contingency	15	15	*16*	*12*		
TOTALS	**218**	**217**	***219***	***219***	**TOTAL AUDIT DAYS: 873**	

RESERVE AUDITS

Council Tax

Additional Individual School Audit(s)

Ethical Standards & Governance

Registrars

WEST NORTHAMPTONSHIRE COUNCIL – AUDIT UNIVERSE

(NB. Blue highlight = coverage in 24/25 audit plan)

Directorate	Auditable Areas
PEOPLE	Adults Public Health Projects Appointeeships & Deputyships Deprivation of Liberty Safeguards (DOLS) Financial Assessments / Client Contributions Social Care Payments Commissioning & Monitoring of Providers Establishments: ➢ Boniface House (closing) ➢ Ridgway House (closing) ➢ Obelisk House ➢ Southfields House ➢ Eleanor Lodge ➢ Reablement West ➢ Gladstone Road ➢ Longlands ➢ Turn Furlong Hospital Discharge Hub Adult Learning & Development Call Care Children Individual Schools School Admissions Early Years Out of Area / Independent School Placements School Attendance Management Special Educational Needs / Disabilities (SEND) Teachers Pensions Schools Support Services Northamptonshire Childrens Trust – Monitoring & Performance
PLACE & ECONOMY	Archive & Heritage Service Everden Centre Parks & Open Spaces Waste & Recycling (Norse JV - Daventry) Waste & Recycling (Veolia - Northampton) Waste & Recycling (Household Waste Disposal Centres) Waste & Recycling (Residual Waste Disposal) Waste & Recycling (Garden Waste) Waste & Recycling (Commercial Waste) Garden Waste Home to School Transport Social Care & Health Transport Concessionary Fares Bus Subsidies Property Management & Maintenance (WNC Assets) Canteen

	Highways Maintenance (Revenue) Commercial & Investment Properties Street Cleansing Fleet Management Licensing Trading Standards Environmental Protection Car Parks On-street Parking Building Control CCTV Grounds Maintenance Development Management Community Infrastructure Levy (CIL) Section 106 Planning Agreements PFI Contracts Property & Land - Ownership, Transfers & Disposals
COMMUNITIES & OPPORTUNITIES	Libraries Museum & Art Gallery Culture Leisure Centres Community Safety Regeneration Economic Growth Homes for Ukraine Community & Voluntary Sector Grants Travellers Site Homelessness Home Adaptations / Disabled Facilities Grants Housing Enforcement Housing Register Care & Repair Northampton Partnership Homes – Monitoring & Performance
FINANCE	Insurance Housing Benefits Council Tax Business Rates (NNDR) Debtors & Income Collection Pension Scheme Treasury Management Budget Monitoring & Financial Planning Procurement General Ledger Housing Revenue Account - Accounting Creditors (Accounts Payable) Risk Management Counter Fraud Capital Programme – Management & Monitoring
CORPORATE SERVICES	Members Allowances Registrars DTI (Information Technology)

	Emergency Planning Business Continuity HR RIPA Blue Badge Scheme Coroners Corporate Health & Safety Payroll Elections Electoral Registration Rainsbrook Crematorium Land Charges GDPR & Information Governance Customer Services, Contact Centre & One Stop Shop Complaints
ASSISTANT CHIEF EXECUTIVE	Environment & Sustainability Business Intelligence Communications
CROSS CUTTING	Programme & Project Management Capital Programme – Individual Schemes Performance Management Safeguarding Prevent Duty Ethical Standards & Governance

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West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL
AUDIT & GOVERNANCE COMMITTEE

27 MARCH 2024

Report Title	**Internal Audit Progress**
Report Author	**Adrian Ward – Head of Audit & Risk Management** **adrian.ward@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
S151 Officer	Martin Henry	15/03/2024

List of Appendices

Appendix A – Internal Audit 2023-24 Progress Update
Appendix B – Limited Assurance Report: Corporate Health & Safety
Appendix C - Management Progress Summary re Corporate Health & Safety Actions

1. Purpose of Report

1.1. To provide an update on work delivered by the Audit & Risk Service and progress against the Internal Audit Plan for 2023/24 up to 29 February 2024.

2. Executive Summary

2.1. The Audit & Risk Management Service provides assurance that organisational controls are effective and adequately mitigating risk. We also provide counter fraud services, supporting the Council in preventing and investigating fraudulent activity.

3. Recommendation

3.1 It is recommended that the Audit & Governance Committee consider and note the progress as summarised in this report.

4. Reason for Recommendation

4.1 To ensure compliance with the practice and principles for audit committees set out in the CIPFA Position Statement for Audit Committees, which include responsibilities for overseeing and supporting the internal audit function.

5. Report Background

5.1 This report summarises progress against the 2023/24 internal audit plan, draws attention to any limited assurance opinions that have been given, and also summarises the work of the Counter Fraud team and the Risk & Internal Controls team.

6. Issues and Choices

Internal Audit Progress

6.1 A detailed progress summary is provided in Appendix A.

6.2 In terms of resources, a new Senior Auditor started in December, but unfortunately that person has handed-in their notice and another recruitment process has therefore commenced. There has also been further sickness absences within the team that have further reduced the resources available to deliver planned audits. As reported previously, additional external resource has been obtained to deliver some of the 2023/24 planned audit work.

6.3 Since the last progress update, the following final audit reports have been issued:

6.3.1 **Corporate Health & Safety**

Assurance	
System Design	Limited
Compliance	Limited

As a limited assurance opinion has been given the full report is attached at Appendix B for information.

A progress summary from the service management is also attached at Appendix C.

6.3.2 **IT Disaster Recovery Follow-up**

This was a follow-up of a previous limited assurance audit report originally issued in July 2022, which raised 7 'important' level recommendations with agreed original action dates between September 2022 and December 2023. The follow-up review determined that actions to implement all the recommendations were still in progress with measures being taken to achieve implementation by September 2024, and that all the actions are interconnected so that the completion of some is dependent on others. A further follow-up review will therefore be undertaken after September 2024.

6.4 The following table summarises amendments to the 2023/24 Audit Plan since the last Committee meeting in November 2023, all of which are audits that have been removed from the Plan:

Audit Area	Update Notes
IT Systems: Carefirst (limited assurance 22/23 formal follow up)	The follow up review was linked to the implementation of a new system, which will not now be implemented until 2024/25.
Council Owned Properties – Health & Safety	This will now be included in the 2024/25 Audit Plan as part of the proposed review of 'Property Management & Maintenance (WNC Assets)'.
Local Area Partnerships	This is not felt to be an area where an internal audit review would add any value at this point in time.
Contract Management – Leisure Services	This is not considered to be a high-risk area, and available audit capacity could be better utilised elsewhere.
Schools – Thematic Audit	This will now be included in the 2024/25 Audit Plan, which includes a proposed review focussing on 'Early Years'.
Rural Bus Services	This is not considered to be a high-risk area, and available audit capacity could be better utilised elsewhere.
Property Management – New Asset Management System (Concerto)	This was a consultancy support / advice review re the new software system, which is now being undertaken by the Internal Controls team rather than by Internal Audit.

Implementation of Audit Recommendations (Actions Tracker)

6.5 A summary of the implementation status of the recommendations made by Internal Audit is set out in the table below:

Year	Total	Complete	%	Not Due / Extended	%	Overdue	%
2021/22	180	123	68	36	20	21	12
2022/23	50	21	42	12	24	17	34
TOTAL	**230**	**144**		**48**		**38**	

6.6 The classification of the 38 overdue recommendations (ie. without an extended agreed implementation date) is as follows:

Essential: 13
Important: 23
Standard: 2

6.7 A review of the overdue recommendations will be undertaken and any issues or concerns will be included in the next progress report to the Committee.

Counter Fraud Team Progress (April 2023 to February 2024)

6.8 Housing investigations undertaken by the Counter Fraud Team are a combination of responsive Investigation work referred from the service staff or the public and proactive work supporting the service with known risk areas, mainly housing and right to buy applications. The following table summarises the 186 housing referrals investigated to date during 2023/24:

Case type	Cases closed	Advice given / no further action	Investigation Outcomes
Housing Tenancy Referrals	119	104	• 10 properties recovered following investigations into 7 sublets, 1 right to buy, and 2 succession matters. According to Cabinet Office estimates this represents a £930k saving in total. These properties will be re-let to families in genuine need. • A further 5 right to buy sales were due to be completed, but following investigation the tenant withdrew their application or cancelled. • Recoverable debts totalling £29.6k were also identified during investigations, relating to housing benefits and council tax reductions.

Housing & Homeless Applications Referrals	67	48	• 19 housing or homeless applications were cancelled, withdrawn, or downgraded. According to Cabinet Office estimates this represents a £61.6k saving. • 2 of these were temporary accommodation properties which were recovered as they had been vacated / not used for purpose intended.
Total	**186**	**151**	

6.9 123 various other non-housing related referrals have also been investigated, as summarised in the table below:

Case type / service	**Cases closed**	**Investigation Outcomes**
Revs & Bens	54	• 5 single person discounts cancelled. At the average Band D rate this would represent an annual saving of £2.6k. • 3 council tax reduction discounts cancelled, and recoverable overpayments identified.
Blue Badge / Parking matters	17	• 1 warning letter issued. • 4 cases where advice was given. • 11 cases referred to the parking team and/or DWP for an eligibility review.
HR / staff matters	18	All staffing related matters are investigated in conjunction with HR colleagues. • 4 resignations following investigation and prior to disciplinary hearings. • 2 dismissals following investigation and disciplinary hearings.
Finance	3	The referrals were investigated and no further action was required.
Grants (Homes for Ukraine)	6	A total of £4.2k in overpayments recovered due to failures to report changes in circumstances.
Adults - NASS	2	Both cases were referred to the service and no further investigation action was taken.
Childrens Trust (NCT)	23	21 cases referred to counter fraud by the No Recourse team to assist with their assessments for financial support. Credit checks and bank statements were reviewed for income and expenditure screening. A further 2 issues relating to direct payments and alleged theft were closed no further action following consultation with NCT.
Total	**123**	

Risk & Internal Controls Team Progress

6.10 The Risk & Internal Controls team aids management with ensuring that robust internal control and risk management frameworks are in place by undertaking informal reviews or 'health checks', to identify areas where improvements to the internal control framework are required.

6.11 The team liaises with service areas to agree the scope of the review and then works with them to produce action plans for any areas where improvements are required, and continues to work with the service area to ensure that these improvements are implemented.

6.12 The team also deal with ad-hoc queries on business process and have been undertaking compliance monitoring on behalf of service areas for example, retrospective purchase orders.

6.13 Service areas the team have worked with, and are currently working with since the last Audit and Governance Committee in November 2023 include:

Area	Details
Council-wide	Refresh of the strategic risk register, and coordination of an initial Governance Health monitoring report (intended to be quarterly in future).
Finance	Monthly monitoring of GPC spend and retrospective orders, review of contract waivers, support with control account reconciliations, and for temporary accommodation finance.
Digital, Technology & Innovation	Management of external resource in relation to follow-up audits of Disaster Recovery and Cyber Security.
Transport	Commencement of support re Home to School Transport financial /budgetary processes.
Legal	Support re Inter Authority Agreements, and Land Registry query.
Place	Support re the implementation of the new Concerto property management system.

7 Implications (including financial implications)

7.1 Resources and Financial

7.1.1 There are no resources or financial implications arising from the proposals.

7.2 **Legal**

7.2.1 As a relevant authority under the Accounts & Audit Regulations 2015, the Council 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.

7.3 Risk

7.3.1 There are no significant risks arising from the proposed recommendations in this report.

7.4 Consultation

7.4.1 None required.

7.5 Climate Impact

7.5.1 None identified.

7.6 Community Impact

7.6.1 None identified.

7.7 Communications

7.7.1 None identified.

8. Background Papers

8.1 None.

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Audit	Status	Assurance		Actions Classification			Comments / summary of matters raised
		System Design	Compliance	Essential	Important	Standard	
Carried Forward (from 22/23) i.e. incomplete at issue of Annual Audit Report 22/23 (July 2023)							
Corporate health & safety	Completed	Limited	Limited	5	4	1	• Development of a corporate health & safety plan. • Development and publication of outstanding procedures. • Assessment of organisation-wide compliance with the risk assessment procedure. • Meeting reporting timescales for RIDDOR events. • Development of a comprehensive audit and inspection schedule. • Review and escalation to management of non-completion of mandatory health and safety training. • Documentation of procedures and appropriate record-keeping arrangements to monitor and follow up on actions within the accident / incident log. • Strengthening of record-keeping arrangements and reporting of critical performance metrics in the annual report.
Performance management	Completed	Good	Satisfactory	2	0	0	• Performance framework be made more prominent on intranet. • Greater communications to embed the process for producing service plans at directorate and service level. • More effective monitoring of service plan development.
Lease car arrangements	Draft report	Briefing Note Report		3	5	0	Audit planned at management's request. Report awaiting management response.
Corporate complaints management	Completed	Briefing Note Report		0	4	0	• Compliance with policy continues to be embedded throughout services.
Adults – commissioning framework	Completed	Briefing Note Report		0	1	0	• To develop and maintain a WNC Adult Social Care fees and charges policy.

Audit	Status	Assurance		Actions Classification			Comments / summary of matters raised
		System Design	Compliance	Essential	Important	Standard	
WNC partner audit							
Payroll 22/23 (incl. payroll control account reconciliations)	Completed	Satisfactory	Satisfactory	0 2	3 2	1 0	• Documented operational procedures be produced to ensure roles and responsibilities are clearly communicated and consistently applied. • Inclusion of performance reporting for the recovery of payroll overpayments in respect of ex-employees to the Lead Authority Board. • Payroll IT access role conflicts to be addressed and measures put in place for prompt review. • Implementation of various recommendations to improve the monitoring and reporting in respect of payroll control account reconciliations.
Northamptonshire Pension fund administration 22/23	Completed	Substantial	Substantial	0	0	0	Reported separately to the Pensions Fund Committee and Local Pension Board.
ERP Gold IT user access controls 22/23	Completed	Good	Good	0	2	0	• A more robust system for recording and retaining evidence of review and approval for superuser access. • Escalation of potential user access conflicts.
Plan 2023/24							
Contract management: parking (limited assurance follow up)	Completed	-	-	0 (0)	2 (0)	0 (0)	All actions confirmed as implemented.
IT disaster recovery (limited assurance follow up)	Completed	-	-	0 (0)	7 (7)	0 (0)	All matters raised in the original audit remain as work in progress, and include: • IT disaster recovery plan should be documented and approved. • Disaster Recovery Plan should be informed by Business Impact Analysis. • Roles and responsibilities of IT staff should be defined. • Disaster Recovery Project should be progressed. • Action plan to enable progression on plans to consolidate IT structure. • Disaster Recovery testing should be undertaken.

Audit	Status	Assurance		Actions Classification			Comments / summary of matters raised
		System Design	Compliance	Essential	Important	Standard	
							• Documentary evidence of lessons learnt from Incident Management and Disaster Recovery Testing should be retained. However, there are measures being taking to complete all actions by the end of September 2024. Additionally, the actions raised are interconnected, thus the completion of one action is dependent on the outcome of another.
IT security framework review	In progress						New audit following on from previous IT Cyber Security audit - audit fieldwork nearing completion.
Temporary staff: non-Opus / long placements	In progress						Audit fieldwork completed and under QA review.
Key financial system: Income processing / debtors (WNC/NNC/CCC)	In progress						On course for completion in 23/24.
Medium term financial plan	In progress						On course for completion in 23/24.
Transformation delivery	In progress						On course for completion in 23/24.
School financial audit - Brington PS	In progress						On course for completion in 23/24.
School financial audit - Harlestone PS	In progress						On course for completion in 23/24.
Community infrastructure levy follow up (briefing note report)	In progress						On course for completion in 23/24.
Section 106 developer contributions follow up (Briefing note report)	In progress						On course for completion in 23/24.
Corporate health and safety (limited assurance follow up audit)	In progress						On course for completion in 23/24.
School financial audit - Harpole PS	In progress						On course for completion in 23/24.
Net zero & sustainability strategies	In progress						On course for completion in 23/24.

Audit	Status	Assurance		Actions Classification			Comments / summary of matters raised
		System Design	Compliance	Essential	Important	Standard	
Homelessness prevention: landlord incentive scheme	In progress						On course for completion in 23/24.
Shared service audits – Cambridgeshire County Council							
Northamptonshire pension fund administration	In progress						On course for completion in 23/24.
Payroll	In progress						On course for completion in 23/24.
Debt recovery	In progress						NOTE – originally an audit being undertaken by WNC, but due to resourcing issues Cambridgeshire's internal audit team will now complete this audit.
Shared service audits – North Northamptonshire Council							
Accounts Payable	In progress						On course for completion in 23/24.

Plan 2023/24 - Cancelled / deferred / covered by other audits (as reported in progress update reports)	Comment	Committee Reported
DTI telephony procurement review (management request)	Request no longer required by management.	Jul 2023
Partnerships - inter authority agreements – contract management & disaggregation	Considered more appropriate as consultancy rather than an audit – Internal Controls team providing support.	
Property management (Concerto – new asset management system)	Considered more appropriate as consultancy rather than an audit. The Internal Controls team is providing advice and support to Finance and the key service area for delivery of the new IT system.	
Income management system	Considered more appropriate as consultancy rather than an audit. The Internal Controls team is providing general oversight and advice as deemed necessary.	
Temporary accommodation	Originally a management request to support the finance officer, therefore considered consultancy. The Internal Controls team are working with that officer to resolve / agree improvements to control environment.	
IT systems security – CareFirst (limited assurance follow up)	Actions implemented / closed with a view to re-auditing once the new IT system is in place. The Internal Controls team is providing advice and support to the implementation process.	
Home to school transport (limited assurance follow up)	Actions implemented / closed with a view to re-auditing once a new IT system is in place. The Internal Controls team will continue to provide advice and support during 24/25.	
Taxi licensing (limited assurance follow up)	Actions under continuous review as a new IT system is put in place. The Internal Controls team is providing advice and support. Service will be re-audited at a later date.	
Schools - thematic audit	Change of auditing approach to provide resource into the undertaking of individual school	

	audits.	
School financial audits	Audit of Chiltern PS started but subsequently deferred to 24/25 at management's request. A further 3 schools audits have not been undertaken in 23/24 due to audit resource issue towards the end of the financial year.	
Contract management - leisure services	Cancelled due to audit resource issue towards the end of the financial year.	
Local area partnerships	Not considered to be an area where an internal audit would add value.	
Rural bus services	Cancelled due to audit resource issue towards the end of the financial year.	
Council owned properties - health and safety	Originally started in 23/24 Q3 but delayed to Q4 at management's request. Subsequently due to further delay the audit is due to be picked up in 24/25 as part of a panned audit of Property Management & Maintenance.	

***Plan Status** - audit progress is measured within several stages:

- Not started
- Planning
- Fieldwork in progress
- Fieldwork complete / draft report being prepared.
- Draft Report issued / considering or awaiting management response.
- Completed - Final Report issued.

Note: Where the draft report has been issued the opinion is classified as provisional until the final report has been issued.

Grant	Status *	Assurance
Grant Verification Work		
WNC - LA Covid-19 Test & Trace Contain Outbreak Management Fund (COMF) 2022/23	Completed	Certification provided
WNC - Disabled Facilities Grant 2022/23 (+ 2021/22 Follow Up)	Completed	Certification provided; follow up still in progress
WNC - LA Bus Subsidy (Revenue) Grant 2022/23	Completed	Certification provided
WNC - Bus Recovery Grant 2021/22	Completed	Certification provided
WNC – Local Transport Fund 2022 to 2023	Completed	Certification provided
WNC - Local Transport Capital Block Funding 2022/23	In progress	

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West Northamptonshire Council

APPENDIX B

Internal Audit Final Report

Corporate Health and Safety 2022/23

Governance Opinion

Adequacy of System	**Limited**
Compliance	**Limited**
Organisational Impact of Findings	**Moderate**

Report Issued	31/08/2023
Follow Up Audit Due	Q3 2023/24

Executive Summary

1 Background

1.1 West Northamptonshire Council ('the Council') recognises and accepts its statutory responsibility to provide safe and healthy working conditions for employees, clients, and others who use or visit Council premises or may be affected by its activities.

1.2 The Council has adopted the Health and Safety Executive's (HSE) 'Plan, Do, Check, Act' (PDCA) approach, as outlined in HSG65 (Managing for Health and Safety) to help achieve a balance between the systems and behavioural aspects of management. This approach treats health and safety management as an integral part of good management generally, rather than a stand-alone system, and encourages a commitment to continuous improvement.

1.3 An internal audit had been scheduled to take place during 2021/22. Whilst some initial enquiries were undertaken to establish the position in the Council's first year of operation, this audit was subsequently rescheduled for 2022/23 in agreement with management.

2 Scope of Audit and Approach

2.1 Scope

This audit relates to the following strategic risks that have been identified through the risk management process:

- Health and safety (E09) - Failure to comply with health and safety legislation, corporate health and safety policies, and corporate health and safety landlord responsibilities.

The scope of the audit sought to determine whether:

- A health and safety policy, plan and procedures exist and are consistent with the requirements of the relevant legislation subject to regular review, and available to key stakeholders.
- Roles and responsibilities are clearly communicated throughout the Council, with the provision of appropriate training, where required.
- There is a planned and systematic approach to risk control and reporting.
- A clear process exists for the recording, reporting, monitoring, and raising awareness of accidents, incidents and near misses.
- A robust health and safety audit and inspection regime is in place.
- Effective monitoring and reporting arrangements exist.

2.2 Limitations

Limitations to the scope of the audit included the following:

- This is an assurance piece of work, and an opinion will be provided on the effectiveness of the Council's corporate arrangements in relation to health and safety.
- The auditor's work does not provide any guarantee against material errors, loss, or fraud. It does not provide absolute assurance that material error, loss, or fraud does not exist.

2.3 Approach

The audit process included an assessment of the controls in place, review of documentation, and sample testing, where appropriate, to determine whether controls had operated as intended.

2.4 Acknowledgements

We would like to thank all the members of staff consulted, for their assistance and co-operation during this review.

3 Internal Audit Opinion and Main Conclusions

3.1 The Council recognises and willingly accepts its responsibility as an employer for providing a safe and healthy workplace for all its employees together with all other persons who may be affected by its activities. To this end, the Council has an approved **Health, Safety and Wellbeing (HS&W) Policy** that promotes wellbeing and safe working practices across its locations and services and encourages all employees to be involved in the safety culture within the authority.

3.2 The presence of health, safety and wellbeing pages on the intranet is a valuable source of information available to employees and continues to be developed and enhanced. Clear points of contact either for urgent or non-urgent support and guidance is available with further awareness provided to management and employees through mandatory training. Roles and responsibilities are clearly defined within the policy and any supporting procedures and documentation.

3.3 While some essential elements of a health and safety management system are in place there are key areas which require attention or improvement. As acknowledged in the policy, a **corporate health and safety plan** which sets out the how the organisation will meet its policy requirements has not yet been designed. One of the key aims of the Council's nominated Director for HS&W is to agree and monitor a such a plan, in collaboration with the JHS&W Committee, with each directorate contributing towards its development and implementation through the preparation of relevant plans to support the achievement of the corporate objectives.

3.4 In addition, many of the **supporting procedures** as listed in the policy do not currently exist (50%) as WNC procedures currently. Where a WNC procedure has not yet been developed, employees are referred to their legacy council procedures accessible via their respective legacy intranet. However, most of the relevant procedures are not available via the legacy intranets of Daventry or Northamptonshire County, and more significantly procedures are no longer available in relation to former employees of Northampton Borough or South Northamptonshire Council's. Therefore, many employees across the organisation do not have access to appropriate online advice. Whilst advice and support are available from the HS&W team, the omission of certain procedures and inconsistencies across the legacy procedures can lead to an increased risk of errors and omissions, poor decision-making, or non-compliance with the requirements of the relevant legislation, all of which could result in financial loss and reputational damage to the Council.

3.5 Another fundamental aspect of any health and safety system is the identification of health and safety hazards / risks arising from the Council's activities, the assessment of the potential consequences of these happening that might be affected by work activities, and then the likelihood. Responsibilities and required actions are clearly communicated within a **risk assessment** procedure which applies to all Council activities, with additional assessments (topic / person specific) required to comply with the requirements of the relevant legislation or HSE guidance.

3.6 A Risk Assessment Procedure requires each directorate management team to develop a health and safety risk profile, documented and maintained within a **risk assessment plan** (inconsistently this is referred to as risk management plan within the policy) and ensure that all required risk assessments are completed, and that actions arising are implemented and reviewed when necessary. Audit enquiries established that a comprehensive mapping exercise has not yet taken place to establish the completion of both risk assessment plans and risk assessments across the organisation. Whilst it may be the case that some plans and assessments have been undertaken within each directorate, it is not known whether these are complete, accurate and / or up to date.

Without this knowledge it is difficult for those key stakeholders identified within the policy to be assured that health and safety risk is being effectively managed.

3.7 Although an **Audit & Inspection** Procedure was finalised and published in January 2023, an inventory of auditable areas and a comprehensive audit and inspection schedule have yet to be agreed and therefore delivered. In undertaking audits and inspections, the Health and Safety Team are an essential line of defence to providing assurance to the JHS&W Committee and senior management. Without the delivery of a risk-based programme of audits it is also difficult for the HS&W team to form an opinion on whether the health and safety management system and procedures are effectively embedded across all areas of the Council, and what aspects may require further attention and / or support. It also makes it difficult for the JHS&W Committee to monitor and provide effective challenge and scrutiny if only limited assurance is being provided.

3.8 The Council has a statutory duty (**RIDDOR - the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013**) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses) to the HSE within the agreed timescales. Our review identified a small number of cases where the required reporting timescales had not been met. For context, failure to report a RIDDOR could result in the employer receiving a £20,000 fine, whereas late reporting is not as prescriptive. Dependent upon the seriousness of the RIDDOR event it may cause the HSE to ask questions or result in an inspection. A trend of late reporting may well put the Council on the HSE's radar, but the likelihood of a visit is relatively low.

3.9 Our review has also confirmed that **record-keeping and monitoring arrangements** require strengthening in relation to the completeness of mandatory training, accident and reporting, the standardisation of reporting for directorate HS&W forums, and the creation of performance metrics in liaison with the JHS&W Committee. In addition, and in line with policy requirements, overall performance has not been collated by the HS&W team into an **annual health and safety report** for both 2021/22 and 2022/23, for consideration by the Executive Leadership Team, Councillors, and the JHS&W Committee.

Internal Audit Opinion

3.10 Gaps or inconsistencies in supporting procedures, non-compliance with established procedures, or a lack of assurance that such activities are adequately in place and embedded, leads to an ineffective health and safety management system. With the inherent risk that health and safety bring this leaves the potential for significant events to occur which may compromise the health and safety environment within the Council. Whilst accidents inevitably occur it is the strength of the health and safety framework which demonstrates the organisation is doing all it can to prevent such events from occurring. If this cannot be reasonably demonstrated, then this leaves the Council vulnerable to an increase in accidents / incidents, compensation claims, potential enforcement by the HSE, and ultimately damage to its reputation.

3.11 The deficiencies in the reviewing, monitoring and reporting mechanisms makes it harder for the JHS&W Committee to meet its obligations. In turn this makes it difficult for the Chief Executive to place suitable reliance on the overall assurance that the committee should be providing. The culmination of the deficiencies identified in the design and/or compliance of the health and safety management system means that the level of assurance given to both the **system design and compliance** is one of **Limited Assurance**, with the organisational impact of the findings assessed as **Moderate**, leaving the Council open to medium risk.

3..12 The actions arising from this audit should be referred to and considered by the JHS&W Committee and ideally Internal Audit should receive feedback before the report is considered by the Audit and Governance Committee. Given the assurance opinion of limited assurance the report will be presented at a meeting of the latter committee where management will be requested to present their response and corrective plan / action.

3.4 **Main recommendations**

Essential

- A corporate health and safety plan should be developed accordingly, after which it should be agreed by the JHS&W Committee and made available to employees via the intranet. **(See MAP 1)**
- A comprehensive action plan should exist to confirm when the relevant outstanding procedures (as listed within the HS&W Policy) will be developed and / or made available to employees via the intranet. **(See MAP 2)**
- Organisation-wide compliance with the risk assessment procedure should be subject to an early health and safety audit with the relevant findings presented to the JHS&W Committee for their consideration. **(See MAP 5)**
- RIDDOR requirements must be complied with and matters relating to incidents / reporting timescales should be presented to the JHS&W Committee for their consideration. (**See MAP 7**)
- A risk-based inventory of auditable areas and a comprehensive audit and inspection schedule should be agreed and start to be delivered as soon as reasonably practicable. Once established, monitoring of progress of audits and the implementation of recommendations should be reported to the JHS&W Committee in accordance with procedure. It is recommended that the first audit to be undertaken should be an assessment of the compliance with the risk assessment procedure. (**See MAP 8**)

Important

- Managers should be reminded of their responsibility for ensuring that all employees have completed the relevant mandatory health and safety training, with issues of non-compliance monitored and escalated by the HS&W team accordingly. (**See MAP 4**)
- Appropriate documented procedures and record-keeping arrangements should exist to provide assurance that the relevant actions within the accident / incident log have been followed up / undertaken accordingly. **(See MAP 6)**
- The relevant key reporting issues identified during this audit should be addressed accordingly. (**See MAP 9**)
- That terms of reference be established to guide the directorate HS&W forums, and their purpose and objectives be set out in the next revision of the policy. **(See MAP 10)**

For all issues identified as part of this audit, actions are agreed with management and are detailed in the Management Action Plan (MAP) from page 12 of this report. When implemented these will positively improve the control environment.

Detailed Findings

4 Assurance Area – Policy, Plans and Procedures

Control Objective – A health and safety policy, plans and procedures exist and are consistent with the requirements of the relevant legislation, subject to regular review, and available to key stakeholders.

Policy

4.1 The Health and Safety at Work Act 1974 requires employers of five or more people to have a written health and safety policy statement. The Council's Health, Safety and Wellbeing (HS&W) Policy ('the policy') had been approved by the Chief Executive and the Leader of the Council in November 2022 and is supported by a Health and Safety Policy Statement (which is also contained within the policy), both of which are available to all employees via the intranet. A further version of the policy has subsequently been published, and whilst this has not been approved, it is noted that it had only been subject to two minor amendments.

4.2 It is understood that whilst the original version of the policy (April 2021) had been subject to consultation with the Future Northants Health and Safety Workstream and Trade Union Health and Safety Representatives, the relevant supporting documentary evidence has not been retained on file. Whilst a formal recommendation has not been made in relation to this, record-keeping arrangements will require strengthening going forward to provide assurance that controls have operated as intended.

4.3 Where necessary to ensure compliance with legislation and the policy, directorates are expected to develop more specific policies and procedures to address HS&W matters pertinent to their operational areas.

Plans

4.4 A health and safety plan sets out how an organisation will meet its policy requirements and is a key element of any health and safety management system, as acknowledged in the policy. The JHS&W Committee (discussed further at 5.1) are responsible for agreeing a corporate health and safety plan, with each directorate contributing towards its development and implementation through preparation of relevant plans to support the achievement of the corporate objectives. This corporate plan should be made available to employees via the intranet in accordance with policy requirements. Whilst the JHS&W Committee meeting minutes record some modest action towards the development of 'health, safety, and wellbeing work plans' at a directorate level, a corporate health and safety plan has not yet been designed and / or agreed. **(See MAP 1)**

Procedures

4.5 Well-designed health and safety procedures are fundamental in standardising workplace practice, reducing risks, and therefore reducing human error and improving compliance. The Council recognises that the policy should be underpinned by such procedures, a list of which has been appended to the document accordingly. Where a WNC procedure has not yet been developed, employees are referred to their legacy council procedure accessible via their respective legacy intranet and advice is available from the HS&W team.

4.6 Our review confirmed that whilst the 34 procedures as listed in Appendix 4 of the policy are consistent with the requirements of the relevant legislation and HSE guidance, 17 of these (50%)

are not currently available via the WNC intranet, and whilst employees are signposted to the relevant procedures via the legacy intranets of Daventry, Northampton Borough, Northamptonshire County, and South Northamptonshire, the following issues have been noted:

- Legacy intranets are no longer available in relation to Northampton Borough or South Northamptonshire.
- The majority of the relevant procedures are not available via the legacy intranets of Daventry or Northamptonshire County (10 or 59% and 15 or 88% respectively).

4.7 It is noted that an action plan does not currently exist to confirm when the relevant outstanding procedures will be developed and / or made available to employees via the intranet. In addition, a version control sheet had not been included within two (12%) of the procedures which are currently available via the intranet, as such it is not clear whether these have been subject to recent review or approval. **(See MAP 2)**

5 Assurance Area – Roles and Responsibilities

Control Objective – Roles and responsibilities are clearly communicated throughout the Council, with the provision of appropriate training, where required.

Roles and Responsibilities

5.1 The JHS&W Committee has oversight responsibility for the implementation of the Council's policy and its Safety Management System (SMS), with such matters communicated accordingly within the Committee Terms of Reference (ToR). The Committee is made up of senior representatives of each Directorate Forum and nominated Trade Union Health and Safety Representatives. The Chief Executive has overall accountability for health and safety for the Authority. However, they have appointed the role of Nominated Director for Health, Safety and Wellbeing (HS&W) to the Executive Director for People, who is also the chair of the Committee. The policy contains further details of this role whose aims are to:

- Provide corporate leadership for HS&W.
- Drive continuous improvement in HS&W culture and practice.
- Agree and monitor a clear health and safety plan.
- Make recommendations about targeting of resources to address areas of highest risk.

They will also delegate responsibility for the completion and maintenance of corporate procedures to the directorate with the appropriate level of expertise.

5.2 In line with the policy statement the Executive Leadership Team and Elected Members:

- Determine the health and safety strategy and objectives.
- Resource and implement this policy.
- Promote a positive culture towards health and safety.
- Monitor the effectiveness of the management systems to ensure that best practice is maintained.

Managers must ensure that the policy and supporting procedures are understood and followed to ensure that all risks are managed appropriately, and employees must take care of their own health and safety and that of others who may be affected by what they do, or fail to do, at work.

5.3 Our review confirmed that other roles and general responsibilities in relation to health and safety are clearly communicated within various documents such as the policy, management guidance (our West Ways of Working) and the current job description and person specification template (published on 03/04/2023). It is noted that whilst the policy stipulates senior and specialist job roles should have additional health and safety elements included within the relevant job descriptions such controls are not consistently exercised, with sample testing confirming non-compliance in nine (82%) of the 11 cases tested (two Executive Directors and seven Assistant Directors). **(See MAP 3)**

Mandatory Health and Safety Training

5.4 It is a requirement of the Council that the policy and its implications are understood and acted upon at all levels within the authority. The Council's HS&W training procedure confirms that training needs are grouped into four categories: induction (including mandatory health and safety training for both managers and employees), occupancy compliance, job specific, and person specific. Beyond the mandatory training, management are responsible for identifying further job specific training relevant to an individual's role.

5.5 As part of the corporate and local induction managers are responsible for ensuring that all employees complete the relevant mandatory health and safety training via the Council's Learning Management System (LMS) within the first two weeks of their induction process and can monitor progress accordingly via the LMS (iLearn).

5.6 Our review of the completion rates for mandatory training confirmed that of the 462 employees who had joined the Council between 01/04/2022 – 31/10/2022, 48 (10%) had not completed the mandatory health and safety induction training at the time of reporting. Further testing of 10 employees who had joined the Council in a management position during the same period confirmed that nine (100% - one employee had joined the Council on 31/10/2022) had not completed the mandatory health and safety awareness training for managers at the time of reporting. **(See MAP 4)**

5.7 It is understood that the HS&W team have been unable to monitor issues of non-compliance in relation to this area, with difficulties in obtaining the relevant reports (via North Northamptonshire Council (NNC)) cited as the reason for this. It is noted that whilst the Council's LMS moved to a new site (from a shared platform) in March 2023 and is no longer hosted / managed by NNC, it is still unclear whether the relevant issues have been resolved at the time of reporting. **(See MAP 4)**

6 Assurance Area – Risk Assessments

Control Objective – There is a planned and systematic approach to risk control and reporting.

6.1 Each directorate management team is required to develop a health and safety risk profile, documented and maintained within a risk assessment plan (referred to as a risk management plan within the policy) and ensure that all required risk assessments are completed, and that actions arising are implemented and reviewed when necessary and in accordance with the Risk Assessment Procedure.

6.2 Responsibilities are clearly communicated within the procedure. Directors are accountable and Assistant Directors are responsible for identifying all activities carried out within their area and populating the relevant columns within a risk assessment plan. Whilst managers are accountable

for ensuring that risk assessments are undertaken for the relevant activities within their area, responsibility for completing this could fall to a separate risk assessor, although this should be someone competent at risk assessment with enough subject knowledge to identify hazards and recommend appropriate controls. Various other responsibilities are set out in a matrix at Appendix 1 to the procedure.

6.3 The risk assessment plan should identify all activities carried out within an area of control. A specific template is provided at Appendix 2 to the procedure. The purpose of a risk assessment is to identify hazards (such as new working practices or accidents and near misses etc.) and evaluate any associated risks to health and safety arising from the Council's activities, enabling informed decisions to be taken to eliminate or minimise any risk of harm to those who may be affected. The process applies to all Council activities, whilst additional assessments (topic / person specific) may be required to comply with the requirements of the relevant legislation or HSE guidance.

6.4 It is noted that whilst in-house training is available in relation to the risk assessment process, a professional qualification (such as the Institution of Occupational Safety and Health (IOSH) Managing Safely Level 2) would be required to assess higher risk activities.

6.5 Discussion with the HS&W Specialist confirmed that a comprehensive mapping exercise has not yet taken place to establish the completion of both risk assessment plans and risk assessments across the organisation. Whilst it may be the case that some plans and assessments have been undertaken within each directorate, it is not known whether these are complete, accurate and / or up to date. **(See MAP 5)**

7 Assurance Area – Accidents, Incidents and Near Misses

Control Objective – A clear process exists for the recording, reporting, monitoring, and raising awareness of accidents, incidents, and near misses.

Process

7.1 The Council's accident, incident reporting and investigation procedure outlines the process for reporting, recording, and investigating all accidents and incidents to ensure compliance with the requirements of the relevant legislation such as the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The procedure applies to all areas of the Council, and covers employees, temporary, agency and contract staff, volunteers, contractors on site and all other persons for whom the Council has a direct or indirect responsibility, including its customers (service users and members of the public). The JHS&W Committee is responsible for promoting continuous improvement by monitoring such incidents and audit outcomes.

7.2 All accidents, incidents or near misses must be reported as soon as is reasonably practicable, and no later than 24 hours of the event occurring, via the Council's online incident reporting and health and safety management system (Frontline).

7.3 A review of the accident / incident log (Frontline report) confirmed that it is unclear which actions require follow up, or whether this process exists in practice, based on the information which is currently available. In addition, a completion date is not included within the log, as such, it is not possible to determine whether actions have been undertaken promptly in the relevant cases. Whilst it is understood that the Frontline system (inherited from NCC) is considered by management as not fit for purpose and early scoping of a new management system is underway, it

remains essential that current procedures and record-keeping arrangements are strengthened to provide assurance that key controls are operating as intended. **(See MAP 6)**

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)

7.4 In relation to RIDDOR, an accident is a separate, identifiable, unintended incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work. Injuries themselves, e.g., "feeling a sharp twinge" are not accidents. There must be an identifiable external event that causes the injury, e.g., a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g., repetitive lifting), are also not classed as "accidents" under RIDDOR.

7.5 The Council has a statutory duty to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses) to the HSE within specified timescales. The HSE maintains a list of what type of accidents must be reported under RIDDOR. They include accidents resulting in:

1) Death of any person.
2) Specified injuries to workers including fractures; amputations; loss of sight etc.
3) Non-fatal accidents requiring hospital treatment to non-workers.
4) Dangerous occurrences; and
5) Over-seven-day injuries to workers. This is where an employee, or self-employed person, is away from work or unable to perform their normal work duties for more than seven consecutive days.

Incidents 1 – 4 are required to be reported without delay to the enforcing authority (HSE) but within 10 days of the incident, whilst point 5 must be notified within 15 days.

7.6 Matters in relation to RIDDOR reporting are included within the Council's accident, incident reporting and investigation procedure, along with a link to the relevant HSE guidance. The procedure confirms that managers must contact the HS&W team without delay, in all cases where there is a suspected RIDDOR reportable event.

7.7 From an accident log spreadsheet covering the period April to November 2022 containing twelve RIDDOR incidents reported during 2022/23, a sample of five (all of which resulted in an over-seven-day incapacitation of the worker) were selected for review. Our testing confirmed that the required timescales had not been met in three cases (late submission from a manager in one case). It should be noted that in one of these cases the incident was reported to the Council's insurers and following a review the HSE accepted that it was not reportable under RIDDOR. Further review of five non-RIDDOR reportable incidents confirmed that these had been classified correctly in accordance with HSE guidance. **(See MAP 7)**

8 Assurance Area – Audit and Inspections

Control Objective – A robust health and safety audit and inspection regime is in place.

8.1 Audits and inspections constitute a method of active monitoring and measuring of the design, development, installation, and operation of management arrangements, which enables an organisation to reinforce, maintain and develop its ability to reduce risks to '*as low as is reasonably practicable*' and to ensure the continual effectiveness of the health and safety management system.

8.2 Our review confirmed that whilst an audit and inspection procedure had been published via the intranet (January 2023), an inventory of auditable areas and comprehensive audit and inspection schedule are yet to be agreed. **(See MAP 8)**

9 Assurance Area – Monitoring and Reporting Arrangements

Control Objective – Effective monitoring and reporting arrangements exist.

9.1 The JHS&W Committee are responsible for overseeing the implementation of the Council's policy and the health and safety management system through the provision of various assurance activities such as monitoring and review. Through such activities they can monitor the effectiveness of the Council's SMS by providing challenge and scrutiny and supporting the implementation of action plans. The Committee consists of senior officers (including the nominated Director for HS&W) and nominated Trade Union Health and Safety Representatives, with meetings primarily held on a quarterly basis.

9.2 Our review confirmed that whilst matters in relation to monitoring and measuring performance are communicated within the policy, critical performance metrics are yet to be agreed. In addition, whilst overall performance should be collated into an annual health and safety report by the HS&W team, for consideration by the Executive Leadership Team, Councillors, and the JHS&W Committee, no such reporting has been completed to date in accordance with policy requirements. **(See MAP 9)**

9.3 Further enquiries with the HS&W team established there are four HS&W Directorate Forums covering the following areas:

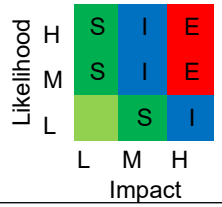
- Chief Executive; Corporate; Finance - meetings are held once every 2 months.
- Place, Economy and Environment - quarterly meetings.
- Communities and Opportunities - no forum meetings have been held to date.
- People Services - no forum meetings have been held to date.

The policy makes no prescriptive reference to these forums, the only reference being to "consultation forums and colleague engagement" at 2.9 but is not clear if this relates to this aspect, given the Consulting with Employees and Employee Representatives procedure has not yet been established. Furthermore, Appendix 2 to the policy - Responsibility, Accountability and Consultation Flow Chart - only refers to a "Directorate Health & Safety Group" which is not in existence. In addition, no reference to the forums can be found on the intranet or within any published WNC procedures.

Of those forums that do meet it was observed that inconsistencies exist with regards to the format, content, frequency and provision of directorate health and safety reports which are currently prepared by the HS&W team. **(See MAP 10)**

MANAGEMENT ACTION PLAN

The Agreed Actions are categorised on the following basis:



Essential - Action is imperative to ensure that the objectives for the area under review are met.

Important - Requires action to avoid exposure to significant risks in achieving objectives for the area under review.

Standard - Action recommended to enhance control or improve operational efficiency.

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
1	**Plans** Whilst the Joint Health Safety and Wellbeing (JHS&W) Committee meeting minutes acknowledge some modest action towards the development of 'health, safety, and wellbeing work plans' at a directorate level, a corporate health and safety plan has not yet been designed and / or agreed. **Risk** Without such controls, there is an increased risk of inefficiencies in operations, and poor decision-making (and in turn, a failure to maximise value for money), all of which could result in financial loss and reputational damage to the Council.	A corporate health and safety plan should be developed accordingly, after which it should be agreed by the JHS&W Committee and made available to employees via the intranet.	WNC comprises of a diverse number of services with many different Health & Safety requirements therefore a single corporate plan would not be sufficient. Activity has commenced on an overall H, S &W strategy (as written in the HSW Policy (item 3 policy statement) to provide direction over medium to long term. **Internal Audit comment:** The management response is accepted but note this will require amendment to the policy.	Essential	Hayden Mead	31/12/2023
2	**Procedures** 17 (50%) of the procedures listed within the Health, Safety and	A comprehensive action plan should exist to confirm when the relevant outstanding	The current HS&W policy put in place at vesting day will firstly be reviewed to ensure the procedures listed within it	Essential	Hayden Mead	31/12/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	Wellbeing (HS&W) Policy are not currently available via the intranet. Whilst employees are signposted to the relevant procedures via the legacy intranets of Daventry, Northampton Borough, Northamptonshire County, and South Northamptonshire the following issues have been noted: • Legacy intranets are no longer available in relation to Northampton Borough or South Northamptonshire. • The majority of the relevant procedures are not available via the legacy intranets of Daventry or Northamptonshire County (10 or 59% and 15 or 88% respectively). It is noted that an action plan does not currently exist to confirm when the relevant outstanding procedures (as listed within Appendix 4 of the policy) will be developed and / or made available to employees via the intranet. In addition, a version control sheet had not been included with two (12%) of the procedures which are currently available via the intranet, as such it is	procedures (as listed within the policy) will be developed and / or made available to employees via the intranet. The action plan should be subject to regular review to provide assurance that key tasks requiring attention are actioned by the relevant named officers within the agreed timescales. In addition, a version control sheet should be included with all procedures to provide an audit trail of all revisions and approvals.	are still relevant for WNC given our workforce mix. Following this review an action plan with appropriate / agreed timescales will be developed to ensure WNC has the relevant procedures, guidance and reporting mechanisms in place, and these will be published via the intranet (with version controls).			

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	not clear whether these have been subject to recent review or approval. **Risk** If health and safety procedures do not exist or are not consistent and available to employees, nor subject to regular review, there is an increased risk of errors and omissions, inconsistent working practice, inefficiencies in operations, poor decision-making (and in turn, a failure to maximise value for money), non-compliance with the requirements of the relevant legislation, and potential legal challenge, all of which could result in financial loss and reputational damage to the Council.					
3	**Roles and Responsibilities** Whilst roles and responsibilities in relation to health and safety are clearly communicated within various documents, the policy requires additional elements be included within the job descriptions for senior and specialist job roles, in addition to manager induction training to ensure the level of competency for their role. Sample testing confirmed that such controls had not operated as	Management should be reminded that additional health and safety elements should be included within the relevant job descriptions (for senior and specialist job roles) in accordance with agreed policy.	There is an overarching legal duty around H&S. Whilst including the information in a job description serves as a helpful reminder to the postholder, it is not a control in itself as it is the experience, knowledge, training and application (assessment of competence) that is critical. Being in the job description or not will also not absolve the postholder of the responsibility in law. However, HR will provide a recommendation to ELT regarding a statement for EDs	Standard	Hayden Mead	30/09/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	intended, whereby additional health and safety elements had not been included within nine (82%) of the 11 relevant job descriptions reviewed (two Executive Directors and seven Assistant Directors). **Risk** Without such controls, there is an increased risk of inefficiencies in operations, and poor decision-making (and in turn, a failure to maximise value for money), all of which could result in financial loss and reputational damage to the Council.		Directors and ADs which they can insert into the job descriptions.			
4	**Mandatory Training and Monitoring** Our review confirmed that of the 462 employees who had joined the Council between 01/04/2022 – 31/10/2022, 48 (10%) had not completed the mandatory health and safety induction training at the time of reporting. Further testing of 10 employees who had joined the Council in a management position during the same period confirmed that nine (100% - one employee had joined the Council on 31/10/2022) had not completed the mandatory health and safety	Managers should be reminded of their responsibility for ensuring that all employees have completed the relevant mandatory health and safety training via the Council's LMS within the first two weeks of their induction process. The HS&W team should determine whether the relevant reports are readily available to enable monitoring to take place, with issues of non-compliance escalated accordingly.	HR will issue a reminder to all managers regarding completion of all mandatory training in line with the Council's induction policy. It should be noted that the H&S elements of mandatory training are currently under review as per the recommendations arising from the review of all mandatory training that took place with ELT in 2022, therefore the extent of the mandatory H & S training may be reduced as it is currently duplicated. The L & D function returned to WNC on 1st April 2023 and the learning	Important	Gill Kennedy & Clare Young	31/10/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	awareness training for managers at the time of reporting. It is understood that the HS&W team have been unable to monitor issues of non-compliance in relation to this area, with difficulties in obtaining the relevant reports (via North Northamptonshire Council (NNC)) cited as the reason for this. It is noted that whilst the Council's Learning Management System (LMS) moved to a new site (from a shared platform) in March 2023 and is no longer hosted / managed by NNC, it is still unclear whether the relevant issues have been resolved at the time of reporting. **Risk** Without such controls, there is an increased risk of errors and omissions, inconsistent working practice, inefficiencies in operations, poor decision-making (and in turn, a failure to maximise value for money), non-compliance with the requirements of the relevant legislation, and potential legal challenge, all of which could result in financial loss and reputational damage to the Council.	Any issues with reporting functionality should be discussed / resolved accordingly with the relevant provider.	management system is now WNC owned, meaning that a WNC reporting strategy can be put in place once the new system is procured (Aug 2023).			

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
5	**Risk Assessments** Whilst management responsibilities are clearly communicated within the procedure, discussion with the HS&W Specialist confirmed that a mapping exercise has not yet taken place to establish the completion of both risk assessment plans and risk assessments across the organisation. Whilst it may be the case that some plans and assessments have been undertaken within each directorate, it is not known whether these are complete, accurate and / or up to date. **Risk** Without such controls, there is an increased risk of poor decision-making (and in turn, a failure to maximise value for money), non-compliance with the requirements of the relevant legislation, and potential legal challenge, all of which could result in financial loss and reputational damage to the Council.	Organisation-wide compliance with the risk assessment procedure should be subject to an early health and safety audit with the relevant findings presented to the JHS&W Committee for their consideration.	H&S will do an audit and report to the JHSW Committee for their consideration.	Essential	Hayden Mead	31/10/2023
6	**Accident / Incident Log** A review of the accident / incident log (Frontline report) confirmed that it is unclear which actions require follow up, or whether this process exists in	Appropriate documented procedures and record-keeping arrangements should exist to provide assurance that the relevant actions within the	The current (inherited) IT system is not fit for purpose, meaning it is not possible to efficiently manage and monitor actions on the existing frontline system, hence the service is	Important	Hayden Mead	31/03/2024

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	practice, based on the information which is currently available. In addition, a completion date is not included within the log, as such, it is not possible to determine whether actions have been undertaken promptly in the relevant cases. Whilst it is understood that the Frontline system (inherited from NCC) is considered by management as not fit for purpose and early scoping of a new management system is underway, it still remains essential that current procedures and record-keeping arrangements are strengthened to provide assurance that key controls are operating as intended. **Risk** Without such controls, there is an increased risk of errors and omissions, inconsistent working practice, inefficiencies in operations, poor decision-making (and in turn, a failure to maximise value for money), non-compliance with the requirements of the relevant legislation, and potential legal challenge, all of which could	accident / incident log have been followed up / undertaken accordingly.	currently exploring funding options for a replacement and funding means. The team will explore further manual interventions to strengthen record keeping arrangements outside of the system, but this activity will need to be within the existing capacity constraints of the service.			

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	result in financial loss and reputational damage to the Council.					
7	**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)** A review of five RIDDOR incidents which had been reported during 2022/23 confirmed that the agreed timescales had not been met in three cases (late submission from a manager in one case). **Risk** Without such controls, there is an increased risk of non-compliance with the requirements of the relevant legislation, and potential legal challenge, both of which could result in financial loss and reputational damage to the Council.	RIDDOR incidents should be reported to the Health and Safety Executive (HSE) within the agreed timescales (10 days of incident or 15 days for accidents resulting in the over-seven-day incapacitation of a worker). In addition, matters relating to RIDDOR (incidents / reporting timescales etc.) should be reported to the JHS&W Committee for their consideration.	Agreed where the incident is considered reportable under RIDDOR.	Essential	Hayden Mead	30/09/2023
8	**Audit and Inspection** As per the Audit and Inspection Procedure, an inventory of auditable areas and comprehensive audit and inspection schedule are yet to be agreed. Therefore, no regime of formal planned audits has taken place since WNC's inception. **Risk**	A risk-based inventory of auditable areas and a comprehensive audit and inspection schedule should be agreed and start to be delivered as soon as reasonably practicable. Once established monitoring of progress of audits and the implementation of	An audit and inspection approach will be designed based on risk over a 12 month period.	Essential	Hayden Mead	31/12/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	Without such controls, there is an increased risk poor decision-making (and in turn, a failure to maximise value for money), non-compliance with the requirements of the relevant legislation, and potential legal challenge, all of which could result in financial loss and reputational damage to the Council.	recommendations should be reported to the JHS&W Committee in accordance with procedure.				
9	**Reporting** The following issues have been noted: • Critical performance metrics are yet to be agreed. • Inconsistencies exist with regards to the format, content, frequency and provisions of directorate health and safety reports which are currently prepared by the HS&W team. • An annual health and safety report had not been completed at the time of reporting, in accordance with policy requirements. **Risk** Without such controls, there is an increased risk of errors and omissions, inconsistent working practice, inefficiencies in operations, and poor decision-making (and in turn, a failure to maximise value for money), all of	The relevant reporting issues identified during this audit should be addressed accordingly.	The establishment of critical metrics are currently being worked on and then regular reporting will take place. The annual report is currently being prepared for a future JHSW committee.	Important	Hayden Mead	31/12/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	which could result in financial loss and reputational damage to the Council.					
10	**Directorate HS&W Forums** There is no prescriptive reference to the four established forums within the policy, a procedure or on the intranet. With that there is no established purpose or terms of reference to direct the forum and ensure it effectively supports the JHS&W Committee and the health and safety management system. Furthermore, Appendix 2 to the policy - Responsibility, Accountability and Consultation Flow Chart - only refers to a "Directorate Health & Safety Group" which is not in existence. Of those forums that do meet it was observed that inconsistencies exist with regards to the format, content, frequency and provision of directorate health and safety reports which are currently prepared by the HS&W team. **Risk** This can lead to ineffective communication and feedback to effectively support the JHS&W Committee, thus potentially resulting in a breakdown in the health and	That terms of reference be established to guide the directorate HS&W forums, and their purpose and objectives be set out in the next revision of the policy, together with appropriate revision to Appendix 2.	There are some gaps in the terms of reference for DCFs, the HSW team are currently working with Executive Directors to review these. The H&S policy will be updated and amended as necessary following review.	Important	Hayden Mead	31/12/2023

Ref	Issue	Recommendation	Management Comments	Priority	Officer Responsible	Due Date
	safety management system, of which could result in financial loss and reputational damage to the Council.					

Appendix 1 – Glossary / Definitions

There are three elements to consider when determining an assurance opinion as set out below.

1 Control Environment / System Assurance

The adequacy of the control environment / system is perhaps the most important as this establishes the key controls and frequently systems 'police/ enforce' good control operated by individuals.

Assessed Level	Definitions
Substantial	There are minimal control weaknesses that present very low risk to the control environment.
Good	There are minor control weaknesses that present low risk to the control environment.
Satisfactory	Systems operate to a moderate level with some control weaknesses that present a medium risk to the control environment.
Limited	There are significant control weaknesses that present a high risk to the control environment.
No Assurance	There are fundamental control weaknesses that present an unacceptable level of risk to the control environment.

2 Compliance Assurance

Strong systems of control should enforce compliance whilst ensuring 'ease of use'. Strong systems can be abused / bypassed and therefore testing ascertains the extent to which the controls are being complied with in practice. Operational reality within testing accepts a level of variation from agreed controls where circumstances require.

Assessed Level	Definitions
Substantial	The control environment has substantially operated as intended with no notable errors detected.
Good	The control environment has largely operated as intended although some errors have been detected.
Satisfactory	The control environment has mainly operated as intended although errors have been detected that should have been prevented / mitigated.
Limited	The control environment has not operated as intended. Significant errors have been detected and/or compliance levels unacceptable.
No Assurance	The control environment has fundamentally broken down and is open to significant error or abuse. The system of control is essentially absent.

3 Organisational Impact

The overall organisational impact of the findings of the audit will be reported as major, moderate or minor. All reports with major organisational impact will be reported to ELT along with the relevant directorate's agreed action plan.

Organisational Impact of Findings	
Level	**Definitions**
Major	The weaknesses identified during the review have left the Council open to significant risk. If the risk materialises it would have a major impact upon the organisation as a whole.
Moderate	The weaknesses identified during the review have left the Council open to medium risk. If the risk materialises it would have a moderate impact upon the organisation as a whole.
Minor	The weaknesses identified during the review have left the Council open to low risk. This could have a minor impact on the organisation as a whole.

4 Findings prioritisation key

When assessing findings, reference is made to the Risk Management matrix which scores the impact and likelihood of identified risks arising from the control weakness found, as set out in the Management Action Plan.

For ease of reference, we have used a high/medium/low system to prioritise our recommendations, as follows:

Category	Definitions
Essential	Action is imperative to ensure that the objectives for the area under review are met.
Important	Requires actions to avoid exposure to significant risks in achieving objectives for the area.
Standard	Action recommended to enhance control or improve operational efficiency.

Distribution List

Full Report Issued for Action:	Stuart Lackenby – Executive Director - People (in the capacity as the Appointed Director and Chair of the Joint Health, Safety & Wellbeing Committee Sarah Reed - Executive Director - Corporate Services Alison Golding - Assistant Director - Human Resources Gill Kennedy - Human Resources Manager Hayden Mead - Health, Safety and Wellbeing Specialist
Full Report Issued for Information:	Martin Henry – Executive Director of Finance (Chief Finance Officer)

This audit and report have been prepared in line with the Internal Audit Manual and has been subject to appropriate review.

Head of Audit & Risk Management Approval:	Jen Morris
Quality Reviewed:	Scott Peasland – Audit Manager Heather Fraser – Principal Auditor
Lead Auditor:	Steve Gresham – Senior Auditor

Corporate Health & Safety - Management Action Plan

Ref	Due Date	owner	Audit Recommendation	HR comment	Activity update	Interdependancy?	What was said at ELT 08/01	Deadline for HSW
1	31/12/2023	HM	A corporate health and safety plan should be developed accordingly, after which it should be agreed by the JHS&W Committee and made available to employees via the intranet	WNC comprises of a diverse number of services with many different Health & Safety requirements therefore a single corporate plan would not be sufficient. Activity has commenced on an overall H, S &W strategy (as written in the HSW Policy (item 3 policy statement) to provide direction over medium to long term. Internal Audit comment: The management response is accepted but note this will require amendment to the policy.	16/08/2023 Hayden has a skeleton ideas document. Currently shared with GK AG and SR , HM to resend link GK and AG to comment and HM to discuss with SR at meeting next weds. 15/09/23 - Meeting been set up with Sarah Reed etc to discuss 11/10/23 - Meeting scheduled for 16/10 08/11/23 - GK to review 06/12/23 - Strategy group names in draft, GK to check with RW for providor, then share list and draft invite email with SL. Invite can be sent from PMO. 31/01/2024 HSW meeting with SL on 6/02 to progress. **28/02/2024 Strategy just going through strategy group 7th March**		H&S strategy in solid daft form. Governance Group being arranged via PMO who will then input into strategy to ensure its workable for whole org. Once strategy is in place we will work with services on their localised plans.	End of April: Governance group has inputted Post April: consult with unions and commenc work on localised plans.
2	31/12/2023	HM	A comprehensive action plan should exist to confirm when the relevant outstanding procedures (as listed within the policy) will be developed and / or made available to employees via the intranet. The action plan should be subject to regular review to provide assurance that key tasks requiring attention are actioned by the relevant named officers within the agreed timescales. In addition, a version control sheet should be included with all procedures to provide an audit trail of all revisions and approvals.	The current HS&W policy put in place at vesting day will firstly be reviewed to ensure the procedures listed within it are still relevant for WNC given our workforce mix. Following this review an action plan with appropriate / agreed timescales will be developed to ensure WNC has the relevant procedures, guidance and reporting mechanisms in place, and these will be published via the intranet (with version controls).	16/08/2023 Re-write and then republish the policy with the procedures stripped out but can't happen until acton 12 re dcf review is complete 15/09/23 - need to ensure we strip procedures right back when we review it all, plus there is inconsistency in terminology 11/10/23 - HSW Steering group to be established, PMO to assist 08/11/23 - HSW membership being looked at meeting on 9/11 06/12/2023 - HSW policy is currently under review, this is clear on the intranet pages. The references to legacy procedures referenced in the 'old' policy have been removed, and the intranet site updated directing colleagues to either the team or relevant HSE guidance and documentation. Once the HSW policy review is complete, any procedures that do not exist currently for WNC will be created. IF THEY ARE NEEDED 31/01/2024 Shortened policy is being drafted currently **8/02/2024 - Aiming to issue statement of intent within next two weeks.**	yes, action 10	Aim to complete shortened h&s policy by end of janauary. We will only create procedures where they are needed and relevant. Once policy agreed we will publish via the intranet with version control. In the meantime we have published any 'missing' procedures.	Jan to complete policy, then consult with unions
3	30/09/2023	HM	Management should be reminded that additional health and safety elements should be included within the relevant job descriptions (for senior and specialist job roles) in accordance with agreed policy.	There is an overarching legal duty around H&S. Whilst including the information in a job description serves as a helpful reminder to the postholder, it is not a control in itself as it is the experience, knowledge, training and application (assessment of competence) that is critical. Being in the job description or not will also not absolve the postholder of the responsibility in law. However, HR will provide a recommendation to ELT regarding a statement for EDs Directors and ADs which they can insert into the job descriptions.	16/08/2023 - HM /GK will pull together short statements for inclusion in relevant job descriptions AG will take item to elt workforce session 18th Sept then we will notify those impacted about why the statement has been included/will be included. 11/10/23 - Wording under review as ELT wanted revisions. 8/11/23 - Wording reviewed - ELT on 20/11 06/12/2023 - currently with AG 31/01/2024 AG has asked for updated JDs to be returned by end of Jan and will review progress next week **28/02/2024 - 80% are back, final ones are being chased by AG and exec support**		AD will ensure locally owned role profiles for Eds and ADs are updated.	Feb
4	31/10/2023	GK and CY	Managers should be reminded of their responsibility for ensuring that all employees have completed the relevant mandatory health and safety training via the Council's LMS within the first two weeks of their induction process. The HS&W team should determine whether the relevant reports are readily available to enable monitoring to take place, with issues of non-compliance escalated accordingly. Any issues with reporting functionality should be discussed / resolved accordingly with the relevant provider.	HR will issue a reminder to all managers regarding completion of all mandatory training in line with the Council's induction policy. It should be noted that the H&S elements of mandatory training are currently under review as per the recommendations arising from the review of all mandatory training that took place with ELT in 2022, therefore the extent of the mandatory H & S training may be reduced as it is currently duplicated. The L & D function returned to WNC on 1st April 2023 and the learning management system is now WNC owned, meaning that a WNC reporting strategy can be put in place once the new system is procured (Aug 2023).	16/08/2023 - GK sent out reminder via managers briefing on 14/08/2023 Seperately a paper is going to ELT in sept to update on mandatory training and also HSW looking at madatory training going forward. Action for next time to pick up with Hannah and Clare re reporting going forwards. 15/09/2023 - Hannah Oswin now attending our HSW team meeting (once a month or as required bearing in mind whatever happening) reporting being looked at. Need to look at courses on ilearn. 11/10/23 - The three year annual refresh of mandatory training is due in 2024, Hannah Oswin is aware and updating iLearn to ensure refreshes every three years for colleagues. 08/11/23 - IOSH Managing Safely dates scheduled every month for 2024 from Feb complete plus regular reminder to be put on HR comms forward plan **29/02/2024 Remains open as action re reporting functionality of ilearn.**		Reminder issued via managers briefing on 14/08/2023 with request to internal comms team to repeat regularly. The three-year annual refresh of mandatory training is first due 2024, once new LMS launched (Jan 2024), reporting capability will be in place and updated so it can schedule reminders. Face to Face Risk Assessment Workshops delivery commenced early 2023 with ongoing program in place. 3 day IOSH Managing Safely training dates have been scheduled monthly for 2024.	
5	31/10/2023	HM	Organisation-wide compliance with the risk assessment procedure should be subject to an early health and safety audit with the relevant findings presented to the JHS&W Committee for their consideration.	H&S will do an audit and report to the JHSW Committee for their consideration.	16/08/2023 HM to device an audit and sampling approach. Could look at doing this in Oct, could target lone working and DSE Assessment.. so looking at what is a risk to people. 15/09/23 - HM will send something out on return from leave to pre warn people it will be going out in Oct. focus on mix of new starters and longer term 11/10/23 - Preparation for audit is in process, email from Sarah R has gone to AD's,HoS. 23/10/23 - Notification of audit and requirements sent to AD's for communication to colleagues. 08/11/23 - Audit is in progress, interviews scheduled during Nov. 06/12/2023 - Findings being collated, need to book onto next jhsw. 13/11/23 - 30/11/23 Two procedures audited (Lone Working & Display Screen Equipment) total of 57 contacted scheduled for one hour meeting. ?? carried out in person, various locations. ?? on Teams. ?? Failed to attend 10, despite three plus attemps to contact (email, phone etc.) and escalation to AD's 22/01/24 - 31/1/24 - 7hrs moderation meetings held GK/HM/KB and lead HSW advisor undertaking audit of various areas. Next step to write report and get to JHSWC on 27th Feb **28/02/2024 - HM still writing up report, not yet ready to go. HM to advise AG when its ready and AG will take to ELT.**		In Oct/Nov 2023 an audit was conducted across services on Risk Assessments. Outcome will go to ELT in Feb and then onto JHSWC.	27th Feb JHSWC
6	31/03/2024	HM	Appropriate documented procedures and record-keeping arrangements should exist to provide assurance that the relevant actions within the	The current (inherited) IT system is not fit for purpose, meaning it is not possible to efficiently manage and monitor actions on the existing frontline system, hence the service is	Not started - we are choosing to focus on a new system. 15/09/23 - still only reliant on what is in system in first place but some amendments done so we will be notified.		Some automation has been put in place with current process to deliver some limited improvements. Better reporting going into JHSWC. It looks like overall numbers of	

			accident / incident log have been followed up / undertaken accordingly.	currently exploring funding options for a replacement and funding means.The team will explore further manual interventions to strengthen record keeping arrangements outside of the system, but this activity will need to be within the existing capacity constraints of the service.	08/11/23 - Application for new system via DTI in process, however indication that this will not be approved currently, when formal response received need to consider the options. 06/12/203 - request for budget for new system part of 2024/25 growth proposals, not all of which can be agreed. Team are looking initially at a bolt on to the existing property management system as this may provide a lower cost solution. 31/01/2024 - **financing for new system was not included in the 2024/25 budget build,** this has been raised with Finance at Jan budget meeting. Concerto bolt on will be in region of £10-15k, AG to ask finance about money for this. Jason is producing an high level options appraisal on spending on concerto. **28/02/2024 - pursuing the concerto option (albeit no budget available as it stands).** **HSW need to visit concerto Leicester to review , currently with Jason to progress**		incident has reduced over the year, however this is because a lot of duplicate, incorrectly classified data has been identified. Detailed breakdown of reporting is being prepared and will go to ELT. System issues: Team are currently exploring whether there is a cheaper 'bolt on' module to the new property system that may be a better option than the current state. The new system exploration will continue into 2024.	
7 -	30/09/2023	HM	RIDDOR incidents should be reported to the Health and Safety Executive (HSE) within the agreed timescales (10 days of incident or 15 days for accidents resulting in the over-seven-day incapacitation of a worker). In addition, matters relating to RIDDOR (incidents / reporting timescales etc.) should be reported to the JHS&W Committee for their consideration.	Agreed where the incident is considered reportable under RIDDOR.	16/08/2023 - Riddors are on the report which goes to JHSWC . HM to devise a communication for both schools and corporate about what is RIDDOR and reporting requirements. Talk to comms about H and S forward plan and include this. Secondly ensure procedures in hsw team re weekly meeting and reporting captures these. 07/09/2023 - RIDDORS now coded into the HSW spreadsheet, if time off work has been indicated a notification will be sent to the team inbox, to DT and KB so it can be followed up. However it is only as good as the ability of the manager to report in first place and provide the right information. 11/10/2023 - Reporting of significant incidents advice note has gone to Sarah Reed. 08/11/23 - on hold pending decision on management system. 24/10/23 - First significant incident distributed to the ELT by Leanne Wightman 31/01/2024 - system now in place to notify key colleagues of incidents, but information can only be impacted upon based on information inputted in first place so remains not foolproof. **Complete and closed**		RIDDORS are listed as an item on the report to JHSWC and a standing item on HSW team weekly agenda. A communication went to schools and corporate to remind managers about what a RIDDOR is and reporting requirements. RIDDORS coded into the HSW spreadsheet, meaning that if time off work has been indicated by the manager, a notification will go to the HSW inbox for the team to follow up. (noting this is only as good as the ability of the manager to i) report and ii) provide the right information.) A 'Reporting of significant incident advice note' is now in place with items being sent directly to ELT as they arise for their consideration and immediate action.	CLOSED
8	31/12/2023	HM	A risk-based inventory of auditable areas and a comprehensive audit and inspection schedule should be agreed and start to be delivered as soon as reasonably practicable.Once established monitoring of progress of audits and the implementation of recommendations should be reported to the JHS&W Committee in accordance with	An audit and inspection approach will be designed based on risk over a 12 month period.	Not started - we will look at this but firstly the procedures and guidance need to be in place to then audit approach and HM will review in due course 31/01/2024 - not started, as per above focussing on other actions first.	yes action 2	Not yet commenced as MAP 1 & 2 need to be in place first.	
9 - CLOSED	31/12/2023	HM	The relevant reporting issues identified during this audit should be addressed accordingly.	The establishment of critical metrics are currently being worked on and then regular reporting will take place.The annual report is currently being prepared for a future JHSW committee.	16/08/2023 - annual report being pulled together. AG going to elt on 21/08 to discuss what elt want to see on a quarterly basis and includes a H and S and HM will consider with team over next few months the desired reporting state. Then as part of system procurement we have an idea of what we need it to do and can then start to report once you system in place. 15/09/23 - HM starting to look at what data can be pulled in from where to compile reporting, and link to data from other reports, need to be mindful potential new system therefore metrics/reporting may then change again. 08/11/23 - Arrangements for H&S Forums under consideration within governance for HSW reporting requirements to be identified. 06/12/2023 - quality reporting suite provided to last jhswc, these will be enhanced once a better system is in place. Discussion with John D over feeding relevant data into the quarterly corporate dashboards, and review of what data can go to directorates on a monthly basis 03/01/2023 - Analysis of previously provided information and data shows significant inconsistencies in data previously supplied as part of reports (included NCT incorrectly reported incidents, duplication i.e multiple reports of the same incident.) Template for annual report. Comparative Analysis of 2021 - 31/01/2024 - **Closed** - Metrics will be going to ELT quarterly (Jo Bonham report) and metrics established for JHSWC and consultation forums. Closed.	yes action 6	End of year annual report to be produced. Quality suite of data provided to last JHSWC (28th November 2023). Discussion underway with HR data lead to feed key metrics into the quarterly corporate dashboards and reviewing what is sent to DMTs on monthly basis	CLOSED
10	31/12/2023	HM	That terms of reference be established to guide the directorate HS&W forums, and their purpose and objectives be set out in the next revision of the policy, together with appropriate revision to Appendix 2.	There are some gaps in the terms of reference for DCFs, the HSW team are currently working with Executive Directors to review these. The H&S policy will be updated and amended as necessary following review.	16/08/2023 - HM currently pulling together report for JHSWC. The Committee need to decide the terms of reference. HM will produce a couple of options around draft TOR recommendations and this can go to SL, ST and SR in advance of next JHSWC for review. Will also include it as agenda item on committee to discuss. Then in terms of feedback set a hard deadline for mid Sept to finalise. Once these are nailed down the actoin on H&S policy can be completed. 15/09/23 - Draft TOR looked at with SR, HM to get draft TOR over to TUs for comment then we can finalise in early oct following HM return from leave. 11/10/23 - Discussion had with Andy Langford re draft TOR, require minor amendments before taking to JHSWC. 08/11/23 - Under review as part of governance arrangements for HSW. 06/12/2023 - These need to go to JHSWC for ratification, date to be arranged (proposed 27/2/24) 09/01/2024 - Meeting UNISON Offices to discuss ToR 11/01/2024 - C&O 2nd standalone HSW Forum held. Chaired by Louise Seymour 15/01/2024 - Meeting GMB to discuss ToR (Cancelled by TU) 29/01/2024 - Meeting GMB to discuss ToR, currently with GMB to comment and this will then go to JHSWC on 27/02	yes action 2	Service actions post audit: Draft ToR created and discussed with TUs. These will now go to next JHSWC (20th February) for ratification.	

					28/02/2024 - TOR went to JHSWC on 27/02. HM/GK to draft email for SL to send to ELT giving them the TOR for information only and ensuring they send subs going forwards for JHSWC - **Can be closed at next meeting.**			

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West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL
AUDIT & GOVERNANCE COMMITTEE

27 MARCH 2024

Report Title	**Public Sector Internal Audit Standards – Self Assessment**
Report Author	**Adrian Ward – Head of Audit & Risk Management** **adrian.ward@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
S151 Officer / Director	Martin Henry	15/03/2024

List of Appendices

Appendix A – Quality Assurance and Improvement Programme
Appendix B – Internal Audit Charter

1. Purpose of Report

1.1. To allow the Committee to consider the results of a self-assessment which has been undertaken against the requirements of the Public Sector Internal Audit Standards (PSIAS), to review the resulting Quality Assurance and Improvement Programme for the internal audit service, and to approve an updated Internal Audit Charter.

2. Executive Summary

2.1 The objectives of the Public Sector Internal Audit Standards (PSIAS) are to:

- define the nature of internal auditing within the UK public sector
- set basic principles for carrying out internal audit in the UK public sector

- establish a framework for providing internal audit services, which add value to the organisation, leading to improved organisational processes and operations, and
- establish the basis for the evaluation of internal audit performance and to drive improvement planning.

2.2 The Local Government Application Note (LGAN) has been developed by CIPFA to provide specific further guidance on local government internal audit practices in relation to PSIAS.

3. Recommendations

3.1 It is recommended that the Audit & Governance Committee should:

a) Note the summary of the results of the internal self-assessment undertaken by the Head of Audit & Risk Management against the PSIAS and endorse the Quality Assessment and Improvement Programme for the internal audit service that has been produced to address the issues noted within the self-assessment (Appendix A);
b) Approve the updated Internal Audit Charter (Appendix B);
c) Approve the proposal for the required external independent assessment against PSIAS to be undertaken during the 2025/26 financial year.

4. Reason for Recommendations

4.1 To ensure compliance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.

5. Report Background

5.1 The PSIAS (the 'Standards') set out the requirements which the Council's internal audit team must comply with in order to deliver a professional, independent and objective service.

5.2 Under the Standards, the Head of Audit & Risk Management (as the chief audit executive) must develop and maintain a quality assurance and improvement programme (QAIP) that covers all aspects of internal audit activity.

5.3 The QAIP must include ongoing monitoring of the performance of the internal audit service, and periodic internal assessments against the Standards.

5.4 Additionally, an external assessment must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the Council.

5.5 The results of the assessments, and the QAIP, must be reported to the Audit & Governance Committee.

6. Issues and Choices

6.1 The Head of Audit & Risk Management has undertaken a self-assessment against the requirements, and has identified a relatively small number of areas of partial or non-compliances.

6.2 For all other areas, the self assessment determined that the internal audit service is complying with the requirements set out in the Standards.

6.2 The improvement plan (attached as Appendix A) has been developed to address the areas of partial or non-compliance, and sets out responsibilities and proposed timescales for improvement actions.

6.3 Progress against the improvement plan will be reported regularly to the Audit & Governance Committee.

6.3 One of the improvement actions was to produce an updated Internal Audit Charter, and this is attached (Appendix B) for the Committee to consider and approve.

7. Implications (including financial implications)

7.1 **Resources and Financial**

7.1.1 The external PSIAS assessment, proposed to be undertaken in 2025/26, will have a cost attached to it which will need to be factored into future budget setting processes.

7.2 **Legal**

7.2.1 There are no legal implications arising from the proposals.

7.3 **Risk**

7.3.1 There are no significant risks arising from the proposed recommendations in this report.

7.4 **Consultation**

7.4.1 None required.

7.5 **Climate Impact**

7.5.1 None identified.

7.6 **Community Impact**

7.6.1 None identified.

7.7 **Communications**

7.7.1 None required.

8 Background Papers

Public Sector Internal Audit Standards PSAIS_1_April_2017.pdf (publishing.service.gov.uk)

APPENDIX A

INTERNAL AUDIT QUALITY ASSURANCE & IMPROVEMENT PLAN (MARCH 2024)

PSIAS REF.	STANDARD	CURRENT COMPLIANCE	ACTION	RESPONSIBILITY	TARGET DATE
3 5.4	Demonstrating quality and continuous improvement. Quality Assurance & Improvement Programme	Partial	This is the first internal assessment against PSIAS that has been undertaken, and this QAIP has been developed following the assessment to work towards full conformity.	Head of Audit & Risk Management	March'24
3	Risk-based assurance, based on an adequate risk assessment	Partial	Develop an 'audit universe' to ensure all auditable areas are identified and risk-assessed to inform future audit planning.	Head of Audit & Risk Management	March'24
5.1	Internal Audit Charter which: ➢ Defines the purpose, authority and responsibility of internal audit ➢ Defines the terms 'board' and 'senior management' ➢ Defines the role of internal audit in any fraud related work ➢ Anti-fraud and corruption policies require CAE to be notified ➢ Defines the nature of any consulting services	 Partial Partial Non-compliant Non-compliant Non-compliant	Review and update the current internal audit charter to ensure full compliance with PSIAS.	Head of Audit & Risk Management	March'24
5.2	CAE's roles and responsibilities outside internal audit need to be defined in the Charter and reviewed by the board.	Partial	Include the Head of Audit & Risk Management's responsibilities for risk management and counter-fraud in the charter for review by the Audit & Governance Committee	Head of Audit & Risk Management	March'24

PSIAS REF.	STANDARD	CURRENT COMPLIANCE	ACTION	RESPONSIBILITY	TARGET DATE
5.3	Knowledge of computer assisted audit techniques (CAATs) and data analysis techniques.	Partial	Investigate use of CAATs to determine whether they would be of any benefit in undertaking audit reviews.	Head of Audit & Risk Management and Audit Manager	Sept'24
5.4	Ongoing performance management: ➢ Comprehensive targets ➢ Targets measured, monitored and reported ➢ Stakeholder feedback	Non-compliant	Develop a comprehensive set of performance targets, including stakeholder feedback, and report these regularly to the Audit & Governance Committee	Head of Audit & Risk Management and Audit Manager	June'24
5.4	External assessment of internal audit's compliance with PSIAS		Intention is to commission an external inspection in 2025/26.		
6.1 6.2	Risk-based audit plan: Consideration of using specialist IT / procurement auditors Assess the Council's information technology governance arrangements	Partial Partial	Consideration to be given to resourcing external specialist expertise to undertake IT audit work for future audit plans.	Head of Audit & Risk Management	June'24
6.1 6.4	Policies and procedures (such as an Audit Manual) to guide staff in performing their duties in a manner that conforms to PSIAS Retention requirements for engagement records	Partial Partial	Develop an Audit Manual to document procedures and provide guidance to audit staff in performing their duties, which should also include retention requirements for audit engagement records.	Head of Audit & Risk Management and Audit Manager	Sept'24
6.5 6.5	Annual internal audit opinion report has regard to PSIAS conformance Annual report includes: ➢ Work carried out vs work planned ➢ Statement on conformance with PSIAS ➢ Results of the QAIP	Partial Partial	Future annual internal audit opinion reports should have regards to all relevant requirements.	Head of Audit & Risk Management	June'24

PSIAS REF.	STANDARD	CURRENT COMPLIANCE	ACTION	RESPONSIBILITY	TARGET DATE
	➢ Progress against QAIP improvement plan ➢ Summary of performance against performance measures and targets				

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West Northamptonshire Council

Internal Audit Charter

Appendix B

Effective from 1st April 2024

Document Version Control

Author (Post holder title): Head of Audit & Risk Management
Type of document: Charter
Version Number: 1.0
Document File Name: Internal Audit Charter (2024)
Issue date: March 2024
Approval date and by who (CMT / committee): Audit & Governance Committee TBC
Document held by (name/section): Adrian Ward – Audit & Risk Management
For internal publication only or external also?: Internal
Document stored on Council website or Intranet?: Intranet
Next review date: March 2025

Change History

Issue	Date	Comments
1.0	March 2024	Substantial re-drafting from previous Charter

NB: Draft versions 0.1 - final published versions 1.0

Consultees

Internal	External
Executive Leadership Team	

Distribution List

Internal	External
Internal Audit Team	
Audit & Governance Committee	
Executive Leadership Team	

Contents

1.0 Introduction

1.1 This Internal Audit Charter is a formal document that defines Internal Audit's mission, authority and responsibility. The Charter establishes Internal Audit's position within the Council, including the nature of the Head of Audit & Risk Management's[1] functional reporting relationship with the Audit & Governance Committee[2]; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of Internal Audit's activities. It provides a framework for the conduct of the service and is approved by the Executive Leadership Team[3] and the Audit & Governance Committee.

2.0 Mandate for Internal Audit

2.1 The requirement for an Internal Audit function derives from local government legislation, including section 151 of the Local Government Act 1972 which requires that all local authorities must '*make arrangements for the proper administration of their financial affairs*'.

2.2 More specific requirements are set out in the Accounts and Audit Regulations 2015 which require the Council to '*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'.* This is reinforced in the Council's Financial Procedure Rules.

2.3 For the Council as a local authority the relevant standards are the Public Sector Internal Audit Standards (PSIAS) and the CIPFA Local Government Application Note (LGAN).

[1] The Head of Audit & Risk Management fulfils the role of the 'Chief Audit Executive' set out in PSIAS.
[2] The Audit & Governance Committee fulfils the role of the 'Board' set out in PSIAS.
[3] The Executive Leadership Team fulfils the role of 'Senior Management' set out in PSIAS.

3.0 Definition and Mission of Internal Audit

3.1 The definition adopted by the Council is that provided in the Public Sector Internal Audit Standards (PSIAS):

'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 bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.'

3.2 Internal Audit is therefore an assurance function which primarily provides an independent and objective opinion to the Council on its governance arrangements and internal controls.

3.3 Internal Audit does this by conducting an independent appraisal of all the Council's activities, financial and otherwise. It provides a service to the whole of the Council and to all levels of management.

3.4 The Council has also adopted the Mission for Internal Audit set out in the PSIAS, which is '*to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.'* The policies and processes established by Internal Audit will work towards the delivery of this Mission. These include complying with the Core Principals for the Professional Practice of Internal Audit which are also set out in the PSIAS.

4.0 Objectives of Internal Audit

4.1 The objective of Internal Audit is to give assurance to the Council on the adequacy of its governance and internal control arrangements. The key elements of this are:

- to provide advice and support to ensure an effective control environment is maintained including completeness, reliability and integrity of financial, performance, risk and other management information and the methods for safeguarding assets;

- to contribute to the achievement of corporate objectives by recommending improvements in control and performance of the systems established;

- to ensure compliance with corporate and departmental policies and procedures and legislative requirements; and

- to provide advice and guidance to ensure management have developed effective arrangements to promote appropriate ethics and values within the Council and arrangements to prevent and detect fraud and corruption, this will include input into the key policies such as the codes of conduct, financial procedure rules and counter fraud and corruption frameworks.

5.0 Scope and Authority of Internal Audit

5.1 All of the Council's activities, regardless of funding source, may be subject to review by Internal Audit. Internal Audit work will cover all of the operational and management controls within the Council. This does not imply that all systems will be subjected to review in any given year, but that all systems will be included in the audit planning process and hence be considered for review following an assessment of risk.

5.2 The scope of audit work extends to services provided through partnership arrangements (including shared services with other local authorities). The Head of Audit & Risk Management will decide, in consultation with all parties, whether the Council's Internal Audit service will conduct the work to derive the required assurance themselves, or rely on assurance provided by other auditors. Where relevant, appropriate access rights will be negotiated and included in contracts and partnership agreements to ensure that Internal Audit can obtain access to the personnel and records within partner organisations to obtain the necessary assurances.

5.3 Internal Audit will consider the adequacy of the controls established by management to secure propriety, economy, efficiency and effectiveness in all areas.

5.4 It is not the remit of Internal Audit to question the appropriateness of policy decisions. However, Internal Audit is required to examine the management arrangements of the Council by which such decisions are made, monitored and reviewed, how policies are applied by the Council and also compliance with agreed policies.

5.5 Internal Audit may also conduct any special reviews and provide independent and objective services, such as consultancy and counter fraud related work as requested by management. There will always be due consideration in planning this work to ensure that Internal Audit maintains its objectivity and independence. The impact of taking on such work in addition to the agreed audit plan will be taken into account and where necessary will be reported to the Executive Director, Finance (s151 Officer) and the Audit & Governance Committee for approval.

5.6 Internal Audit does not have responsibility for the prevention and detection of fraud or corruption. It is the responsibility of management to ensure appropriate procedures are put in place to prevent and detect fraud. Internal Auditors will, however, be alert in all their work to risks and exposures that could allow fraud or corruption to occur and to any indications that fraud or corruption may have been occurring.

5.7 In line with the Council's Counter Fraud and Corruption Policy, the Head of Audit & Risk Management should be notified of all suspected or detected fraud, corruption or impropriety within the Council. Where relevant the Counter Fraud team (also line managed by the Head of Audit & Risk Management) will advise and assist managers in the investigation of any suspected fraud or corruption.

6.0 Responsibility of Internal Audit

6.1 The Council has a responsibility for conducting, at least annually, a review of the effectiveness of the governance arrangements and producing an Annual Governance Statement (AGS). The review of the effectiveness of the governance arrangements is informed by, amongst other relevant sources of assurance:

- the work of Internal Audit;
- information from managers within the Council who have responsibility for the development and maintenance of governance arrangements; and
- findings reported by external auditors and other review agencies and inspectorates.

6.2 To assist with this review the Head of Audit & Risk Management is responsible for producing an Annual Internal Audit report summarising the areas that have been subject to Internal Audit review in the year. This annual report will include an opinion, based on the areas examined, on whether the Council's governance arrangements, including those for economy, efficiency and effectiveness, are adequate and have been properly applied in the year.

6.3 In order to provide the required opinion Internal Audit will undertake a programme of work on the advice of the Head of Audit & Risk Management. The programme of work will aim to achieve the following objectives:

- to appraise the soundness, adequacy, and application of the whole internal control system;
- to ascertain the extent to which the systems of internal control ensure compliance with current policies and procedures;
- to ascertain the extent to which assets and interests entrusted to or funded by the Council are properly controlled and safeguarded from losses arising from fraud, irregularity or corruption;
- to ascertain that accounting and other information is reliable as a basis for the production of accounts, and financial, statistical and other returns;
- to ascertain the integrity and reliability of financial and other information provided to management, including that used in the decision making processes;
- to ascertain that systems of control are laid down and operate to promote the economic and efficient use of resources;
- to investigate, where appropriate, frauds or significant breaches of the internal control system.

6.4 Management, and not Internal Audit, have ultimate responsibility for ensuring that internal controls throughout the Council are adequate and effective. This responsibility includes the duty to continuously review internal controls and ensure that they remain suitable in design and effective in operation. The existence of Internal Audit does not diminish the responsibility of management to establish and maintain systems of internal control to ensure that activities are conducted in a secure, efficient and effective manner.

6.5 Responsibility for the response to advice and recommendations of Internal Audit lies with management, who either accept and implement the advice or formally reject it accepting the risks involved in doing so. Internal Audit advice and recommendations are given without prejudice to the right of Internal Audit to review and offer an opinion on the relevant policies, procedures and operations at a later stage.

7.0 Statutory Requirement and Standards of Approach

7.1 Internal Audit work will be performed with due professional care and in accordance with the Accounts and Audit Regulations 2015 (as amended), the Public Sector Internal Audit Standards (PSIAS), CIPFA's Local Government Application Note (LGAN) and any subsequent guidance which updates or replaces these.

7.2 Internal Audit will adopt a risk-based approach to auditing in order to meet its primary objective of reviewing the governance arrangements of the Council. In undertaking its work Internal Audit will:

- identify all elements of control systems on which it is proposed to place reliance;

- evaluate those systems, identify inappropriate or inadequate controls and recommend improvement in procedures or practices where deficiencies or scope for improvement are found;

- provide advice on the management of risk, predominantly but not exclusively surrounding the design, implementation and operation of systems of internal control;

- produce clear, concise reports that provide management with an opinion on the soundness, adequacy and application of internal controls;

- ascertain that those systems of internal control are designed and operate to achieve the economic, efficient, and effective use of resources;

- draw attention to any apparently uneconomical or unsatisfactory results flowing from decisions, practices or policies;

- contribute to the general management and conduct of business through the provision of expertise on appropriate working-groups and participation in ad-hoc exercises, subject to adequate resources being available in the audit plan; and

- liaise with external auditors.

7.3 All Internal Auditors working in local authorities are required to comply with the Nolan Principles of Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership and the Code of Ethics contained in the PSIAS, in addition to any requirements placed on them by the Council or any other professional body that they are members of. The PSIAS Code of Ethics also covers 4 principles; Integrity, Objectivity, Confidentiality and Competency which Internal Auditors must also comply with. Compliance with the Code of Ethics will be monitored as set out in the Quality Assurance and Improvement Plan (QAIP).

7.4 Internal Audit will also work in accordance with the Core Principles for the Professional Practice of Internal Audit as set out in the PSIAS, which are as follow:

- demonstrates integrity;

- demonstrates competence and due professional care;

- is objective and free from undue influence (independent);

- aligns with the strategies, objectives, and risks of the organisation;

- is appropriately positioned and adequately resourced;

- demonstrates quality and continuous improvement;

- communicates effectively;

- provides risk-based assurance;

- is insightful, proactive, and future-focused;

- promotes organisational improvement.

8.0 Independence of Internal Audit

8.1 Internal Audit will remain independent of the systems and procedures which are subject to its review. Internal Audit will also remain free from interference by any element of the Council, and the scope of its work will not be restricted in any way.

8.2 To enable the auditors to perform their duties in a manner which facilitates impartial and effective professional judgements and recommendations Internal Audit staff will not be responsible for activities outside of Internal Audit's main responsibilities. All audit staff will act with due professional care ensuring that they are fair and objective, free from any conflicts of interest and abide by professional standards and guidelines.

8.3 In seeking to provide an independent and objective opinion it is accepted that, being located within the organisation, Internal Audit cannot be wholly independent of all management. Internal Audit's independence will therefore be achieved through its organisational status and from the fact that the Head of Audit & Risk Management has alternative reporting lines which can be used if necessary to report information and concerns.

8.4 The Head of Audit & Risk Management reports to the Executive Director, Finance (s151 officer) but has the right to report directly to the Chief Executive; Monitoring Officer; Chair of the Audit & Governance Committee or external auditor should it be deemed necessary.

8.5 The Head of Audit & Risk Management has operational line management responsibility for the Risk Management and Internal Control team, and for the Counter Fraud team. If these areas are to be audited the Head of Audit & Risk Management will act as the 'client' and the Audit Manager will lead the audit reporting directly to the Executive Director, Finance. Wherever possible an external contractor will be asked to carry out any such audits to bring further independence.

8.6 The Head of Audit & Risk Management will make the Audit & Governance Committee aware if the independence of Internal Audit is impaired or appears to be impaired. The nature of such a disclosure will depend upon the nature of the impairment.

8.7 Internal Audit may at times be consulted during system, policy or procedure development. This is a good practice as it enables comments to be made on potential control weaknesses and tries to ensure that systems, policies or procedures are adequate prior to be being introduced. However, this does not preclude Internal Audit from reviewing and making comments for improvements during routine audits or other reviews where they were consulted during the system, policy or procedure development stage.

8.8 Internal Audit determines its work priorities in consultation with the Executive Leadership Team, the s151 Officer and the Audit & Governance Committee.

8.9 The Head of Audit & Risk Management will report to the Audit & Governance Committee in relation to the delivery of the Internal Audit Plan, the Annual Internal Audit Annual Report and periodic updates regarding Internal Audit work.

8.10 The Head of Audit & Risk Management is responsible for the content of all written reports produced by Internal Audit, and has the right to report in his or her own name and to offer an audit opinion without 'fear or favour' to all officers and members, and in particular to those charged with governance at the Council.

9.0 Authority and Rights of Access

9.1 In order to perform their duties Internal Audit has the authority, as set out in the Council's Financial Procedure Rules, to:

- enter council premises or land at any time, subject to any statutory or contractual restrictions that may apply, e.g. health and safety;
- access all records, documents, correspondence, information and data relating to all areas of the Council regardless of how the information is held and to remove any such records as is necessary for the purposes of their work (including that of the Council's agents and contractors);
- require and receive such explanations as are necessary concerning any matter under examination;
- require any employee or agent of the Council to produce cash, stores or any other Council property under their control;
- have direct access and the right of report to the Chief Executive, Chief Officers, Heads of Service, the Monitoring Officer, the Council's external auditors, the Cabinet, the Leader, the Cabinet member with responsibility for Audit and the Chair of the Audit Committee.

Those powers Are supported by the Accounts and Audit Regulations 2015.

9.2 Where necessary such rights of access may be called upon and should be granted to Internal Audit on demand, and not subject to prior notice or approval.

9.3 All employees are required to assist Internal Audit in fulfilling its roles and responsibilities.

9.4 Internal Audit will comply with any requests from external auditors for access to any information, files or working papers obtained or prepared during the audit work that they need in order to discharge their responsibilities.

10.0 Objectivity and Confidentiality

10.1 Internal Auditors must demonstrate the highest level of professional objectivity in gathering, evaluating and communicating information about the function or process being examined. They must make a balanced assessment of all relevant circumstances and not be unduly influenced by their own interests or by others in forming judgements.

10.2 All records, documentation and information accessed in the course of undertaking Internal Audit activities shall be used solely for that purpose. The Head of Audit & Risk Management and individual internal auditors (including contractors and external providers performing work on behalf of Internal Audit) are responsible and accountable for maintaining the confidentiality of the information they receive during the course of their work.

10.3 All Internal Audit reports are confidential and written for management, however they may be requested by the public under freedom of information legislation. The Head of Audit & Risk Management must be consulted before making any Internal Audit report available under the Freedom of Information Act and, where necessary and, in compliance with the relevant exemptions from public disclosure, elements of a report may be redacted.

10.4 The Head of Audit & Risk Management should also be consulted before any Internal Audit report, or extracts from it, are included in a public committee report or released to any other party and, subject to applicable exemptions, redactions may be applied where required.

11.0 Internal Audit Resources

11.1 The Council has a statutory duty to provide sufficient resources to allow an adequate and effective Internal Audit service to be provided. Where it is felt that the resources are inadequate to meet the objectives of Internal Audit, the Head of Audit & Risk Management will formally report this to the s151 Officer, Chief Executive and the Audit & Governance Committee].

11.2 The Head of Audit & Risk Management will hold a relevant professional qualification (CCAB, CMIIA or equivalent) and will be suitably experienced.

11.3 The Head of Audit & Risk Management is responsible for ensuring that internal auditors receive appropriate training and experience to fulfil their duties and that levels of competence are maintained via the use of continual professional development.

11.4 Where necessary access to appropriate specialists from other departments or external sources should be made available to Internal Audit to assist in any audit or investigation requiring detailed specialist knowledge.

12.0 Internal Audit Management

12.1 The Head of Audit & Risk Management is responsible for the day-to-day management of Internal Audit (supported by the Audit Manager) and fulfils the requirements of the 'Chief Audit Executive' role required by the PSIAS. The Head of Audit & Risk Management will:

- prepare an audit plan to review all relevant areas, and to update the plan regularly to account for changes in Council priorities and risks. The plans will be presented to the Audit & Governance Committee annually;
- manage a portfolio of work for each auditor to achieve the annual audit plan;
- ensure the issue of a terms of reference document for each audit assignment undertaken setting out the scope and objectives of the work, timescales and reporting arrangements;
- ensure that relevant testing is carried out on which sound judgements can be based;
- ensure that work is undertaken, completed and issued in a timely manner;
- ensure that a written report is produced for each assignment giving an assurance opinion on the control environment and identifying actions to address any weaknesses;
- ensure that follow-up work is undertaken, where appropriate, to monitor the implementation of agreed management actions;
- ensure that all audit work is completed to high standards in accordance with relevant professional standards;
- establish and maintain effective relationships with managers of all levels and obtain feedback from them on the work of the section including the use of user satisfaction surveys;

- monitor the work of the Audit & Governance Committee and consider, where appropriate, whether changes need to be made to the Internal Audit Plan as a result of the issues arising from the work of the Committee;

- establish and maintain effective relationships with the external auditors;

- monitor the effectiveness of the service delivered to clients and compliance with relevant standards:

- undertake an annual review of the development and training needs of Internal Audit employees and arrange for appropriate training to be provided to address the needs where possible; and

- develop and maintain a quality assurance and improvement programme (QAIP) covering all aspects of Internal Audit Activity.

13.0 Internal Audit Plan

13.1 The work of Internal Audit is based on the delivery of an agile, risk-based Audit Plan and is conducted on a predominantly risk-based audit approach. The Head of Audit & Governance will prepare a new Audit Plan each year in line with the requirements of the PSIAS, and the Audit Plan will be periodically reviewed and updated, if required, as each year progresses.

13.2 The Audit Plan is derived from all of the auditable areas that have been identified for potential review and following an assessment of the risks relating to each area. This is referred to as the 'Audit Universe'.

13.3 In developing the Audit Universe account is taken of the risks identified in the Council's strategic risk register and from other sources of assurance such as external inspections and performance management information. Internal Audit also undertakes its own assessment of the risks inherent in the potential areas for audit review based on a number of criteria including financial materiality, potential public interest issues, and cumulative audit knowledge (ie. the findings of previous Internal Audit work, and the length of time since the relevant area was last subject to audit or review).

13.4 Areas within the Audit Universe are then evaluated according to a risk-based methodology and the Audit Plan is developed to allocate the available Internal Audit resources to address the areas of highest assessed risk.

13.5 The Executive Leadership Team are also consulted to determine their views on any risks or areas within their services which they feel should be taken into account in developing the Audit Plan.

13.6 The Audit Plan will also include a 'contingency' element to provide for any urgent or unplanned work or emerging risk areas. The level of contingency allowed for in the Audit Plan will be determined by the Head of Audit & Risk Management, but will be considered by the Audit & Governance Committee when the Audit Plan is presented to them for consideration.

13.7 The Audit Plan will also include provision for the follow-up of recommendations to ensure that they have been implemented satisfactorily within the timescales agreed by managers.

13.8 Internal Audit may provide audit work for other organisations, which currently includes internal audit work for Northamptonshire Childrens Trust. Any further such work external to the Council, including any consultancy type services, will only be undertaken by Internal Audit with prior approval from the Audit & Governance Committee [the Board].

14.0 Quality Assurance and Improvement Programme

14.1 The Head of Audit & Risk Management will develop and maintain a Quality Assurance and Improvement Programme (QAIP) in accordance with the PSIAS.

14.2 The QAIP will form the basis of the annual internal review of the system of Internal Audit as required by the PSIAS/LGAN.

14.3 The QAIP will show conformance with PSIAS/LGAN requirements and will offer explanations where conformance with PSIAS/LGAN is not achieved. An improvement plan will be developed as a result of the QAIP to achieve or improve levels of conformance. The outcome of the review and any resulting action plan will be reported to the Audit & Governance Committee and a statement regarding conformance with the PSIAS will be included in the Annual Internal Audit Report.

14.4 An independent external review of Internal Audit will be carried out as part of the QAIP at least once every five years. The Executive Director, Finance (s151 Officer) will act as sponsor to agree the scope and nature of the external review in consultation with the Head of Audit & Risk Management, which will then be approved by the Audit & Governance Committee.

14.5 Where non-conformance with PSIAS/LGAN impacts on the overall scope or operation of Internal Audit activity the nature of the impact will be disclosed to the Audit & Governance Committee. Serious deviations from conformance will need to be considered for inclusion in the Council's Annual Governance Statement (AGS).

15.0 Relationship with Elected Members

15.1 The Head of Audit & Risk Management will maintain an effective working relationship with the Chair and other members of the Audit & Governance Committee, and will have direct access to the Chair of the Committee if required.

15.2 Unless stated elsewhere, the Audit & Governance Committee will fulfil the roles and responsibilities of the 'Board' for the purposes of the PSIAS.

16.0 Relationship with Senior Management

16.1 The members of the Executive Leadership Team will fulfil the role of 'Senior Management' as defined in the PSIAS. The Head of Audit & Risk Management will work to maintain an on-going relationship with all members of the Executive Leadership Team.

16.2 A written report will be produced for each audit assignment and presented to relevant managers. Such reports will:-

- include an overall assurance opinion on the adequacy of the internal control environment for the area under review;
- identify any areas of weaknesses in the control environment and risks which have not been addressed;
- make recommendations for the necessary improvements needed to address the weaknesses identified;

- detail management's responses and timescales for corrective action to be taken.

16.3 The Internal Audit Plan, quarterly progress reports and the Annual Internal Audit Report will be circulated to the Executive Leadership Team prior to being submitted to the Audit & Governance Committee.

17.0 Relationship with Statutory Officers

17.1 The Head of Audit & Risk Management will maintain a close relationship with the statutory officers of the Council (Head of Paid Service, s151 Officer and Monitoring Officer) and others with assurance or governance responsibilities.

17.2 The statutory officers will support the work of Internal Audit and provide the necessary backing to ensure that key weaknesses are addressed and recommendations implemented, and will support Internal Audit's position in upholding good governance within the Council. The Statutory Officers should also ensure that Internal Audit is provided with all necessary advice, explanations and information needed for them to effectively carry out their role.

17.3 The 'Role of the Chief Financial Officer in Local Government' guidance document produced by CIPFA places a direct responsibility on the s151 Officer to '*support the Council's Internal Audit arrangements*' and to ensure that they are '*effectively resourced and maintained*' to comply with the Accounts and Audit Regulations.

18.0 Review of the Internal Audit Charter

18.1 The Head of Audit & Risk Management will regularly review the Audit Charter and any revisions will be presented to the Executive Leadership Team and the Audit & Governance Committee for approval.

19.0 Glossary of Terms / Definitions

Term	**Definition**
AGS	Annual Governance Statement
Board	Audit & Governance Committee
CCAB	Consultative Committee of Accountancy Bodies
Chief Audit Executive	Head of Audit & Risk Management
CIPFA	Chartered Institute of Public Finance & Accountancy
CMIIA	Chartered Member of the Institute of Internal Auditors
Head of Paid Service	Chief Executive
LGAN	CIPFA's Local Government Application Note (to the PSIAS)
Monitoring Officer	Director of Legal & Democratic
PSIAS	Public Sector Internal Audit Standards
QAIP	Quality Assurance and Improvement Programme
s151 Officer	Executive Director, Finance (Chief Finance Officer)
Senior Management	Executive Leadership Team

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West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL
AUDIT & GOVERNANCE COMMITTEE

27 MARCH 2024

Report Title	**CIPFA Position Statement on Audit Committees**
Report Author	**Adrian Ward – Head of Audit & Risk Management** **adrian.ward@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
S151 Officer / Director	Martin Henry	15/03/2024

List of Appendices

Appendix A - CIPFA's Position Statement: Audit Committees in Local Authorities and Police 2022
Appendix B – Audit Committee Self-Assessment Checklist
Appendix C – Updated Terms of Reference

1. Purpose of Report

1.1. To allow the Committee to consider its compliance with CIPFA's Position Statement: Audit Committees in Local Authorities and Police 2022 (the 'Position Statement').

Executive Summary

1.1 This report considers the Audit &Governance Committee's current compliance with the Position Statement, and sets out some improvement actions for consideration.

2. Recommendations

2.1 It is recommended that the Audit & Governance Committee:

a) Consider the self-assessment checklist (Appendix B) and endorse the improvement actions set out in this report,

b) Consider the updated terms of reference for the Committee (Appendix C) and whether they should be recommended to the Democracy & Standards Committee for updating the Constitution.

3. Reason for Recommendations

4.1 To ensure compliance with the practice and principles set out in the CIPFA Position Statement for Audit Committees 2022.

4. Report Background

4.1 In 2022 the Chartered Institute of Public Finance and Accountancy (CIPFA) issued an updated Position Statement (Appendix A) setting out their view on the audit committee practice and principles that local government bodies in the UK should adopt.

4.2 CIPFA expects that local government bodies should make their best efforts to adopt the principles of the Position Statement, which will enable them to meet their statutory responsibilities for governance and internal control arrangements, financial management, financial reporting and internal audit.

5. Issues and Choices

5.1 The Audit and Governance Committee's current arrangements have been considered against the self-assessment checklist produced by CIPFA to measure compliance against the Position Statement, in consultation with the Chair and Vice-chair, and the initial results are set out in Appendix B.

5.2 CIPFA recommend that the self-assessment should be undertaken collaboratively with the audit committee members, and so the Committee is invited to consider the document at this meeting.

5.3 Potential areas for improved compliance with the Position Statement noted in the self-assessment are summarised in the table below:

Issue	Comments / Improvement Actions
Do the terms of reference clearly set out the purpose of the committee in accordance with CIPFA's 2022 Position Statement?	Suggested updated terms of reference to fully comply with the Position Statement have been developed (Appendix C).
Does the governing body (ie. full council) hold the audit committee to account for its performance at least annually?	An annual report is produced, and this should be presented to full Council each year.

The annual report needs to refer to compliance with the Position Statement.	To be included for 2023/24 onwards.
Do the committee's terms of reference explicitly address all the core areas identified in CIPFA's Position Statement?	Suggested updated terms of reference produced to address the core areas (Appendix C).
Has the committee been established in accordance with the 2022 guidance as follows? • A size that is not unwieldy and avoids use of substitutes. • Inclusion of lay/co-opted independent members in accordance with legislation or CIPFA's recommendation.	• Review the size of the Committee following the 2025 elections. • Recruitment of up to 2 independent members in progress (awaiting full Council approval).
Have all committee members been appointed or selected to ensure a committee membership that is knowledgeable and skilled?	Provide guidance to political groups to assist with selecting members to serve on the Committee.
Across the committee membership, is there a satisfactory level of knowledge, as set out in the 2022 guidance?	Skills and knowledge assessment completed by committee members, and training programme being developed accordingly.
Has the committee obtained positive feedback on its performance from those interacting with the committee or relying on its work?	To be considered for the production of the next annual report.

5.4 For information, the main changes between the current terms of reference and the proposed version (Appendix C), which is based on CIPFA's model terms of reference for an audit committee, are:

- To remove the reference to the Committee having responsibility for the 'scrutiny of the Council's financial and non-financial performance', as this is a scrutiny function; and
- To add in the 'Other Responsibilities' section at the end to retain the specific additional functions that relate to this Council; namely the Chair being the Member Risk Champion, and the Committee also receiving reports on complaints and Ombudsman matters.

6. Implications (including financial implications)

6.3 **Resources and Financial**

6.3.1 There are no resources of financial implications arising from the proposals.

Legal

6.3.2 There are no legal implications arising from the proposals.

6.4 **Risk**

6.4.1 There are no significant risks arising from the proposed recommendations in this report.

6.5 **Consultation**

6.5.1 Not applicable.

6.6 **Climate Impact**

6.6.1 Not applicable.

6.7 **Community Impact**

6.7.1 Not applicable.

6.8 **Communications**

6.8.1 Not applicable.

7. Background Papers

7.1 None.

CIPFA's Position Statement: Audit Committees in Local Authorities and Police 2022

Scope

This position statement includes all principal local authorities in the UK, corporate joint committees in Wales, the audit committees for PCCs and chief constables in England and Wales, PCCFRAs and the audit committees of fire and rescue authorities in England and Wales.

The statement sets out the purpose, model, core functions and membership of the audit committee. Where specific legislation exists (the Local Government & Elections (Wales) Act 2021 and the Cities and Local Government Devolution Act 2016), it should supplement the requirements of that legislation.

Status of the position statement

The statement represents CIPFA's view on the audit committee practice and principles that local government bodies in the UK should adopt. It has been prepared in consultation with sector representatives.

CIPFA expects that all local government bodies should make their best efforts to adopt the principles, aiming for effective audit committee arrangements. This will enable those bodies to meet their statutory responsibilities for governance and internal control arrangements, financial management, financial reporting and internal audit.

The 2022 edition of the position statement replaces the 2018 edition.

The Department for Levelling Up, Housing and Communities and the Home Office support this guidance.

CIPFA's Position Statement 2022: Audit committees in local authorities and police

Purpose of the audit committee

Audit committees are a key component of an authority's governance framework. Their purpose is to provide an independent and high-level focus on the adequacy of governance, risk and control arrangements. The committee's role in ensuring that there is sufficient assurance over governance risk and control gives greater confidence to all those charged with governance that those arrangements are effective.

In a local authority the full council is the body charged with governance. The audit committee may be delegated some governance responsibilities but will be accountable to full council. In policing, the police and crime commissioner (PCC) and chief constable are both corporations sole, and thus are the individuals charged with governance.

The committee has oversight of both internal and external audit together with the financial and governance reports, helping to ensure that there are adequate arrangements in place for both internal challenge and public accountability.

Independent and effective model

The audit committee should be established so that it is independent of executive decision making and able to provide objective oversight. It is an advisory committee that has sufficient importance in the authority so that its recommendations and opinions carry weight and have influence with the leadership team and those charged with governance.

The committee should:

- be directly accountable to the authority's governing body or the PCC and chief constable
- in local authorities, be independent of both the executive and the scrutiny functions
- in police bodies, be independent of the executive or operational responsibilities of the PCC or chief constable
- have rights of access to and constructive engagement with other committees/functions, for example scrutiny and service committees, corporate risk management boards and other strategic groups
- have rights to request reports and seek assurances from relevant officers
- be of an appropriate size to operate as a cadre of experienced, trained committee members. Large committees should be avoided.

The audit committees of the PCC and chief constable should follow the requirements set out in the Home Office Financial Management Code of Practice and be made up of co-opted independent members.

The audit committees of local authorities should include co-opted independent members in accordance with the appropriate legislation.

Where there is no legislative direction to include co-opted independent members, CIPFA recommends that each authority audit committee should include at least two co-opted independent members to provide appropriate technical expertise.

Core functions

The core functions of the audit committee are to provide oversight of a range of core governance and accountability arrangements, responses to the recommendations of assurance providers and helping to ensure robust arrangements are maintained.

The specific responsibilities include:

Maintenance of governance, risk and control arrangements

- Support a comprehensive understanding of governance across the organisation and among all those charged with governance, fulfilling the principles of good governance.

- Consider the effectiveness of the authority's risk management arrangements. It should understand the risk profile of the organisation and seek assurances that active arrangements are in place on risk-related issues, for both the body and its collaborative arrangements.

- Monitor the effectiveness of the system of internal control, including arrangements for financial management, ensuring value for money, supporting standards and ethics and managing the authority's exposure to the risks of fraud and corruption.

Financial and governance reporting

- Be satisfied that the authority's accountability statements, including the annual governance statement, properly reflect the risk environment, and any actions required to improve it, and demonstrate how governance supports the achievement of the authority's objectives.

- Support the maintenance of effective arrangements for financial reporting and review the statutory statements of account and any reports that accompany them.

Establishing appropriate and effective arrangements for audit and assurance

- Consider the arrangements in place to secure adequate assurance across the body's full range of operations and collaborations with other entities.

- In relation to the authority's internal audit functions:

    - oversee its independence, objectivity, performance and conformance to professional standards

    - support effective arrangements for internal audit

    - promote the effective use of internal audit within the assurance framework.

- Consider the opinion, reports and recommendations of external audit and inspection agencies and their implications for governance, risk management or control, and monitor management action in response to the issues raised by external audit.

- Contribute to the operation of efficient and effective external audit arrangements, supporting the independence of auditors and promoting audit quality.

- Support effective relationships between all providers of assurance, audits and inspections, and the organisation, encouraging openness to challenge, review and accountability.

Audit committee membership

To provide the level of expertise and understanding required of the committee, and to have an appropriate level of influence within the authority, the members of the committee will need to be of high calibre. When selecting elected representatives to be on the committee or when co-opting independent members, aptitude should be considered alongside relevant knowledge, skills and experience.

Characteristics of audit committee membership:

- A membership that is trained to fulfil their role so that members are objective, have an inquiring and independent approach, and are knowledgeable.

- A membership that promotes good governance principles, identifying ways that better governance arrangement can help achieve the organisation's objectives.

- A strong, independently minded chair, displaying a depth of knowledge, skills, and interest. There are many personal skills needed to be an effective chair, but key to these are:

    - promoting apolitical open discussion

    - managing meetings to cover all business and encouraging a candid approach from all participants

    - maintaining the focus of the committee on matters of greatest priority.

- Willingness to operate in an apolitical manner.

- Unbiased attitudes – treating auditors, the executive and management fairly.

- The ability to challenge the executive and senior managers when required.

- Knowledge, expertise and interest in the work of the committee.

While expertise in the areas within the remit of the committee is very helpful, the attitude of committee members and willingness to have appropriate training are of equal importance.

The appointment of co-opted independent members on the committee should consider the overall knowledge and expertise of the existing members.

Engagement and outputs

The audit committee should be established and supported to enable it to address the full range of responsibilities within its terms of reference and to generate planned outputs.

To discharge its responsibilities effectively, the committee should:

- meet regularly, at least four times a year, and have a clear policy on those items to be considered in private and those to be considered in public
- be able to meet privately and separately with the external auditor and with the head of internal audit
- include, as regular attendees, the chief finance officer(s), the chief executive, the head of internal audit and the appointed external auditor; other attendees may include the monitoring officer and the head of resources (where such a post exists). These officers should also be able to access the committee members, or the chair, as required
- have the right to call on any other officers or agencies of the authority as required; police audit committees should recognise the independence of the chief constable in relation to operational policing matters
- support transparency, reporting regularly on its work to those charged with governance
- report annually on how the committee has complied with the position statement, discharged its responsibilities, and include an assessment of its performance. The report should be available to the public.

Impact

As a non-executive body, the influence of the audit committee depends not only on the effective performance of its role, but also on its engagement with the leadership team and those charged with governance.

The committee should evaluate its impact and identify areas for improvement.

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AUDIT COMMITTEE – SELF ASSESSMENT OF GOOD PRACTICE

Good Practice Questions		Does not comply	Partially complies – and extent of improvement needed			Fully complies
		Major improvement	**Significant improvement**	**Moderate improvement**	**Minor improvement**	**No further improvement**
Audit committee purpose and governance						
1	Does the authority have a dedicated audit committee that is not combined with other functions (eg standards, ethics, scrutiny)?					√
2	Does the audit committee report directly to the governing body (ie. full council)?					√
3	Has the committee maintained its advisory role by not taking on any decision-making powers?					√
4	Do the terms of reference clearly set out the purpose of the committee in accordance with CIPFA's 2022 Position Statement?				√ Under review	
5	Do all those charged with governance and in leadership roles have a good understanding of the role and purpose of the committee?					√
6	Does the audit committee escalate issues and concerns promptly to those in governance and leadership roles?					√
7	Does the governing body (ie. full council) hold the audit committee to account for its performance at least annually?			√ Annual report to Council every year		
8	Does the committee publish an annual report in accordance with the 2022 guidance, including:					
	• compliance with the CIPFA Position Statement 2022			√ To be included		
	• results of the annual evaluation, development work undertaken and planned improvements					
	• how it has fulfilled its terms of reference and the key issues escalated in the year?					√

Good Practice Questions		Does not comply	Partially complies – and extent of improvement needed			Fully complies
		Major improvement	**Significant improvement**	**Moderate improvement**	**Minor improvement**	**No further improvement**
Functions of the committee						
9	Do the committee's terms of reference explicitly address all the core areas identified in CIPFA's Position Statement as follows?					
	Governance arrangements				√ Under review	
	Risk management arrangements				See above	
	Internal control arrangements, including: • financial management • value for money • ethics and standards • counter fraud and corruption				See above	
	Annual governance statement				See above	
	Financial reporting				See above	
	Assurance framework				See above	
	Internal audit				See above	
	External audit				See above	
10	Over the last year, has adequate consideration been given to all core areas?					√
11	Over the last year, has the committee only considered agenda items that align with its core functions or selected wider functions, as set out in the 2022 guidance?					√

Good Practice Questions		Does not comply	Partially complies – and extent of improvement needed			Fully complies
		Major improvement	**Significant improvement**	**Moderate improvement**	**Minor improvement**	**No further improvement**
12	Has the committee met privately with the external auditors and head of internal audit in the last year?					√
Membership and support						
13	Has the committee been established in accordance with the 2022 guidance as follows?					
	• Separation from executive (ie. Cabinet)					√
	• A size that is not unwieldy and avoids use of substitutes			√ Review after 2025 elections		
	• Inclusion of lay/co-opted independent members in accordance with legislation or CIPFA's recommendation	√ In progress				
14	Have all committee members been appointed or selected to ensure a committee membership that is knowledgeable and skilled?				√ Provide guidance to political groups	
15	Has an evaluation of knowledge, skills and the training needs of the chair and committee members been carried out within the last two years?					√
16	Have regular training and support arrangements been put in place covering the areas set out in the 2022 guidance?					√
17	Across the committee membership, is there a satisfactory level of knowledge, as set out in the 2022 guidance?				√ Training being delivered	
18	Is adequate secretariat and administrative support provided to the committee?					√

Good Practice Questions		Does not comply	Partially complies – and extent of improvement needed			Fully complies
		Major improvement	**Significant improvement**	**Moderate improvement**	**Minor improvement**	**No further improvement**
19	Does the committee have good working relations with key people and organisations, including external audit, internal audit and the CFO?					√
Effectiveness of the committee						
20	Has the committee obtained positive feedback on its performance from those interacting with the committee or relying on its work?				√ Consider how to best obtain feedback	
21	Are meetings well chaired, ensuring key agenda items are addressed with a focus on improvement?					√
22	Are meetings effective with a good level of discussion and engagement from all the members?					√
23	Has the committee maintained a non-political approach to discussions throughout?					√
24	Does the committee engage with a wide range of leaders and managers, including discussion of audit findings, risks and action plans with the responsible officers?					√
25	Does the committee make recommendations for the improvement of governance, risk and control arrangements?					√
26	Do audit committee recommendations have traction with those in leadership roles?					√
27	Has the committee evaluated whether and how it is adding value to the organisation?					√ Annual report
28	Does the committee have an action plan to improve any areas of weakness?					√

TERMS OF REFERENCE

4.7 Audit and Governance Committee

Members : 9 councillor members (appointed having regards to the rules on political proportionality), and 2 independent co-opted non-voting members. Quorum: 3 councillor members.

Purpose:

4.7.1 The purpose of the Audit and Governance Committee is to:

(a) Provide an independent and high-level focus on the adequacy of governance, risk and control arrangements. Its role in ensuring there is sufficient assurance over governance, risk and control gives greater confidence to all those charged with governance that those arrangements are effective.

(b) Have oversight of both internal and external audit, together with the financial and governance reports, helping to ensure there are adequate arrangements in place for both internal challenge and public accountability.

Terms of Reference:

4.7.2 Governance, Risk & Control:

(a) To review the council's corporate governance arrangements against the good governance framework, including the ethical framework, and consider the local code of governance;

(b) To monitor the effective development and operation of risk management in the council;

(c) To monitor progress in addressing risk-related issues reported to the committee;

(d) To consider reports on the effectiveness of internal controls and monitor the implementation of agreed actions;

(e) To consider reports on the effectiveness of financial management arrangements, including compliance with CIPFA's Financial Management Code;

(f) To consider the council's arrangements to secure value for money and review assurances and assessments on the effectiveness of these arrangements;

(g) To review the assessment of fraud risks and potential harm to the council from fraud and corruption;

(h) To monitor the counter fraud strategy, actions and resources;

(i) To review the governance and assurance arrangements for significant partnerships or collaborations.

4.7.3 Governance Reporting:

(a) To review the Annual Governance Statement (AGS) prior to approval and consider whether it properly reflects the risk environment and supporting assurances, including the head of internal audit's annual opinion;

(b) To consider whether the annual evaluation for the AGS fairly concludes that governance arrangements are fit for purpose, supporting the achievement of the authority's objectives.

4.7.4 Financial Reporting:

(a) To monitor the arrangements and preparations for financial reporting to ensure that statutory requirements and professional standards can be met;

(b) To review the annual statement of accounts. Specifically, to consider whether appropriate accounting policies have been followed and whether there are concerns arising from the financial statements or from the audit that need to be brought to the attention of the council;

(c) To consider the external auditor's report to those charged with governance on issues arising from the audit of the accounts.

4.7.5 External Audit:

(a) To support the independence of external audit through consideration of the external auditor's annual assessment of its independence and review of any issues raised by Public Sector Audit Appointments (PSAA) or the authority's auditor panel as appropriate;

(b) To consider the external auditor's annual letter, relevant reports and the report to those charged with governance;

(c) To consider specific reports as agreed with the external auditor;

(d) To comment on the scope and depth of external audit work and to ensure it gives value for money;

(e) To consider additional commissions of work from external audit;

(f) To advise and recommend on the effectiveness of relationships between external and internal audit and other inspection agencies or relevant bodies;

(g) To provide free and unfettered access to the audit committee chair for the auditors, including the opportunity for a private meeting with the committee.

4.7.6 Internal Audit:

(a) To approve the internal audit charter;

(b) To review proposals made in relation to the appointment of external providers of internal audit services and to make recommendations;

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

(d) To approve significant interim changes to the risk-based internal audit plan and resource requirements;

(e) To make appropriate enquiries of both management and the head of internal audit to determine if there are any inappropriate scope or resource limitations;

(f) To consider any impairments to the independence or objectivity of the head of internal audit arising from additional roles or responsibilities outside of internal auditing and to approve and periodically review safeguards to limit such impairments;

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

- updates on the work of internal audit, including key findings, issues of concern and action in hand as a result of internal audit work
- regular reports on the results of the Quality Assurance and Improvement Programme (QAIP)
- reports on instances where the internal audit function does not conform to the Public Sector Internal Audit Standards and the Local Government Application Note, considering whether the non-conformance is significant enough that it must be included in the AGS;

(h) To consider the head of internal audit's annual report, including:

- the statement of the level of conformance with the PSIAS and LGAN and the results of the QAIP that support the statement (these will indicate the reliability of the conclusions of internal audit)
- the opinion on the overall adequacy and effectiveness of the council's framework of governance, risk management and control, together with the summary of the work supporting the opinion (these will assist the committee in reviewing the AGS);

(i) To consider summaries of specific internal audit reports as requested;

(j) To receive reports outlining the action taken where the head of internal audit has concluded that management has accepted a level of risk that may be unacceptable to the authority or there are concerns about progress with the implementation of agreed actions;

(k) To contribute to the QAIP and in particular to the external quality assessment of internal audit that takes place at least once every five years;

(l) To consider a report on the effectiveness of internal audit to support the AGS where required to do so by the accounts and audit regulations;

(m) To provide free and unfettered access to the audit committee chair for the head of internal audit, including the opportunity for a private meeting with the committee.

4.7.7 Accountability Arrangements

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

(b) To report to full council on an annual basis on the committee's performance in relation to the terms of reference and the effectiveness of the committee in meeting its purpose by means of a published annual report on the work of the committee, including a conclusion on the compliance with the CIPFA Position Statement.

4.7.8 Other Responsibilities

(a) The Chair of the Audit and Governance Committee shall act as the Member Risk Champion;

(b) To receive annually statistical reports and details of complaints received and investigated through the Council's Corporate Complaints Procedure which have resulted in payments or other benefits being provided by the Council in cases of maladministration;

(c) Receive on behalf of the Council reports issued by the Local Government Ombudsman into investigations that the Council's actions have amounted to maladministration causing injustice.

West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL

AUDIT & GOVERNANCE COMMITTEE

27TH MARCH 2024

Report Title	**Risk Management Strategy and Strategic Risk Register**
Report Author	**Adrian Ward – Head of Audit & Risk Management** **adrian.ward@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
S151 Officer / Director	Martin Henry	15/03/2024

List of Appendices

Appendix A – Risk Management Strategy
Appendix B – Strategic Risk Register

1. Purpose of Report

1.1. To allow the Committee to consider the updated Risk Management Strategy and the Strategic Risk Register, both of which were approved by Cabinet at their meeting on 12th March 2024.

2. Executive Summary

1.2. The Risk Management Strategy has been reviewed and updated to reflect current good practice, and the Strategic Risk Register has been comprehensively reviewed to reflect the current significant risks and threats that the Council is faced with, to make the documents more user friendly and to evaluate and present these in accordance with the guidance contained within the updated Strategy document.

3. Recommendations

3.1 It is recommended that the Audit & Governance Committee considers the updated Risk Management Strategy, and the Strategic Risk Register and the mitigating actions contained within it.

4. Reason for Recommendations

4.1 To ensure that the Council has an effective strategy for identifying and evaluating risks and opportunities, and an up to date and comprehensive strategic risk register which identifies the most significant key risks facing the organisation and the relevant mitigating actions, which is subject to ongoing monitoring and oversight by the Audit & Governance Committee.

5. Report Background

5.1 The current Risk Management Strategy approved in June 2021 and a Strategic Risk Register was developed, which ELT and the Audit & Governance Committee have kept under periodic review.

5.2 The Strategy has been subject to review and updating to ensure it reflects current best practice and is logical and easy to understand.

5.3 The Strategic Risk Register has also been subject to an extensive and comprehensive review and updating process, and a new register has been developed following the processes set out in the updated Strategy.

6. Issues and Choices

6.1 The updated Risk Management Strategy seeks to establish a clear and logical approach to risk management that can be applied to all the Council's relevant activities, including strategic and operational risks, and programme and project risks.

6.2 It also recognises that as well as identifying and mitigating threats, good risk management also includes the identification and consideration of potential opportunities, and it seeks to adopt a consistent Council-wide approach, including an approach for establishing a 'risk appetite' (which may vary according to the type of threat or opportunity being considered).

6.3 The Strategy specifies that risks should be assessed based on likelihood and impact both at gross (or inherent) risk level (ie. before any mitigating actions or factors are considered, and again at met risk level (ie. taking into account any mitigations).

6.4 A 'traffic light' scoring approach is then be used to categorise gross and net risks scores into high (red), medium (amber) and low (green) categories.

6.5 The Strategy also sets out the risk management responsibilities of relevant parties, including Cabinet, Audit & Governance Committee, senior managers, and other officers and groups.

6.6 The Strategic Risk Register has been compiled following consultation with senior managers and includes 15 high-level significant risks that have been identified which could impact on the Council's abilities to achieve its key corporate objectives.

6.7 The strategic risks are set out in detail in the register, together with mitigating actions, and are summarised below:

Ref.	Summary	Gross Risk	Current Net Risk	Target Net Risk	Risk Owner	Cabinet Portfolio
SR01	Data management (including Cyber Security)	**20**	**12**	**6**	Chief Information Officer	HR & Corporate Services
SR02	NPH residential – change in regulations	**12**	**9**	**9**	Director of Communities & Opportunities	Housing, Culture & Leisure
SR03	Cost of living impact – increased demand for services	**16**	**16**	**12**	Executive Director of People	Adult Care, Wellbeing & Health Integration
SR04	Availability of affordable rented accommodation	**20**	**9**	**9**	Director of Communities & Opportunities	Housing, Culture & Leisure
SR05	Health and safety of WNC properties	**16**	**12**	**9**	Executive Director of Corporate Services and Executive Director Place	HR & Corporate Services
SR06	Inability to recruit, and therefore deliver	**16**	**9**	**8**	Assistant Director HR	HR & Corporate Services
SR07	Change of policy and strategic direction	**16**	**12**	**12**	Chief Executive	Strategy (Leader)
SR08	Inter authority agreements	**20**	**16**	**8**	Director of Legal & Democratic Services	Finance
SR09	NCT relationship management (WNC / NNC/ NCT)	**16**	**6**	**4**	Director of Childrens Services	Children, Families & Education
SR10	NCT financial pressures	**25**	**20**	**9**	Director of Childrens Services	Children, Families & Education
SR11	Strategic communications and reputational risk	**16**	**9**	**9**	Assistant Chief Executive	Strategy (Leader)

SR12	RAAC (reinforced aerated autoclaved concrete)	**25**	**9**	**1**	Director of Childrens Services	Children, Families & Education
SR13	Cladding	**15**	**9**	**1**	Director for Communities & Opportunities	Housing, Culture & Leisure
SR14	Financial sustainability	**20**	**10**	**10**	Executive Director - Finance	Finance
SR15	Disaggregation and other disputes	**20**	**12**	**8**	Executive Director - Finance	Finance

7. Implications (including financial implications)

7.1 **Resources and Financial**

7.1.1 The strategic risk register considers a range of issues, including finance and resources, which could impact on the operations of the Council.

7.2 **Legal**

7.2.1 There are no specific legal implications arising from the proposal.

7.3 **Risk**

7.3.1 There are no significant risks arising from the proposed recommendations in this report. If approved, the Strategic Risk Register will replace the current document, and therefore will be taken account of in future Cabinet and Committee reports, where relevant.

7.4 **Consultation**

7.4.1 Senior management has been engaged on the updated Risk Management Strategy and Strategic Risk Register and it has also been endorsed by the Executive Leadership Team.

7.5 **Climate Impact**

7.5.1 Any implications relating to climate impact are considered as part of the development of the risk strategy

7.6 **Community Impact**

7.6.1 Any implications relating to climate impact are considered as part of the development of the risk strategy.

7.7 **Communications**

7.7.1 The Strategy and the Strategic Risk Register will be made available on the intranet.

8. Background Papers

8.1 None.

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West Northamptonshire Council

APPENDIX A

Risk Management Strategy & Framework

Version 2.0

www.westnorthants.gov.uk

Document Version Control

Document File Name	*Risk Management Strategy & Framework*
Document Type	*Strategy & Framework*
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Contact	*Risk & Internal Control Manager – Joanne Bonham*
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Change History

Issue	Date	Comments
0.1	26/05/2021	Draft
1.0	08/06/2021	Final version
0.2	23/01/24	Draft – Strategy update
2.0		Final version update

NB: Draft versions 0.1 - final published versions 1.0

Consultees

Internal	External
S151 Officer	
Executive Leadership Team	
Chief Internal Auditor	

Distribution List

Internal	External
All staff	WNC Website

Links to other documents

Document	Link

Contents

West Northamptonshire Council

1. Introduction

The purpose of the risk management approach outlined in this document is to:

- Provide standard definitions and language to underpin the risk management process
- Ensure risks are identified and assessed consistently throughout the organisation through the clarification of key concepts
- Clarify roles and responsibilities for managing risk
- Implement an approach that meets current legislative requirements and follows best practice and relevant standards.

Risk is the chance or possibility of loss, damage, injury or failure to achieve objectives caused by and unwanted or uncertain action or event.

Risk Management is the process whereby the Council addresses key risks or barriers to achieving its vision and corporate objectives. Risk arises from possible threats to objectives as well as failure to take advantage of possible opportunities.

Risk can be operational in nature and exist at service or team level or organisational, such as disaster recovery or health and safety risks, but are barriers to achieving operational outcomes and objectives. Unless effectively managed, risks can escalate in their nature and impact to become much more significant and strategic in their impact.

WNC has set six core values to support its corporate strategy and these are:

1) Trust – We are honest, fair, transparent and accountable. We can be trusted to do what we say will.
2) High Performance – We get the basics right and what we do, we do well.
3) Respect – We respect each other and our customers in a diverse, professional and supportive environment.
4) Innovate – We encourage curiosity, are creative and seize opportunities to grow individually as an organisation and as an area.
5) Value – We value each other's skills, experience and ideas and we celebrate our similarities, differences and environment.
6) Empower – We believe in people, will listen, learn and trust them to make decisions. We help people to realise their ambitions.

The aim of risk management at WNC is not to remove all risks, but to understand the nature of risks and to implement controlled, sensible, balanced and cost effective measures, to manage risk and achieve objectives. Risk management is not about being 'risk averse,' but about being 'risk aware' and this awareness will mean that the Council and its leadership team is better able to avoid threats and hazards and also take full advantage of opportunities that arise in the course of its business.

WNC recognises there is uncertainty in everything it does, and the uncertainties present both threats and opportunities. This strategy describes how the Council will manage these uncertainties by identifying, evaluating and controlling risk, increasing the authority's success

in achieving its priorities and objectives and also by putting in place contingencies and an organisational agility for both planned and also unforeseen events.

The relationship between risk management and objectives is shown in Diagram 1 below:

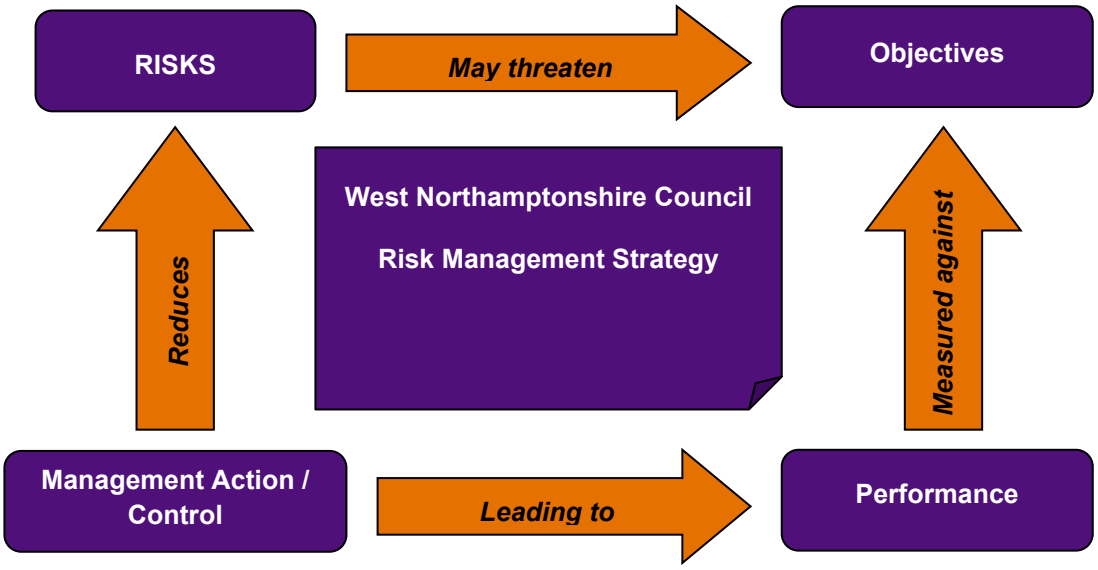


Diagram 1: Risks and Objectives

2. The benefits of risk management

There are a number of benefits to the Council in continuing to develop and embed a sound risk management function. The key benefits include:

- Supporting the Council in achieving its priorities and objectives at all levels within the organisation;
- Supporting better decision-making throughout the Council;
- Creating and contributing to effective governance procedures and protocols;
- Providing a framework for internal and external assurance;
- Targeting resources at areas and issues of greatest risk where the Council's objectives are most under threat;
- Providing an early-warning system to alert Officers and Members to potential threats and opportunities;
- Providing an organisational agility and rapid response capability to the above opportunities and threats and also any unforeseen events;
- Enabling the Council to act proactively, avoiding reactive management wherever possible;
- Protecting and enhancing the reputation of WNC.

3. Risk Management Policy Statement

Definition of Risk Management

Risk is the chance or possibility of loss, damage, injury or failure to achieve objectives caused by an unwanted or uncertain action or event. Risk management is a planned and systematic approach to the identification, evaluation and control of those risks which can threaten the assets or financial and organisational well-being of the Council.

Policy Statement

WNC recognises that it has a duty of care to its residents, customers, employees, partners and visitors. In fulfilling this duty, the Council will endeavour to apply high standards of governance and to be efficient, effective, transparent and accountable.

Effective risk management is a statutory responsibility for the Council and is central to its good governance. Importantly, risk management is an integral part of the Council's business processes and assists with decision making and achievement of key objectives whilst providing evidence of effective management and control in support of the Annual Governance Statement.

It is impossible to remove all risk but the Council are committed to adopting a governance-driven, corporate, systematic and structured approach to the management of risk at WNC with the Council's leadership team setting a "tone from the top".

It will be also be the responsibility of councillors, all employees and partner organisations of the Council to review, understand the nature and take responsibility for controlling the risks within their service areas.

To give effect to this the Council will put in place this risk management strategy & framework document, the core elements of which will include procedures, protocols and detailed guidance to council officers. The objectives of the strategy are to:

- Adopt a strategic approach to risk management to make better informed decisions which is vital to successful transformational change;
- Set the 'tone from the top' on the level of risk we are prepared to accept on our different service delivery activities and priorities;
- Acknowledge that with even good risk management and our best endeavours, things can go wrong. Where this happens, we use the lessons learnt to try to prevent it from happening again;
- Develop leadership capacity and skills in identifying, understanding and managing the risks facing the Council;
- Integrate risk management into how we run Council business and/or services. Sound risk management processes help us to achieve our core purpose, priorities and outcomes;
- Support a culture of well-measured risk taking throughout the Council's business, including strategic, partnership, project and operational. This includes setting risk ownership and accountabilities and responding to risk in a balanced way, considering the level of risk, reward, impact and cost of control measures;

- Ensure that the Council continues to meet all statutory and best practice requirements in relation to risk management; and
- Ensure risk management continues to be a key and effective element of our Corporate Governance arrangements.

We will meet these objectives by:

- Establishing and articulating our risk culture; setting out expectations of behaviour throughout the Council;
- Maintaining a consistent and robust risk management approach that will;
  - Identify and effectively manage strategic, operational and project risk; and
  - Focus on those key risks that, because of their likelihood and impact, make them priorities;
- Utilise the internal control team to conduct health checks within service areas to ensure processes are robust;
- Ensuring accountabilities, roles and responsibilities for managing risks are clearly defined and communicated;
- Considering risk as an integral part of service improvement planning, key decision-making processes, and project and partnership governance;
- Communicating risk information effectively through a clear reporting framework; and
- Increasing understanding and expertise in risk management through targeted training and sharing of good practice.

Signatures:

Anna Earnshaw

Chief Executive

Date signed

Martin Henry

Executive Director of Finance (S151)

Date signed

4. Risk Management Approach

The council's approach to risk management is based on best practice and involves a number of key steps as outlined below:

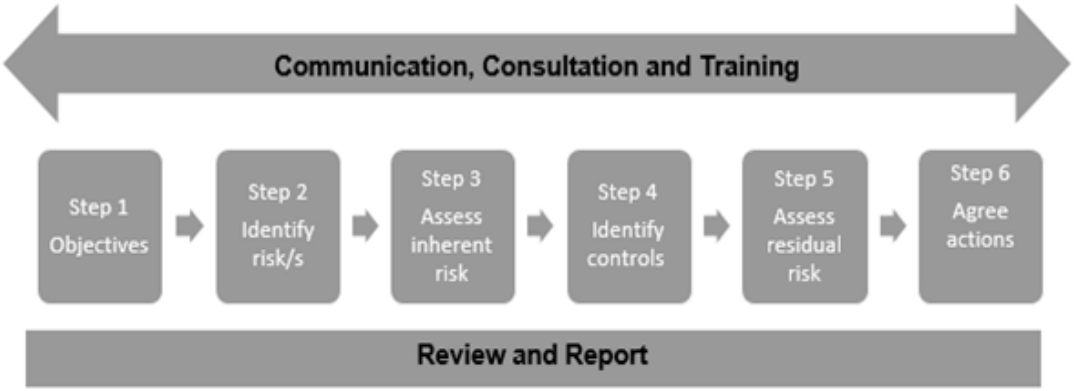


Diagram 2: WNC's Risk Management Approach

Risk can exist at a more operational level as part of the Council's day to day activities and importantly also in programmes and project management. At WNC, and similarly to the strategic level, this is being strongly embedded and integrated into the culture of the Council, with responsibility for managing risk assigned to managers and staff as part of their individual job profile and service area performance objectives. The approach of WNC is one of top down whereby senior management focus on the risks to strategic objectives, and bottom up where officers focus on the risks to achievement at an operational level.

Directorates and service areas within WNC may not carry the same risk profile and risk management will be via the operation of risk registers which may be used to support managers in decision-making such as designing business processes, evaluating opportunities and for choosing and prioritising what areas of performance are monitored.

The purpose of the risk management approach outlined in this document is to:

- Provide standard definitions and language to underpin the risk management process;
- Ensure risks are identified and assessed consistently throughout the Council through the clarification of key concepts;
- Clarify roles and responsibilities for managing risks;
- Implement an approach that meets current legislative requirements and follows best practice and relevant standards.

5. Risk management roles and responsibilities

Although the corporate risk management framework is set and regularly monitored by Cabinet (who have ultimate responsibility for it) and the Council's Executive Leadership, core delivery of the approved risk management framework is primarily led by and rests with the Chief Executive, directors and statutory officers acting individually and collectively as part of the Executive Leadership Team, and who are then supported by their departmental management

teams or equivalent. The Risk Team will work in collaboration with corporate directors offering advice and challenge and support reporting and monitoring.

All elected members, managers and staff of the Council, including when acting in partnership and joint venture with other bodies and organisations, have a general responsibility and duty to manage risk as an integral part of their role.

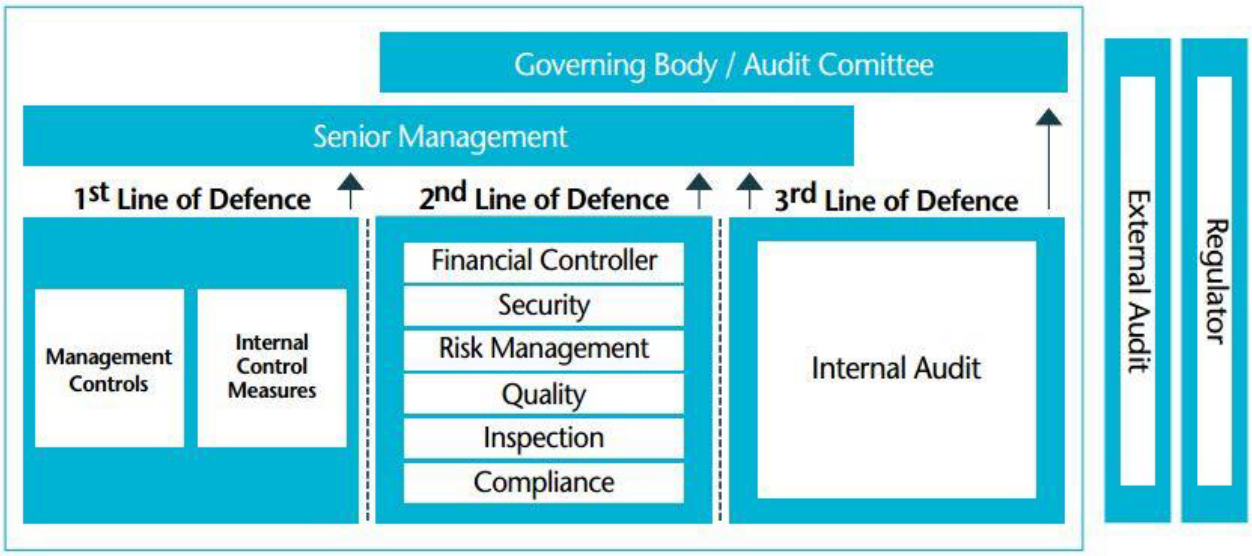
In addition, specific core risk-related/risk-driven support service activities, such as the performance management function, health and safety, insurance, emergency business continuity planning and programme and project management in addition all contribute to the overall corporate risk management process.

The Council and its leadership team will set the "tone from the top" on risk management and will directly oversee the risk management function in achieving its objectives and these will be to:

- Continuously develop WNC's risk management framework to support the achievement of the Council's core values and its ambition to be one the best councils in the country;
- Facilitate the achievement of Council priorities and objectives by embedding an effective process of identification and management of strategic, service level and key operational risks;
- Similarly facilitate the achievement of Council priorities and objectives by embedding an effective process of identification and management of major programme and project risks;
- Ensure, where appropriate, risks are effectively escalated, and escalation is timely;
- Ensure the risks associated with partnerships are effectively identified and managed;
- Promote risk-awareness, particularly business risk awareness, risk-intelligence and risk management throughout the Council;
- Capture, expand and act upon positive risk opportunities;
- Support the effective identification and management of risks associated with delivering existing and new council services into both existing and new markets;
- Proactively identify and manage emergent risk;
- Clearly state and communicate to all council officers, managers, partners and residents their risk management responsibilities;
- Manage risk in line with recognised best practice in public sector governance.

A summary overview of responsibilities for risk management at the Council is at Annex A with further detail at Annex B.

The 'Three Lines of Defence' model is a way of explaining the relationship between the monitoring and assurance functions and a guide to how senior management should divide these responsibilities:



6. Risk registers

Whilst the management of risk at different management levels within the Council will vary in terms of focus and level of formal analysis, in order to ensure good practice, it is important that consistency and clarity of risk information is achieved on risk registers.

For this reason, a standard risk register format will be used throughout WNC to align service and programme risk registers with the corporate risks. The register has been kept in a simple form to enable service areas to understand the fields and get used to updating the register on a regular basis.

An overall risk register matrix and risk map has been added on the front-cover sheet of the corporate risk register to provide an at-a-glance helicopter view of the risks captured and to better reveal any potential form, pattern, spread or cluster of risks on the register.

7. Risk management process

Identify Risks

There are a number of different types of risks that an organisation may face including financial loss, failure of service delivery, physical risks to people, and damage to the organisation's reputation.

To act as a prompt and to ensure completeness, a checklist of risk categories has been developed around the acronym PERFORMANCE:

Political	**O**pportunities/Outcomes	**N**ew partnerships/projects/contracts
Economic	**R**eputation	**C**ustomers/Citizens
Regulatory	**M**anagement	**E**nvironment
Financial	**A**ssets	

Describing the risk is equally important to ensure that risks are fully understood and to assist with the identification of actions, the cause and effect of each risk must also be detailed. Once identified, all risks are recorded in a risk register.

A risk owner must be allocated and recorded against each risk on the risk register. Such accountability helps to ensure ownership of the risk is documented and recognised. A risk owner is defined as a person with the accountability and authority to effectively manage the risk. At this stage there may well be a long list of possible risks. The next step will help to prioritise these in order of importance.

Assess Gross (Inherent) Risk Level

To ensure resources are focused on the most significant risks, the council's approach to risk management is to assess the risks identified in terms of both the potential likelihood and impact so that actions can be prioritised.

The risk management process requires each risk to be assessed twice – gross (or inherent) and net (or residual) risk levels. The first assessment (the 'gross' risk level) is taken on the basis that there is no action being taken to manage the identified risk and/or any existing actions are not operating effectively. In other words, the worst-case scenario if the risk were to occur.

To ensure that a consistent scoring mechanism is in place across the Council, risks are assessed using the agreed criteria for likelihood and impact via reference to the risk matrix shown below. The matrix uses a "traffic light" approach to show high (red), medium (amber) and low (yellow/green) risks.

Risk Scorecard – Residual Risks						
		Likelihood				
		1 – Very rare	2 - Unlikely	3 - Possible	4 - Likely	5 – Very likely
Impact	5 – Very high					
	4 - High					
	3 - Medium					
	2 - Low					
	1 - Negligible					

Diagram 3: Risk Matrix

Where probability and impact meet this determines the risk level. For example, possible probability (3) and major impact (4) would result in a risk level of 12.

Identify Existing Controls

Existing controls, which are helping to minimise the likelihood and/or impact of the risk occurring, are identified for each risk. These controls are specifically those in place or completed and should not include planned or aspirational actions.

Assess Net (Residual) Risk Level

The second assessment (the net risk level) re-evaluates the risk, taking into consideration the effectiveness of the identified existing actions and controls. In other words, the reality if the risk were to occur in the immediate future.

Net risks are prioritised by applying the same criteria and matrix used for assessing the gross risk level. It is the risk owner's responsibility to ensure that the agreed net risk level for each risk is an accurate reflection of the likelihood and impact measures detailed in Appendix 2.

The council considers the net risk to ensure that:

- Identified risks are prioritised in terms of their significance as it is not practical or possible to manage every risk all the time; and
- Existing actions are relevant and effectively managing and/or reducing the likelihood or impact of the identified risks.

Risk Response and Further Actions

Not all risks can be managed all the time, so having assessed and prioritised the identified risks, cost effective action needs to be taken to manage those that pose the most significant threat. Based on risk scores there are four response actions:

- **Terminate** – In this situation the risk is avoided by deciding not to proceed with an activity.
- **Tolerate** – in this case, it may not always be necessary (or appropriate) to take action to treat risks.
- **Transfer** – another party bears or shares all or part of the risk.
- **Treat** – this involves identifying mitigating actions or controls to reduce risk.

The response is recorded on the risk register for each risk item.

Risk Appetite

The amount of risk at the strategic and corporate level that the Council and its leadership team are willing to take on, accept, tolerate or be exposed to in the pursuit of its business objectives, is generally referred to as its risk appetite.

Risk Appetite is not static and can be adjusted by the Cabinet with supporting advice from the Executive Leadership Team.

Importantly, in deciding the risk appetite and delegated risk appetite, Cabinet considers:

- Environmental and wider macro-economic factors, including central government legislation and any required reductions in spending and other efficiencies in services
- The amount of risk that is acceptable (what risk could be justified if it actually happened)
- The Council's funding levels and its overall capacity to bear risk.
- The areas/directorates within the Council that have an expertise and skill set for taking risk
- The extent and prevalence of operational and commercial opportunities capable of being exploited by the council

The Council's approach to risk appetite will evolve over the next few years as the risk management within the organisation is embedded and matures. Interviews and discussion throughout 2024/25 at corporate level will enable the risk appetite to be assessed and developed using a risk statement for each Directorate.

The risk statement has been designed to cover strategy, financial & value for money, operational service delivery & policy delivery, legal & regulatory and reputation & credibility. Risk appetite ratings are based on the following levels of risk appetite: averse, minimalist, cautious, open and seeking/hungry.

The risk appetite for each risk is also recorded on the risk register to give an indication of the overall appetite of risk owners. The categories are:

- Averse
- Minimalist
- Cautious
- Open
- Seeking

Risk Mitigation

These are controls and actions put in place to reduce the likelihood of the risk occurring or minimising the impact if it does. An internal control system incorporating policies, processes, business continuity arrangements and other aspects of operations should:

- enable the Council to respond appropriately to business risks;
- help ensure the quality of internal and external reporting. This requires the maintenance of proper records and processes that generate the flow of timely, relevant and reliable information; and
- help ensure compliance with applicable laws and regulations and also with internal policies.

Mitigating controls are recorded in the risk register as SMART actions which define the detail of the controls either in place or to be implemented and will include action plans for any risks that fall in to the 'red' area.

The residual risk that remains is the net risk, it is also good practice to define "target risk" which indicates the tolerable level of risk that the Council should aim for.

Review and Report

Risk management should be thought of as an ongoing process and as such risks need to be reviewed regularly to ensure that prompt and appropriate action is taken to reduce their likelihood and/or impact. WNC's approach is one where such reviews are:

- where possible, part of existing performance monitoring timetables; or
- focus on those risks that, because of their likelihood and impact, make them priorities.

Regular reporting enables senior managers and members to be more fully aware of the extent of the risks and progression being made to manage them.

Risk registers are currently created and maintained on standard spreadsheets but will eventually be held on dedicated software once the risk management process is in place. This enables the council to create a corporate risk profile, linked to its objectives, to record and manage risks in a consistent way, monitor and review risks and produce meaningful management reports.

The Strategic Risk Register is reviewed on a quarterly basis and overseen by the Executive Leadership Team (ELT). There is also a quarterly review of the strategic register by the Executive programme Board (EPB) which is made up of Cabinet Members and Officers of the Council with the option for the Head of Internal Audit and Risk Management to attend if there is significant risk escalation.

Risk escalation

It is the responsibility of individual risk owners to raise risks which they believe require action by a higher authority. It should be emphasised though that we want to discourage people from escalating risks that they should be dealing with themselves. High risk issues should be escalated through the hierarchy that makes up the risk universe so that they are captured in the appropriate register for information purposes. However, responsibility for addressing the risk may still remain with the originator. Regular reviews will take place of directorate and service risk registers once they have been developed by the risk team for identification of risks that should be escalated to a corporate level. Should a risk present itself that requires urgent management attention the S151 Officer and Monitoring Officer should be informed who will evaluate the risk and forward to the Executive Leadership Team for inclusion in the corporate risk register.

Risks should feature as a standard agenda item at management team meetings. Discussions on risk should include:

- new or emerging issues and risks;
- evaluation and criticality of new or emerging issues and risks;
- decisions required and by whom;
- mitigating actions, action owners, timescales and review points;
- ownerships of new risks;
- the review of existing risks and the effectiveness of the current controls in place.

8. Monitoring and reporting arrangements

Monitoring risks

Risk management needs to be embedded in everyday activity. It is the responsibility, therefore, of each risk owner to review risks on a regular basis and identify whether any revisions are required. The revision may involve a re-assessment of impact and likelihood or planned mitigating actions.

As previously stated, it is important that risk is included as a standing item on the agenda for management teams (at all levels within the organisation) and working groups so that risks can be identified and captured. Initially, on a monthly basis during the management team meetings, each Director will seek assurance that the risks in their assigned areas are being adequately monitored and action is being completed as agreed in formal action plans.

The Strategic Risk Register will be included in a Corporate Governance/Health Report that will be presented to the ELT & Assistant Directors (AD's) meeting on a quarterly basis. The purpose will be to discuss the current risks and to identify any 'new' or emerging risks that may need to be escalated to the Strategic Risk Register.

The Strategic Risk Register is a dynamic document and will be updated to reflect any changes, any risks that are no longer seen as strategic will be removed but not deleted should the risk resurface at a later date.

Monitoring Process for risks

Previously the Corporate Risk Register was issued to senior management for review and updates on their risks on a quarterly basis. The revised process will see the following review and updates based on the residual scores:

Red risk	Review and update on a monthly basis
Amber risk	Review and update on a quarterly basis
Green risk	Review and update on a 6 monthly basis

Reporting and assurance arrangements

WNC's risk management framework will be supported through agreed reporting and assurance arrangements. This is to ensure that the key risks and their owners are clearly identified that mitigation and specified actions are appropriate and that actions are being carried out. The arrangements include:

Corporate level

The Executive Leadership Team will review and approve risk management policies and strategies and will consult with the Audit and Governance Committee on these matters.

On a routine basis the Audit and Governance Committee will receive updates on WNC's risk management framework and risks. Reporting will include:

- the Corporate Risk Register including associated action plans for the higher rated risks; and

- reports on the changing risk profile within WNC including areas of increasing risk, where controls are not considered to be effective and horizon scanning for areas of possible future risk.

Directorate/service level

Each Director will review risks and actions in mitigation of risk on a regular basis as an integral part of the business planning process. These officers will also ensure that risks identified at a service level and which may have a wider impact on the organisation are escalated through to the Executive Leadership Team through the CRMG. The following should be considered:

- the status of all high risks (including actions taken)
- any new risks
- changed risks (especially where risk is increasing)
- risks escalated
- risks removed from registers.

Programme level

Programme and project management is very much about managing uncertainties. Poor risk management is a key element as to why many projects often fail. Risk taking in projects is inevitable since projects are enablers of change and change introduces uncertainty, hence risk.

Throughout the life of the programme or project there will be risks that need to be managed; to reduce the probability and impact of unwanted outcomes such as project time and cost overruns. To manage the risks the Project Manager will maintain a project risk register on behalf of the project.

Managing risks within a programme or a project will ensure that responsibilities are clear to:

- Implement appropriate measures and controls to manage risks during the life of the project
- Review the risks on a regular basis
- Identify and assess the impact of risks and their influence on the project schedule and other important project variables such as cost and quality
- Have appropriate contingency plans in place to remove or limit the risk (these can be either controls (already in place) or actions (yet to be undertaken but planned)

Where suppliers/and or partners are involved in the project, it is essential that there is a shared understanding of risk. There may need to be contingency plans and risk allowances (funding and time identified to manage such risks) allocated to allow for the possibility of (for example) delays or failure for a service to be taken up.

At a project level, a risk register is a key tool for managing risk, which must be reviewed and updated continually throughout the life of the project.

Within a programme or project, responsibility and ownership for managing risks must be assigned to individuals with the authority to take appropriate action on risk.

Performance management

The effectiveness of the risk management function is reviewed on an on-going basis by the Executive Leadership Team and its effectiveness is appraised and evaluated by the Audit and Governance Committee, who also monitor and challenge activities and progress. The risk management function is also audited against public sector best practice by both internal and external audit.

In addition, specific core risk-related/risk-driven support service activities, such as performance management, health and safety, insurance, emergency and business continuity planning and programme and project management all contribute to the overall corporate risk management process.

Review and control

This strategy and policy will be subject to regular review (at least annually) by the S151 Officer and the Executive Leadership Team with any changes reflected in related guidance, training and tools as appropriate.

Annex A & B are on the following pages.

Annex A Summary Overview of Risk Management Responsibilities

Risk Strategy Activity / Council Group/ Team/Officer or Commercial Partner	Develop the Risk Management Strategy	Agree the Risk Management Strategy	Provide Advice and Support on the Strategy	Implement the Strategy	Share experience of risk management issues	Review the effectiveness of the Strategy
Cabinet		●				●
Audit and Governance Committee			●		●	●
Executive Leadership Team	●			●	●	●
Directors	●			●	●	●
Section 151 Officer	●		●	●	●	
Monitoring Officer	●		●	●	●	
Major Programme & Project Boards				●	●	
WNC Trading Companies				●	●	
Commercial Partners/Joint Ventures					●	
Public Sector Partnerships					●	
Large WNC Procurement Contracts				●	●	
Shared Services (WNC Service-Lead)				●	●	
Shared Services (WNC Non-Leading)					●	
Departmental management teams			●	●	●	●
Council Committees/Boards/Groups				●	●	
Service Managers			●	●	●	●
Internal Audit	●		●	●	●	●
External Audit						●
Council Staff				●	●	
Northampton Residents					●	

(Source of Model – CIPFA; Risk Management in the Public Services)

Annex B Detailed Risk Management Responsibilities

Position	Role /Responsibilities
Cabinet	• Annually approve the Council's Risk Management Strategy & Framework • Provide leadership on risk management in the organisation • Consider the strategic risks associated with the decisions taken. • Monitor the Council's risk management arrangements, including via the Council's strategic performance and audit reports. • Assess risks in Cabinet reports and provide challenge, where necessary and identify risks associated with Cabinet decisions
Executive Leadership Team	• To lead risk management by example • To develop, implement and review the Council's Risk Management Strategy & Policy • To champion the effective application of risk management processes and principles across the Council's business systems • Seek assurance at least annually that all risks comprising barriers to achievement of the Council's corporate objectives have been identified and accurately assessed and are being managed • To review and update the corporate risk register and ensure mitigating actions are completed • Seek assurance at least annually that all directorates and major programmes and projects are appropriately complying with the Council's risk management policies and framework
Directorate Management Teams, or Equivalent	• Collectively support and contribute to their corporate discharge of their risk management responsibilities • Make arrangements for continuing to embed risk management and a risk aware culture throughout their respective directorates • Ensure risk is regularly reported (at least quarterly) to their Director • Maintain and review directorate rate risk register(s) on a quarterly basis
Service Managers	• Accept responsibility for managing risk as a core managerial competency • Manage the risks associated with their area, including those crossing area boundaries within their Directorate and their delegated budget allocation and service plan responsibilities • Ensure there is effective risk management within their service area • Ensure a risk register is in place for any business or major programme or project related risks and the risk registers are reviewed at least quarterly • Compliance with risk policies and ensure staff are trained in risk Management • Encourage staff to raise risks and send a message to staff that escalated risks will be evaluated and acted upon if necessary • Promptly advise senior managers of significant identified risks

Annex B: Detailed Risk Management Responsibilities

Position	Role / Responsibilities
Department management teams	• Review and discuss risk exception reporting • Discuss and review Directorate risk register(s), as necessary • Where appropriate, escalate risks for discussion and consideration by Management Board or the Borough Secretary for inclusion on the corporate risk register.
Programme and Project Boards	• Review and update risk registers/action plans for programme and project level risks • Report risks to the Programme/ or Project Board • Escalate any risks that exceed risk appetite to the next level or to the Borough Secretary for inclusion in the corporate risk register • Provide a copy of the updated risk register/action plan to the Borough Secretary
Other Council Boards, Panels, Steering Groups & Committees	• Produce a written Terms of Reference which requires risks to achieving Board/Committee/Panel/Group objectives, or opportunities to accelerating or enhancing achievement, to be identified, assessed, managed and reported by the Board/Committee/Panel/Group
Audit Committee	• Promote, support and co-ordinate risk management at Member level ensuring a positive and cogent attitude toward the understanding and treatment of risk at the Council • Monitor, advise and review at least annually the effectiveness of the Council's overall risk management framework and arrangements prior to submission to Cabinet and review the Council's key risks to ensure these are being adequately managed • To hold the Management Board accountable for effective risk management across the Council
Public Sector Partners	• Ensure that appropriate arrangements are in place to manage partnership related risks including risk escalation procedures • Actively manage risks within the partnership participating in the regular update and maintenance of a joint partnership risk register. • Report on risk management issues to the respective partnership board. • Show a clear link between objectives and outcomes that is customer focused • Escalate risks for inclusion on the service or corporate risk register
Commercial & Private Sector Partners	• Ensure that appropriate arrangements are in place to manage commercial partnership related risks including risk escalation procedures to relevant Board and/or DMT/Management Board • Actively manage risks within the commercial partnership and participating in the regular update and maintenance of a joint commercial partnership risk register. • Report on risk management issues to the respective partnership board. • Show a clear link between objectives and outcomes that is customer focused

Annex B: Detailed Risk Management Responsibilities

Position	Roles/Responsibilities
Council Commercial Trading Companies and/or LLP Partnerships	• Develop, implement and review the trading company's or partnership's risk management strategy • Seek assurance at least annually that all risks comprising barriers to the achievement of the strategic objectives of the company or LLP Partnership have been identified and accurately assessed and are being managed • Seek assurance at least annually that all divisions and departments within the company or LLP Partnership are appropriately complying with the company or partnership's risk management policies and framework • Ensure adequate risk escalation procedures are in place for the trading company or LLP Partnership • Escalate and report risks, as appropriate, quarterly for consideration and action by Management Board and the Borough Secretary
Shared Services (WNC Non-Lead)	• Ensure that appropriate arrangements are in place to manage and escalate shared services related risks. • Actively manage risks within the shared-service arrangements participating in the regular update and maintenance of a shared-services risk register. • Report on risk management issues to the Lead-Authority. • Show a clear link between objectives and outcomes that is customer focused
Internal Audit	• Independently evaluate the effectiveness of the Council's risk management arrangements and where appropriate make recommendations for improvement
Monitoring Officer	• Where it appears to the Monitoring Officer that a proposal under this framework gives rise to a contravention of law or maladministration to alert the Council to this
All Council Officers	• To use risk management as a tool to support decision-making • Raise/escalate any concerns or risks identified or considered within their working environment that are not being sufficiently addressed or directly to the appropriate council manager • Maintain vigilance and a risk-aware attitude of mind at all time

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APPENDIX B: STRATEGIC RISK REGISTER

			Inherent risk								Current risk				
No	**Risk Description**	**Risk Owner**	**Impact**	**Likelihood**	**Inherent Risk Rating**	**Response**	**Risk Appetite**	**Mitigating Actions (These must be SMART actions with implementation dates) (Key Controls)**	**Monitoring frequency**	**Monitoring forum e.g. ELT, DMT etc.**	**Impact**	**Likelihood**	**Residual Risk Rating**	**Target Risk Rating**	**Cabinet Portfolio**
SR01	**Data Management including Cyber Security:** Insufficient security or recovery plans for data held and IT systems used by the council resulting in a risk of: data breach, loss of service, malicious attacks or inability to deliver services due to loss of systems and data.	Chief Information Officer	5 - Very high	4 - Likely	**20**	**Treat**	**Minimalist**	Our Cyber Action Plan tackles the four major objectives defined by the Cyber Assessment Framework produced by the National Cyber Security Centre: A - Managing security risk B - Protecting against cyber attack C - Detecting cyber security events D - Minimising the impact of incidents The plan includes various milestones through to June 2024 which progressively tackle these objectives and decrease risk	Quarterly	DTI Strategy Board	4 - High	3 - Possible	**12**	**6**	HR & Corporate Services
SR02	**NPH Residential - Change in Regulations:** Recent change in regulations to have more emphasis on WNC managing the deliverables of NPH. Reputational, financial, H&S and legal risks of non-compliance.	Director Communities & Opportunities	4 - High	3 - Possible	**12**	**Treat**	**Minimalist**	Completion of DHLUC registration of properties - mid sept 2023 - completed Incorporate building standards monitoring, as per new regulation in regular monitoring process at appropriate NPH forums . Work with NPH to ensure capital programme reflects the priorities outlined in the building condition surveys to achieve all minimum standards.	Monthly	WNC /NPH - Place , People & Finance Forums.	3 - Medium	3 - Possible	**9**	**9**	Housing, Culture & Leisure
SR03	**Cost of living impact - increased demand for services:** Lack of resources and systems in place locally to cope with additional demand on core services. Significant increase in self neglect being encountered.	Executive Director of People	4 - High	4 - Likely	**16**	**Treat**	**Minimalist**	Household support fund distribution was prioritised to areas assessed of greatest need but is now expected to cease from March 2024. Migiations to implement will focus on communication and engagement with parents and schools with the main risk area being the end of support for children on free school meals during the holidays.	Monthly	People SLT	4 - High	4 - Likely	**16**	**12**	Adult Care, Wellbeing & Health Integration
SR04	**Availability of affordable rental accommodation:** Lack of supply of appropriate local affordable housing.	Director of Communities and Opportunities	4 - High	5 - Very likely	**20**	**Treat**	**Open**	1. Develop clear strategic plan re housing needs and development 2. Review of preventative actions to confirm effectiveness of existing measures and develop new . 3. review of temp accomm residents to ascertain move on plans and incentivise to move into PRS 4. Review of existing nightly paid accomm to determine best value (All from July 2023). Weekly performance stand up to measure real time effectiveness 5. New DPS proposal to Cabinet October 2023 for implementation 2024.	Monthly	WNC /NPH - Place , People & Finance Forums.	3 - Medium	3 - Possible	**9**	**9**	Housing, Culture & Leisure
SR05	**Health and Safety of WNC properties:**	Executive Director of Corporate Services and Executive Director Place	4 - High	4 - Likely	**16**	**Treat**	**Open**	1. New system being implemented for Property management - will provide wider assurance and better governance of all properties 2. New system being procured for H and S and linkages to property 3. H and S overarching strategy being developed 4. H and S audit recommendations being implemented 5. Working group across directorates to pick up key actions 6. Reminder comms given to all ADs.	Monthly	SLT/ELT	4 - High	3 - Possible	**12**	**9**	HR & Corporate Services
SR06	**Inability to recruit and therefore deliver:** Workforce skills and capacity – Inability to attract or retain staff with the right skills, experience and knowledge. Succession planning and over reliance on key individuals, retention.	Assistant Director HR	4 - High	4 - Likely	**16**	**Treat**	**Open**	Our People strategy delivery (Yr 2) is underway with a series of projects designed to ensure we are an employer of choice and can attract and retain staff with the right knowledge, skills and experience. Key activity pertinent to this risk includes: I) Implementation of new pay and grading structure and investment in annual pay awards to ensure we offer market rate salaries for the majority of roles with ability to flex via market factor supplements. ii) Employer brand implementation underway supported by fully staffed resourcing team, robust applicant tracking system and use of a variety of different media in order to increase our brand reach, target particular groups and head hunt as required. iii) Monitoring of exit interviews and glassdoor/indeed ratings and taking corrective action as necessary and contract in place to utilise agency workers as required. iv) Apprenticeship strategy in place, review of learning and development offer underway and formation of our internal mobility strategy planned for Aut 2023.	Quarterly	ELT and Transformation Board	3 - Medium	3 - Possible	**9**	**8**	HR & Corporate Services
SR07	**Risk of significant change in policy direction:** Outcome of the next general and local elections and the potential impact of political change on service delivery through government instability and changes in law/regulations/policy/funding.	Chief Executive	4 - High	4 - Likely	**16**	**Treat**	**Open**	Continue to engage with all political groups at West Northamptonshire Council to maintain awareness of key issues and ensure members are fully briefed. Facilitate cross party working on priority initiatives e.g. Sustainability and anti poverty to ensure buy in from all groups. As an active member of the Local Government Association continue to engage with national lobbying initiatives by the local government community.	Monthly	ELT	3 - Medium	4 - Likely	**12**	**12**	Strategy (Leader)

No	Risk Description	Risk Owner	Impact	Likelihood	Inherent Risk Rating	Response	Risk Appetite	Mitigating Actions (These must be SMART actions with implementation dates) (Key Controls)	Monitoring frequency	Monitoring forum e.g. ELT, DMT etc.	Impact	Likelihood	Residual Risk Rating	Target Risk Rating	Cabinet Portfolio
SR08	**Inter authority agreements:** The lack of legally constituted arrangements and consensus for the inter-authority agreements means the Council's financial situation is uncertain and an inability to finalise accounts and balanced budgets	Director of Legal and Democratic Services	4 - High	5 - Very likely	**20**	**Treat**	**Minimalist**	46 Finance schedules should be in place to determine a clear basis for claiming against NNC. Un-executed agreements as to how the authorities charge each other have been agreed and are in place for 22/23. There is a need for agreements to be prepared and agreed for 23/24 onwards which are in the process of being developed. The agreements should include: 1. Finance Schedules (Schedule 3s) 2. Service Schedules for the services in the agreement (Schedule 2s) - so we can hold the North to account for delivery. 3. Exit plans for those services going through disaggregation so that disaggregation doesn't leave us with stranded costs etc.	Monthly	STORM, IAA Group	4 - High	4 - Likely	**16**	**8**	Finance
SR09	**NCT - relationships management (WNC / NNC / NCT)** Complexity of management relationship impacts on the services provided	Director of Children's Services	4 - High	4 - Likely	**16**	**Tolerate**	**Seeking**	1 Continue to reset relationships, we have some challenging times ahead linked to finances, but we need to continue to work open and transparently with NCT /NNC. (contract sum agreed - review March24) 2 Consider remodelling current meetings to ensure the right conversations are taking place, and not duplicating. This may help reset relationships and linked to the new T&E Baord this has taken place but will be reviewed in 6 months June 24 to ensure working effectivlely) 3. Review of the ICF is underway to reset the work this does on both Councils behalf (March 24)	Monthly	Operation Group / Strategic Group	2 - Low	3 - Possible	**6**	**4**	Children, Families & Edcuation
SR10	**NCT - Financial pressures:** There is a risk that the finances are not controlled by the Trust leading to continued poor ratings, intervention and additional cost to the Council who remain statutorily responsible despite having no delivery responsibility	Director of Children's Services	5 - Very high	5 - Very likely	**25**	**Treat**	**Open**	1. Contract Sum Workshops completed - review again in March 24 2. Understand NCTs Forecasting Methodology - informal step in and work undertaken with the Trust has given more assurance - review again in March 24 3. Continue to hold NCT to account around spend and understanding spending control - regular reviews through contract meetings	Monthly	Contract Sum / Joint Officer Board	5 - Very high	4 - Likely	**20**	**9**	Children, Families & Edcuation
SR11	**Strategic communications and reputational risk:** Historic issues relating to legacy councils are not managed or communicated in a timely and effective manner.	Assistant Chief Executive	4 - High	4 - Likely	**16**	**Treat**	**Cautious**	Communications and engagement business partners to continue to work closely with portfolio holders and DMTs to ensure any communications issues are proactively identified and managed to maintain the council's reputation.	Monthly	SLT/ELT	3 - Medium	3 - Possible	**9**	**9**	Strategy (Leader)
SR12	**RAAC (Reinforced Aerated Autoclaved Concrete) -** Concerns re the safety of School (any WNC Buildings) built between 1950 and 1990 and which are of a flat roof construction - this is a national issue which could result in school closures or partial closure and could result in children NOT having a school place and missing out on education (including children with EHCPs who have named educational within their plan). Significant impact on children's education if schools closed, safeguarding and reputational risk.	Director of Children's Services	5 - Very high	5 - Very likely	**25**	**Treat**	**Open**	All local authority schools have been inspected following government guidance with the result that only one LA maintained school has been found to have limited RAAC in part of the roof with minimal educational impact. A further Trust School NIA (not the responsibility of WNC) has also been found to have more significant issues and will require more assistance and support in regard to maintaining the educational support and possible relation of some of the children. Each school has now been appointed a DFE project manager and these will continue to work with the council to progressing the mitigations. Education to continue to maintain a dialogue with DFE in regard to support required. Education to maintain a dialogue with assets to ensure rapid deployment of required infrastructure of temporary buildings is provided. December 23 - no further school identifed, those identifed (2) have plans in place and children remain in education	Monthly	SLT/ELT	3 - Medium	3 - Possible	**9**	**1**	Children, Families & Edcuation
SR13	**Cladding** Participation in a HE pilot project has identified 8 buildings across WNC , managed by NPH, that do not meet the new fire safety standards applied to external cladding. Therefore a new FRAEW needs to be undertaken and all process reviewed regarding the access into and out of the buildings .	Director for Communities and Opportunities	5 - Very high	3 - Possible	**15**	**Treat**	**Minimalist**	All buildings have access to open to air corridors - all cladding in those corridors is being removed between end of October to end of December. Whilst work is being undertaken the residents have been informed that in the case of fire a " evacuation" process will be in place. A 24 hr waking watch is in place for the buildings whilst the work is being undertaken . As the cladding in the corridors is removed and the risk substantially reduced, the waking watch ends and the building reverts to an "In case of fire stay put" policy . 162 vulnerable tenants have been identified to be communicated with seprately for extra support in case of fire. NPH bus is on sight with dtaff to reassura staff around new processes. All residents have received a letter	Monthly	ELT/ NPH Board	3 - Medium	3 - Possible	**9**	**1**	Housing, Culture & Leisure
SR14	**Financial Sustainability** Increasing demand for services, increasing cost of services and uncertainty relating to local governement funding is a continuing risk to the Council which needs to be closely and carefully monitored	Executive Director - Finance	5 - Very high	4 - Likely	**20**	**Treat**	**Open**	Pro-active approach to budget management, monitoring and setting Regular updates on Finance to ELT each week Professionally qualified and competent finance staff Business partnering model aligned and working closely with services Cohesive senior management team that works well together and pulls in the same direction Linked into wider professional finance networks to receive early intelligence on emerging issues Professional advisors commissioned to provide specialist advice in areas such as tax planning and treasury management	Monthly	ELT/Cabinet	5 - Very high	2 - Unlikely	**10**	**10**	Finance

No	Risk Description	Risk Owner	Impact	Likelihood	Inherent Risk Rating	Response	Risk Appetite	Mitigating Actions (These must be SMART actions with implementation dates) (Key Controls)	Monitoring frequency	Monitoring forum e.g. ELT, DMT etc.	Impact	Likelihood	Residual Risk Rating	Target Risk Rating	Cabinet Portfolio
SR15	**Disaggregation and other disputes** There are several areas with a potential financial impact currently in dispute. The most significant one is agreeing how some of the closing balances of the County Council will be split between West and North Northants.	Executive Director - Finance	4 - High	5 - Very likely	20	Treat	Open	Discussions have taken place with North Northants but we cannot reach an acceptable agreement and we are therefore progressing formal dispute resolution mechanisms to seek to progress in as timely a fashion as possible.	Monthly	ELT	4 - High	3 - Possible	12	8	Finance

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Grant Thornton

West Northamptonshire Council Update Report

Year ending 31 March 2022

West Northamptonshire Council

January 2024

Contents

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The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you as part of our audit planning process. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Council or all weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Audit Progress

2021/22 Financial Statements Audit

Our audit planning has been delayed as the Council has needed to focus on the completion of the legacy council audits. The delay in completing the legacy council audits has also had an impact on the Council's ability to prepare financial statements for 2021/22. We have not therefore undertaken any financial statements work.

Planning work to date

We have been able to partially complete our planning work including:

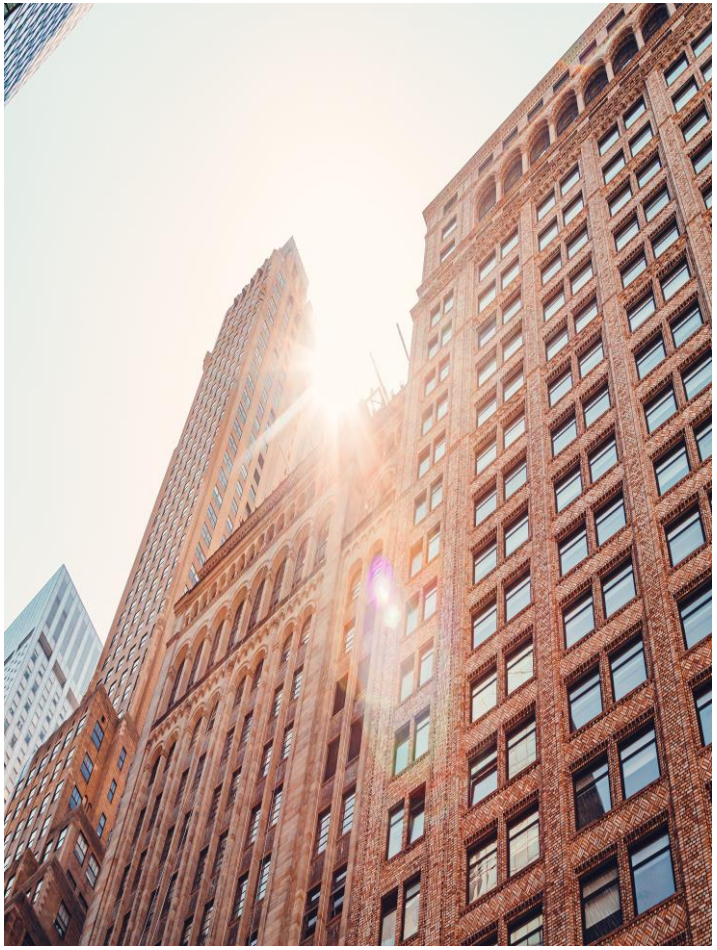
- Preliminary going concern assessment
- Review of the journal control environment
- Review of the IT environment
- Gained an understanding of some business processes for significant transactions in the financial statements.

Our work in these areas identified issues in relation to the IT and the journal control environments. Our findings in relation to the IT environment are documented on page 10.

In our review of the journal control environment we identified that within the ERP financial ledger 62 users have been granted the auto-approval rights when posting journals. We would not expect any user to have the ability to approve their owns journals.

We have not commenced our planning for the 2022/23 audit (for the reasons set out above).

We do not plan to undertaken any further work for 2021/22 and 2022/23. We discuss this as part of the section on the Government backstop arrangements on the next page.



Audit Progress

Backstop

As reported at the previous Audit & Governance Committee meeting to address the current backlog of Local Government audits the Government is implementing a backstop. It was previously communicated to us that the Backstop date would be 31 March 2024. The Government has revised its plans and has begun consultation on a 30 September backstop date.

The Backstop will require auditors to issue a disclaimed opinion on all audits up to and including 2022/23 that have not been signed off by this date.

Due to delays in the completion of the legacy council audits and preparation of the Council's 2021/22 financial statements we will not be able to complete the audit of 2021/22 & 2022/23 before 30 September and therefore we intend to issue a disclaimer opinion for both of these years. We will not therefore undertake any further work on the 2021/22 or 2022/23 audits

2023/24 Workplan

We have commenced our planning work for the 2023/24 audit and are planning to commence our audit of the draft accounts in July 2024 on receipt of the draft financial statements. We will bring our audit plan to the next Audit Committee.

If the 2022/23 opinion audit is disclaimed it is likely that we will have to undertake additional work on the opening balances for 2023/24. We are working closely with the NAO and CIPFA to determine the scope of this work and will report back on the time and extent of the work once confirmed.

Our work plan for 2023/24 will include, amongst other matters, an assessment of the Council's: control environment, going concern, journal control environment, IT environment, business processes, and group. We will also need to consider data migration, consolidation of systems, and opening balance transfer.

As part of our work we will also consider key metrics such as aged debtor and creditor analysis, bad debt provisions and credit loss allowances, control of POs and GRNI, suspense accounts and bank reconciliations, and collection rates.

Audit Progress

Disaggregation

The Council is currently working with North Northamptonshire Council to disaggregate the closing balances of Northamptonshire County Council at 31 March 2021. Although the Councils have been able to agree a significant proportion of these balances there are a small number of areas where there is disagreement on how the balances should be split. For these areas the Councils are currently seeking arbitration to determine the disaggregation.

We have held discussions with the Council over the disaggregation and in particular reviewed the work around the split of the Capital Financing Requirement (CFR). We cannot complete our work on opening balances until the disaggregation has been completed.

It is nearly three years since the Council was established. We remain concerned that the disaggregation process has not yet been completed. We will report this matter as a significant weakness in our Value for Money assessment of the Council for 2022/23 and will consider whether the use of our wider powers is appropriate if the matter is not brought to a timely conclusion.

Audit Planning

We set out below details of the work we have undertaken as part of our audit planning.

Journals Control Environment

During the year the Council operated 4 general ledger systems. This is because during 2021/22 the GL for each of the 3 legacy Councils are used for recording income at the 3 Councils (Collection Fund) and Housing Benefit Payments. The transactions recorded on these 3 legacy Councils GLs are then mapped into the central Country ERP Gold GL so that all transactions are eventually recorded on one ledger.

As a result we have had to review the journal control environment in operation for each of these general ledgers. Our findings are detailed below:-

- On the West Northamptonshire ledger we found that it is possible for Senior Financial Reporting personnel to post journals. It is also possible for 62 users to auto-approve their own journals, this includes 6 members of the Systems Business Team (system administrators).

- For the Northampton Borough Council legacy ledger we found that system administrators had posted journals in-year.

- For the South Northamptonshire Council legacy ledger we have that all finance staff can post and approve their own journals, with no subsequent check performed to ensure postings are accurate.

- For the Daventry District Council legacy ledger we found that the system administrators can also post journals.

Systems

We have documented our understanding of the business processes that related to classes of transactions that are significant to the financial statements. This included the following areas

- Fees & Charges / Debtors	- Grant Income	- Payroll
- Operating Expenditure / Creditors	- Housing Benefit Expenditure	- PFI
- Property, Plant & Equipment	- Pensions	- Cash
- Investments	- Borrowing	- Provisions

Our work in these areas to date has not identified any issues around segregation of duties. We did, however, note that the Council is currently operating 4 fixed asset registers which (WNC / legacy County Council and 1 FAR for each of the legacy District Councils).

Significant risks identified

Based on the planning work we have completed to date we have identified the following significant risks.

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

Risk	Reason for risk identification
Fraudulent revenue recognition (rebutted)	Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. This presumption can be rebutted if the auditor concludes that there is no risk of material misstatement due to fraud relating to revenue recognition. Having considered the risk factors set out in ISA240 and the nature of the revenue streams at the Council, we have determined that the risk of fraud arising from revenue recognition can be rebutted except for General Sales Income and Fine and Penalty Income, because: • there is little incentive to manipulate revenue recognition • opportunities to manipulate revenue recognition are limited • the culture and ethical frameworks of local authorities, including West Northamptonshire Council, mean that all forms of fraud are seen as unacceptable.
Fraudulent expenditure recognition (not applicable)	Whilst not a presumed significant risk, Practice Note 10 states that as most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure may be greater than the risk of material misstatements due to fraud related to revenue recognition. Having considered the risk factors set out in Practice Note 10 and the nature of the expenditure at the Council, we have determined that there is not a significant risk of misstatement arising from fraud in expenditure recognition, for the same reasons as set out above.

'Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, due to either size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty.' (ISA (UK) 315)

Significant risks identified

Risk	Reason for risk identification
Management over-ride of controls	Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Council faces external scrutiny of its spending and this could potentially place management under undue pressure in terms of how they report performance. We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk, which was one of the most significant assessed risks of material misstatement.
Opening Balances	The Council's opening balances are made up of the closing balances of Daventry District Council, Northampton Borough Council and South Northamptonshire Council at the 31 March 2021, in addition to a share of Northamptonshire County Council's closing balances. The Council is currently working with North Northamptonshire Council to disaggregate the closing balances of Northamptonshire County Council at 31 March 2021. Although the Councils have been able to agree a significant proportion of these balances there are a small number of areas where there is disagreement on how the balances should be split. For these areas the Councils are currently seeking arbitration to determine the disaggregation. Given the complexity of this area and the amount of progress made to date we have identified opening balances, as a significant risk, which was one of the most significant assessed risks of material misstatement.
Group Consolidation	The Council has inherited a number of interests in companies from the legacy Councils. The most significant of these as The Children's Trust and Northampton Partnership Homes. As a result the Council will need to prepare Group Accounts for the first time in their 2021/22 financial statements. We are still awaiting an assessment of which Companies will need to be consolidated into the Council's financial statement. Given the complexity of this area and the amount of progress made to date we have identified the preparation of Group Accounts, as a significant risk, which was one of the most significant assessed risks of material misstatement.

Significant risks identified

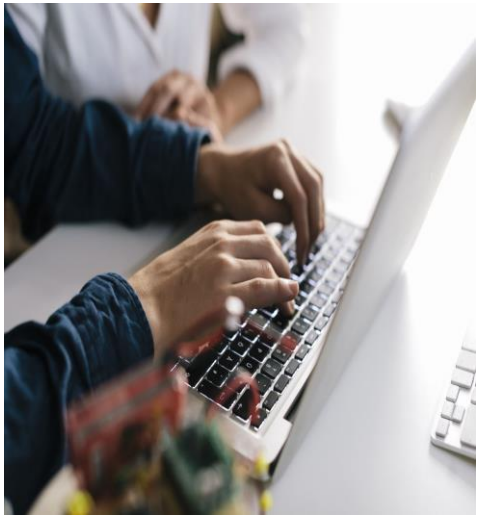
Risk	Reason for risk identification
Valuation of land and buildings (inc Council Dwellings)	These valuations represent a significant estimate by management in the financial statements due to the size of the numbers involved and the sensitivity of this estimate to changes in key assumptions. Additionally, management will need to ensure the carrying value in the Council's financial statements is not materially different from the current value or the fair value (for surplus assets) at the financial statements date, where a rolling programme is used. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement.
Valuation of the pension fund net liability	The Council's pension fund net liability, as reflected in its balance sheet as the net defined benefit liability, represents a significant estimate in the financial statements. The pension fund net liability is considered a significant estimate due to the size of the numbers involved and the sensitivity of the estimate to changes in key assumptions. We therefore identified valuation of the Council's pension fund net liability as a significant risk, which was one of the most significant assessed risks of material misstatement.

Management should expect engagement teams to challenge management in areas that are complex, significant or highly judgmental which may be the case for accounting estimates and similar areas. Management should also expect to provide to engagement teams with sufficient evidence to support their judgments and the approach they have adopted for key accounting policies referenced to accounting standards or changes thereto.

Where estimates are used in the preparation of the financial statements management should expect teams to challenge management's assumptions and request evidence to support those assumptions.

IT Environment

We set out below details of the work we have undertaken on the Council's IT environment.



In accordance with ISA (UK) 315 Revised, we are required to obtain an understanding of the relevant IT and technical infrastructure and details of the processes that operate within the IT environment. We are also required to consider the information captured to identify any audit relevant risks and design appropriate audit procedures in response. As part of this we obtain an understanding of the controls operating over relevant Information Technology (IT) systems i.e., IT general controls (ITGCs). Our audit will include completing an assessment of the design and implementation of relevant ITGCs.

The IT environment for West Northamptonshire is complex, due to the legacy systems that it inherited on vesting. As a result we have had to review the design and implementation of the ITGCs for the following systems:

ERP Gold Business World (Unit 4)

ICON

Civica

Agresso (Unit 4)

AIM

Academy (Capita)

Northgate

Active Directory

We have completed this work for 2021/22, we have identified a number of matters that we are discussing with management. We will report our IT findings to the Audit Committee in more detail once these discussion have been completed. We will be undertaking follow-up work, to review the implementation of our recommendations as part of our 2023/24 audit.

Value for Money arrangements

2021/22

We completed our work on the Value for Money arrangements for 2021/22 and reported our findings in July 2023. A summary of our findings are detailed below.

Criteria	Risk assessment	21/22 Auditor Judgment	
Financial sustainability	No risks of significant weakness identified	Amber	No significant weaknesses in arrangements identified, but 11 improvement recommendation made
Governance	No risks of significant weakness identified	Amber	No significant weaknesses in arrangements identified, but 5 improvement recommendation made
Improving economy, efficiency and effectiveness	No risks of significant weakness identified	Amber	No significant weaknesses in arrangements identified, but 4 improvement recommendation made

No significant weaknesses in arrangements identified or improvement recommendation made.
No significant weaknesses in arrangements identified, but improvement recommendations made.
Significant weaknesses in arrangements identified and key recommendations made.

2022/23

Our work on your Value for Money arrangements for 2022/23 is underway and we will report our findings at the next Audit & Governance Committee meeting. As highlighted earlier, we consider that the lack of progress on the disaggregation of the opening balances to be a significant weakness in the Council's arrangements.

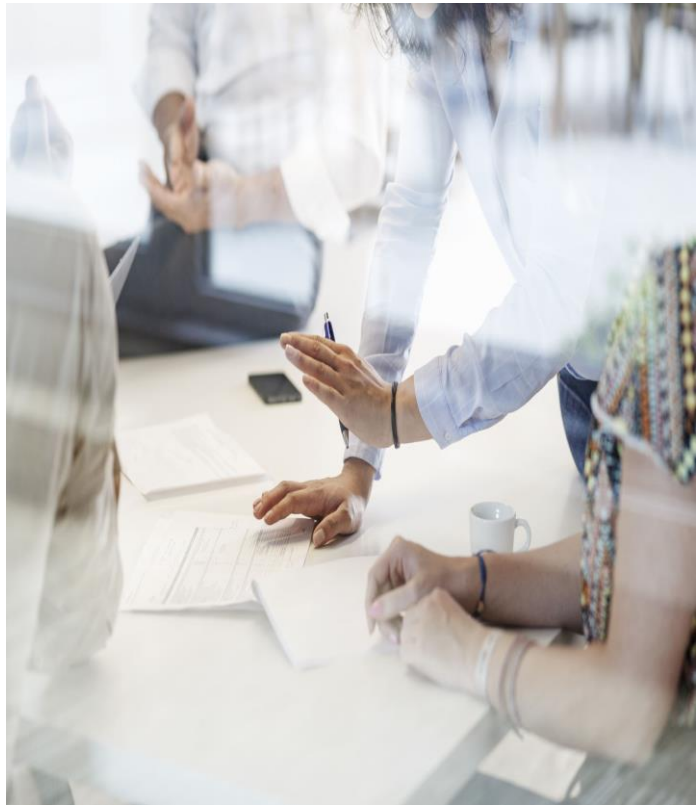
Audit fees

In 2021, PSAA awarded Grant Thornton a contract of audit for West Northamptonshire Council for 2 years with effect from 2021/22. Following another national procurement exercise by PSAA in 2022 this contract has been extended to 2027/28.

As previously reported we have not been able to complete our audits for 2021/22 & 2022/23 and expect the backstop to come into effect for these audits. Although we have not been able to complete these audits we have incurred costs in relation to the work we have already completed and these are detailed in the table below, with a detailed analysis on the next page. We have not undertaken any non-audit services for the Council.

	Scale Fee	Costs incurred to date
2021/22	£350,000	£155,000
2022/23	£350,000	£45,000
2023/24	£754,109*	TBC

* The Scale Fee for 2023/24 does not include any additional work required on opening balances due to a disclaimer opinion in 2022/23.



Audit fees – detailed analysis

Breakdown of costs incurred to date	
2021/22	
IT audit work	£35,000
Audit planning work	£75,000
Liaison meetings and attendance at Audit & Governance Committee	£15,000
Work on disaggregation	£5,000
VfM	£25,000
Total	**£155,000**
2022/23	
Liaison meetings	£10,000
Work on disaggregation	£5,000
VfM	£30,000
Total	**£45,000**

All variations to the scale fee will need to be approved by PSAA

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West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL AUDIT AND GOVERNANCE COMMITTEE

27 March 2024

Report Title	**Grant Thornton Audit Plan for Northamptonshire Pension Fund 2023-24**
Report Author	**Fiona Coates, Fiona.Coates@westnorthants.gov.uk**

Contributors/Checkers/Approvers

West DMO	Sarah Hall	19/03/2024
West S151	Martin Henry	27/03/2024

List of Appendices

Appendix A – Northamptonshire Pension Fund Audit Plan Year ended 31 March 2024
Author: Grant Thornton (GT)

1. Purpose of Report

1.1 To present the Audit and Governance Committee with the External Audit Plan from Grant Thornton, the Fund's external auditor.

2. Executive Summary

2.1 Grant Thornton act as Northamptonshire Pension Fund's external auditors. As the external auditors they have produced a plan of the upcoming audit 2023-24 of the Northamptonshire Pension Fund.

2.2 The key risks and areas of focus for Grant Thornton are valuation of Level 3 investments and management over-ride of controls.

2.3 Planning materiality for the financial statements is £48.5m, 1.5% of estimated gross assets. Planning materiality for the fund account is £13.2m, 10% of prior year gross expenditure.

2.4 The total audit fees for the year £132,848, excluding IAS 19 letters for employer body auditors. The scale fee for the year is £123,818.

3. Recommendations

3.1 The Committee is asked to:

a) Note the External Audit Plan 2023-24 and the presentation by Grant Thornton.

West Northamptonshire Council

4. Reason for Recommendations

4.1 To accord with the Audit and Accounts Regulations 2015.

5. Report Background

5.1 The Pension Fund's Statement of Accounts (SOA) form part of West Northamptonshire Council's Statement of Accounts. These are audited by the Council's external auditor Grant Thornton (GT). The auditor confirms whether, in their opinion, the SOA reflect a true and fair view of the financial position of the authority (and the Fund within it) for the financial year 1 April to 31 March and that the SOA is free from material mis-statement.

6. Content, Responsibilities and Timeline

6.1 Grant Thornton (GT) have been appointed as Independent External Auditors to provide an audit opinion on:

6.1.1 whether the financial statements of Northamptonshire Pension Fund give a true and fair view of the financial transactions of the Pension Fund during the year ended 31 March 2024 and the amount and disposition of the Fund's assets and liabilities as at 31 March 2024; and

6.1.2 the consistency of the Pension Fund financial statements within the Pension Fund annual report with the published financial statements of West Northamptonshire Council.

6.2 GT have produced an audit plan, setting out identified audit risks, expected materiality levels, the audit logistics and the planned delivery of the audit process. A Key Audit Manager from Grant Thornton, Grant Patterson, will attend this meeting to present the audit plan.

6.3 Page 7 of the accompanying report identifies the key risks and areas of auditor focus, details the Auditor's planned approach to these risk areas. These, along with the Fund's approach are summarised in the following table.

Risk/area of focus	Audit approach	Fund approach
Valuation of Level 3 investments (annual valuation)	• Evaluate management's processes for valuing level 3 investments; • Review the nature and basis of estimated values and consider what assurance management has over the year end valuations provided for these types of investment to ensure the requirements of the code are met;	• Provide working papers demonstrating the value used at the year end and the valuation methodology • Provide quarterly reconciliation reports • Liaise with Investment Managers to provide information to auditors on a timely basis

Risk/area of focus	Audit approach	Fund approach
	• Independently request year end confirmations from Investment Managers; • Sample testing of investment values; • Obtain and review service audit reports; and • Sample testing of purchases and sales.	
Management over-ride of controls	• Evaluate the design effectiveness of management controls over journals; • Analyse the journals listing and determine the criteria for selective high risk unusual journals; • Test unusual journals recorded during the year and after the draft accounts stage for appropriateness and corroboration • Gain an understanding of the accounting estimates and critical judgements applied by management and consider their reasonableness with regard to corroborative evidence; and	• Ensure process notes include identified risks • Provide written process notes which detail controls • Make copy journals available • Provide working papers demonstrating the value used for the journals

6.4 Page 11 of the accompanying report sets out the planned materiality levels for the audit. Financial statement materiality is set at 1.5% of the estimated Gross Assets, as opposed to net, to be more reflective of the risks associated with asset valuations. A lower materiality is set in respect of fund account transactions, at 10% of prior year gross expenditure, for a more focused approach.

Audit Area	Materiality
Planning Materiality – financial statements	£48.5m
Planning Materiality – fund account	£13.2m
Unadjusted misstatements – triviality threshold	£2.4m

6.5 Page 14 of the accompanying report sets out the proposed timeline for delivery of the audit. The key planned milestones are:

Milestone	Planned dates	Status
Report audit plan	March 2024	Completed
Interim Audit	February - March 2024	To be completed
Year end Audit	July - August 2024	To be completed
Audit Findings Report	October 2024	Deadline 30 September 2024

6.6 Page 16 sets out the audit fees for the year. The fees are:

	Proposed Fee
Scale Fee	£123,818
ISA 315	£7,530
Potential impact of delayed 2021-22 and 2022-23 audits	£1,500
IAS 19 assurance letters	TBC
Total Fee	£132,848 (+TBC)

6.7 The statutory date for publication of the final set of the Council's Statement of Accounts is the end of September, or as soon as reasonably practicable after the receipt of the auditor's final findings (if later).

6.8 The statutory date for publication of the Pension Funds Annual Report is 1st December.

6.9 A copy of the audit risk assessment is available to members on request.

7. Implications (including financial implications)

7.1 Resources and Financial

7.1.1 There are no resource or financial implications arising from the proposals in this paper. This paper is for information only.

7.2 Legal

7.2.1 Under the Audit and Accounts Regulations 2015, the Council must ensure appropriate and effective audits are undertaken to evaluate the effectiveness of its risk management, control and governance processes.

7.3 Risk

7.3.1 There are no significant risks arising from the proposed recommendations in this report.

7.3.2 The Fund's full risk register can be found on the Fund's website at the following link:

https://pensions.northamptonshire.gov.uk/governance/key-documents/northamptonshire/

7.4 **Consultation**

7.4.1 The Pension Fund Accounts are produced utilising information and advice provided by Investment Managers, the Fund's Custodian Northern Trust and the Fund's Actuary, Hymans Robertson.

7.5 **Consideration by Overview and Scrutiny**

7.5.1 Not applicable

7.6 **Climate Impact**

7.6.1 Not applicable

7.7 **Community Impact**

7.7.1 Not applicable

8. Background Papers

8.1 None.

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Grant Thornton

Northamptonshire Pension Fund audit plan

Year ending 31 March 2024

Northamptonshire Pension Fund

March 2024

Contents

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The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you as part of our audit planning process. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Pension Fund or all weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Key matters

National context

The national and international economic context continues to present challenges for pension funds. Inflationary pressures at home and abroad and wider geo-political issues mean there is volatility in global markets with a consequential impact on the investments held by pension funds.

Triennial valuations for local government pension funds have been published. These valuations, which are as at 31 March 2022, provide updated information regarding the funding position of local government pension funds and set employer contribution rates for the period 2023/24 – 2025/26. For Northamptonshire Pension Fund, the valuation was undertaken by Hymans Robertson, and showed that the solvency funding level is 113% therefore the funds held, plus future expected investment returns and future contributions are sufficient to meet expected future pension benefits payable.

In November 2023, the Department for Levelling Up, Housing and Communities (DLUHC) published the outcome of their consultation on local government pension scheme investments. The government will now implement proposals which include revised investment strategy statement guidance that funds should transfer all assets to their pool by 31 March 2025, regulation to require funds to set a plan to invest up to 5% of assets in levelling up the UK and revised investment strategy statement guidance to require funds to consider investments to meet the government's ambition of a 10 % allocation to private equity. The Chancellor has also outlined plans that local government pension funds will be invested in pools of £200bn or more by 2040.

DLUHC have also consulted on proposals to require local government pension scheme administering authorities in England and Wales to assess, manage and report on climate-related risks, in line with the recommendations of the Taskforce on Climate-related Financial Disclosures (TCFD). Climate risk (TCFD) reporting in the LGPS is expected to commence from 1 April 2024, with first reports due in late 2025. We are also aware that administration teams will be tasked with implementing the McCloud remedy for qualifying members' pensions which came into force from 1 October 2023.

In planning our audit, we have taken account of this national and international context in designing a local audit programme which is tailored to your risks and circumstances.

Audit Reporting Delays

Against a backdrop of ongoing audit reporting delays, in October 2023 PSAA found that only five local government accounts had been signed by the September deadline. In June 2023 the Public Accounts Committee (PAC) also produced a report setting out their concerns over these audit reporting delays. We issued our repot About time? In March 2023 which explored the reasons for delayed publication of audited local authority accounts.

Local authorities which administer local government pension funds are required to publish full pension fund accounts in the same document as their local authority accounts. This requirement means that the audited accounts of the host authority and related fund cannot be finalised until both audits have been completed. This co-dependency has compounded delays in the conclusion of pension fund audits and publication of audited accounts and annual reports, including Northamptonshire Pension Fund.

In our view, to enable a timely sign off of the financial statements, it is critical that draft local authority accounts are prepared to a high standard and are supported by strong working papers.

Key matters - continued

Our Responses

- In 2021, PSAA awarded a contract of audit for Northamptonshire Pension Fund to begin with effect from 2021/22. This contract was re-tendered in 2023 and Grant Thornton have been re-appointed as your auditors. As a firm, we are absolutely committed to audit quality and financial reporting in the local government sector. Our proposed work and fee, as set out in this Audit Plan, has been agreed with the Head of Pensions. Page 16 of this Audit Plan, sets out the four contractual stage payments for this fee, with payment based on delivery of specified audit milestones.
- To ensure close working with our local audited bodies and an efficient audit process, our preference as a firm is to work on site with you and your officers. Please confirm in writing if this is acceptable to you, and that your officers will make themselves available to our audit team. This is also in compliance with our delivery commitments in our contract with PSAA.
- We offer a private meeting with the Head of Pensions quarterly as part of our commitment to keep you fully informed on the progress of the audit and can extend these to the Director of Finance if you so wish.
- At an appropriate point within the audit, we would also like to meet informally with the Chair of your Pensions Committee, to brief them on the status and progress of the audit work to date.
- We will continue to provide you and your Pensions Committee with sector updates providing our insight on issues from a range of sources and other sector commentators via our Pensions Committee updates.
- There is an increased incentive and opportunity for organisations in the public sector to manipulate their financial statements due to ongoing financial pressures. We are required to identify a significant risk with regard to management override of controls.
- We identified a significant audit risk relating to the valuation of level 3 investments- refer to page 8.

Introduction and headlines

Purpose

This document provides an overview of the planned scope and timing of the statutory audit of Northamptonshire Pension Fund ('the Pension Fund') for those charged with governance.

Respective responsibilities

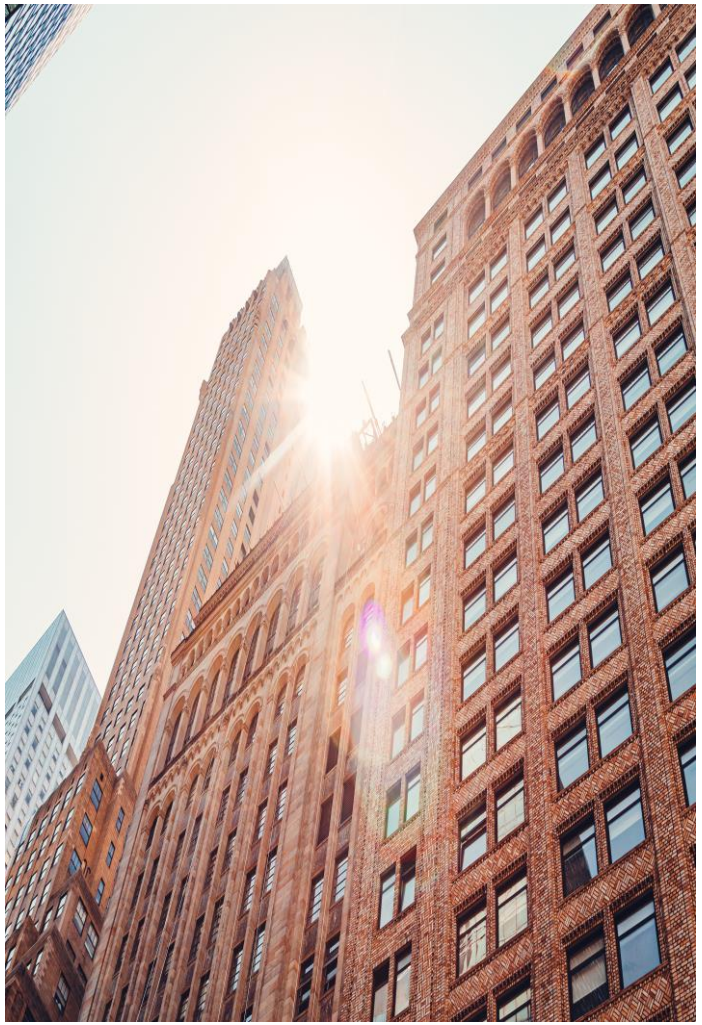
The National Audit Office ('the NAO') has issued a document entitled Code of Audit Practice ('the Code'). This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. The NAO is in the process of updating the Code. Our respective responsibilities are also set out in the agreed in the Terms of Appointment and Statement of Responsibilities issued by Public Sector Audit Appointments (PSAA), the body responsible for appointing us as auditor of Northamptonshire Pension Fund. We draw your attention to these documents.

Scope of our audit

The scope of our audit is set in accordance with the Code and International Standards on Auditing (ISAs) (UK). We are responsible for forming and expressing an opinion on the Pension Fund's financial statements that have been prepared by management. West Northamptonshire Council is the administering authority for the Pension Fund and we consider that its Audit Committee has final oversight of the preparation of the financial statements as those charged with governance. However, the Pensions Fund Committee considers the draft financial statements and is part of the overall member oversight process and we therefore have determined that our primary communications will be to them.

The audit of the financial statements does not relieve management or the Audit Committee or Pension Fund Committee of their responsibilities. It is the responsibility of the Pension Fund to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the Pension Fund is fulfilling these responsibilities.

Our audit approach is based on a thorough understanding of the Pension Fund's business and is risk based.



Introduction and headlines

Significant risks

Those risks requiring special audit consideration and procedures to address the likelihood of a material financial statement error have been identified as:

- Management over-ride of controls
- Valuation of Level 3 Investments

We will communicate significant findings on these areas as well as any other significant matters arising from the audit to you in our Audit Findings (ISA 260) Report.

Materiality

We have determined planning materiality to be £48.5m (PY £48.1m) for the Pension Fund, which equates to 1.5% of your gross investment assets as at 31 March 2023.

We have determined a lower specific planning materiality for the Fund Account of £13.2m (PY £12.9m), which equates to 10% of prior year gross expenditure on the fund account.

We are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. Clearly trivial has been set at £2.4m (PY £2.4m).

Audit logistics

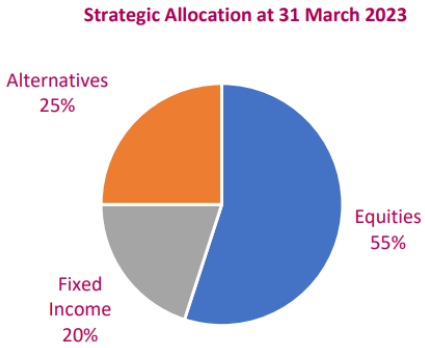
Our planning visit will take place in January, our interim visit will take place in February and our final visit will take place in July and August. Our key deliverables are this Audit Plan and our Audit Findings Report.

Our preference is for all our work to take place on site alongside your officers.

Our proposed fee for the audit will be £132,848 (PY: £58,250) for the Pension Fund, subject to the Pension Fund delivering a good set of financial statements and working papers and no significant new financial reporting matters arising that require additional time and/or specialist input.

Our understanding is, as shown opposite, the Fund will be transition more from equities into fixed income (Level 1 and 2 assets) whilst maintaining its proportion of alternative assets (Level 3 assets). The Fund's Custodians do not independently value its Level 1 and 2 Investments. This means we are not able to 'triangulate' valuations included in the financial statements to investment manager and custodian confirmations for these investments. As a result, we carry out further audit procedures to gain assurance over the valuations of these investments. For Level 1 and Level 2 investments we will:

- independently request year end confirmations from investment managers;
- check the unit price to the market quoted price (if available) at the reporting date, or; test the valuation to direct confirmation of capital balances from investment managers and, where available latest audited financial statements;
- complete sample testing of purchases and sales to prime documentation across the period to support out reconciliation of the opening and closing balances.



See page 8 for further details regarding our approach to auditing the valuation of Level 3 Investments.

We have complied with the Financial Reporting Council's Ethical Standard (revised 2019) and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements.

Significant risks identified

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Presumed risk of fraud in revenue recognition ISA (UK) 240 Risk of fraud related to expenditure recognition PAF Practice Note 10	Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. This presumption can be rebutted if the auditor concludes that there is no risk of material misstatement due to fraud relating to revenue recognition. As external auditors in the public sector, we are also required to give regard to Practise Note 10, which interprets the ISA in a public sector context and directs us to consider whether the assumption also applies to expenditure.	Having considered the risk factors set out in ISA 240 and the nature of the revenue streams at the Fund, we have determined that the risk of fraud arising from revenue and expenditure recognition can be rebutted, because: • There is little incentive to manipulate revenue and expenditure recognition; • Opportunities to manipulate revenue and expenditure recognition are very limited; and • The culture and ethical frameworks of local authorities, including the administering authority, West Northamptonshire Council, mean that all forms of fraud are seen as unacceptable. Therefore, at the planning stage we do not consider this to be a significant risk for Northamptonshire Pension Fund. We will continue our risk assessment throughout the audit to identify any circumstances indicating a requirement to alter this decision.
Management over-ride of controls	Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Fund faces external scrutiny of its spending and stewardship of assets, and this could potentially place management under undue pressure in terms of how they report performance. We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk of material misstatements	We will: • evaluate the design and implementation of management controls over journals • analyse the journals listing and determine the criteria for selecting high risk unusual journals • identify and test unusual journals made during the year and the accounts production stage for appropriateness and corroboration • gain an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness.

'Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, due to either size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty.' (ISA (UK) 315)

Significant risks identified - continued

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Valuation of Level 3 investments	By their nature, Level 3 investments valuations lack observable inputs. These valuations therefore represent a significant estimate by management in the financial statements due to the size of the numbers involved and the sensitivity of this estimate to changes in key assumptions. Under ISA 315, significant risks often relate to significant nonroutine transactions and judgemental matters. Level 3 investments by their very nature require a significant degree of judgements to reach an appropriate valuation at year end. We therefore identified valuation of Level 3 investments as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	We will: • evaluate management's processes for valuing Level 3 investments and perform a walkthrough to confirm that controls are implemented as designed; • review the nature and basis of estimated values and considered what assurance management has over the year end valuations provided for these types of investments to ensure the requirements of the Code are met; • independently request year end confirmations from investment managers; • for a sample of investments, test the valuation by comparing the valuation per the General Ledger (typically based on investor statement as at the reporting date, or in the case of harder to value assets, the latest capital statement available adjusted for known cash movements in the final quarter of the year) to direct confirmation of capital balances from investment managers and, where available latest audited financial statements; • obtain and review service audit reports for the investment managers where available; and, • complete sample testing of purchases and sales to prime documentation across the period to support out reconciliation of the opening and closing balances.

Management should expect engagement teams to challenge areas that are complex, significant or highly judgmental. This may be the case for accounting estimates and similar areas. Management should also expect to provide to engagement teams with sufficient evidence to support their judgments and the approach they have adopted for key accounting policies, with reference to accounting standards or changes thereto.

Where estimates are used in the preparation of the financial statements management should expect teams to challenge management's assumptions and request evidence to support those assumptions.

Other matters

Other work

The Pension Fund is administered by West Northamptonshire Council (the 'Council'), and the Pension Fund's accounts form part of the Council's financial statements.

Therefore, as well as our general responsibilities under the Code of Practice a number of other audit responsibilities also follow in respect of the Pension Fund, such as:

- We read any other information published alongside the Council's financial statements to check that it is consistent with the Pension Fund financial statements on which we give an opinion and is consistent with our knowledge of the Authority.
- We consider our other duties under legislation and the Code, as and when required, including:
    - Giving electors the opportunity to raise questions about your 2023/24 financial statements, consider and decide upon any objections received in relation to the 2023/24 financial statements;
    - Issue of a report in the public interest or written recommendations to the Fund under section 24 of the Act, copied to the Secretary of State.
    - Application to the court for a declaration that an item of account is contrary to law under Section 28 or for a judicial review under Section 31 of the Act; or
    - Issuing an advisory notice under Section 29 of the Act.
- We carry out work to satisfy ourselves on the consistency of the pension fund financial statements included in the pension fund annual report with the audited Fund accounts.

Other material balances and transactions

Under International Standards on Auditing, 'irrespective of the assessed risks of material misstatement, the auditor shall design and perform substantive procedures for each material class of transactions, account balance and disclosure'. All other material balances and transaction streams will therefore be audited. However, the procedures will not be as extensive as the procedures adopted for the risks identified in this report.

Progress against prior year audit recommendations

We identified the following issues in our 2022/23 audit of the Pension Fund's financial statements, which resulted in two recommendations being reported in our 2022/23 Audit Findings Report. We are pleased to report that management have implemented all of our recommendations.

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
✓	We identified an instance of a self-authorised journal being posted within the previous financial year which was not in line with the Fund's controls for recording journal entries. This represented a segregation of duties issue as the posting of journals without appropriate oversight leads a higher risk of fraudulent journal entries impacting the financial statements.	Management have informed the relevant teams that journals should not be self-authorised.
✓	Administrative access to Altair was allocated to user who has operational and financial responsibilities. The combination of operational and financial responsibilities with the ability to administer end-user security is considered a segregation of duties conflict.	Access for the 'business user' has now been restricted to view only.

Assessment

✓ Action completed

x Not yet addressed

Our approach to materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to the monetary misstatements but also to disclosure requirements and adherence to acceptable accounting practice and applicable law.

Matter	Description	Planned audit procedures
1	**Determination** We have determined financial statement materiality by applying a reasonable measurement percentage to an appropriate benchmark. Materiality at the planning stage of our audit is £48.5m, which equates to 1.5% of your gross investment assets as at 31 March 2023.	We determine planning materiality in order to: – establish what level of misstatement could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; – assist in establishing the scope of our audit engagement and audit tests; – determine sample sizes and – assist in evaluating the effect of known and likely misstatements in the financial statements.
2	**Other factors** An item does not necessarily have to be large to be considered to have a material effect on the financial statements.	An item may be considered to be material by nature where it may affect instances when greater precision is required. We have determined a lower specific planning materiality for the Fund Account of £13.2m (PY 12.9m), which equates to 10% of prior year gross expenditure on the fund account. The lower specific materiality for the fund account will be applied to the audit of all fund account transactions, except for investment transactions, for which materiality for the financial statements as a whole will be applied.
3	**Reassessment of materiality** Our assessment of materiality is kept under review throughout the audit process.	We reconsider planning materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality.
4	**Other communications relating to materiality we will report to the Audit Committee** Whilst our audit procedures are designed to identify misstatements which are material to our opinion on the financial statements as a whole, we nevertheless report to the Audit Committee any unadjusted misstatements of lesser amounts to the extent that these are identified by our audit work. Under ISA 260 (UK) 'Communication with those charged with governance', we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA 260 (UK) defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.	We report to the Pensions Committee and Audit Committee any unadjusted misstatements of lesser amounts to the extent that these are identified by our audit work. In the context of the Pension Fund, we propose that an individual difference could normally be considered to be clearly trivial if it is less than £2.4m (PY £2.4m). If management have corrected material misstatements identified during the course of the audit, we will consider whether those corrections should be communicated to the Pensions and Audit Committees to assist them in fulfilling their governance responsibilities.

Our approach to materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to the monetary misstatements but also to disclosure requirements and adherence to acceptable accounting practice and applicable law.

	Amount (£)	Qualitative factors considered
Materiality for the financial statements	£48.5m	Materiality is calculated as approximately 1.5% of gross assets per the prior year draft accounts. We deem this to be a level above which errors or omissions would alter the economic decisions of users of the accounts.
Materiality for the fund account	£13.2m	Materiality is calculated as approximately 10% of gross expenditure in the prior year draft accounts. We deem this to be a level above which errors or omissions would alter the economic decisions of users of the accounts.

IT audit strategy

In accordance with ISA (UK) 315 Revised, we are required to obtain an understanding of the relevant IT and technical infrastructure and details of the processes that operate within the IT environment. We are also required to consider the information captured to identify any audit relevant risks and design appropriate audit procedures in response. As part of this we obtain an understanding of the controls operating over relevant Information Technology (IT) systems i.e., IT general controls (ITGCs). Our audit will include completing an assessment of the design and implementation of relevant ITGCs.

The following IT systems have been judged to be in scope for our audit and based on the planned financial statement audit approach we will perform the indicated level of assessment:

IT system	Audit area	Planned level IT audit assessment
ERP Gold	Financial reporting	• Detailed ITGC assessment completed by internal expert. We plan to test the design and implementation of ITGCs.
Altair	Member data	• Detailed ITGC assessment completed by internal expert. We plan to test the design and implementation of ITGCs.

Audit logistics and team

Planning and risk assessment

Pensions Fund Committee March 2024

Audit Plan

Interim audit February/ March 2024

Year end audit July-August 2024

Pensions Fund Committee October 2024

Audit Findings Report

Audit opinion

Araminta Allen, Audit Incharge

Key audit contact responsible for the day to day management and delivery of the audit work.

William Howard, Audit Manager

Provides oversight of the delivery of the audit including regular engagement with Governance Committees and senior officers

Grant Patterson, Key Audit Partner

Provides oversight of the delivery of the audit including regular engagement with Governance Committees and senior officers.

Audited Entity responsibilities

Where audited bodies do not deliver to the timetable agreed, we need to ensure that this does not impact on audit quality or absorb a disproportionate amount of time, thereby disadvantaging other audited bodies. Where the elapsed time to complete an audit exceeds that agreed due to an entity not meeting its obligations we will not be able to maintain a team on site. Similarly, where additional resources are needed to complete the audit due to an entity not meeting their obligations we are not able to guarantee the delivery of the audit to the agreed timescales. In addition, delayed audits will incur additional audit fees.

Our requirements

To minimise the risk of a delayed audit, you need to :

- ensure that you produce draft financial statements of good quality by the deadline you have agreed with us, including all notes and the Annual Report
- ensure that good quality working papers are available at the start of the audit, in accordance with the working paper requirements schedule that we have shared with you. In line with previous years, this will include the use of Inflo.
- ensure that the agreed data reports are cleansed, are made available to us at the start of the audit and are reconciled to the values in the accounts, in order to facilitate our selection of samples for testing
- ensure that all appropriate staff are available on site throughout (or as otherwise agreed) the planned period of the audit (as per our responses to key matters set out on slide 4)
- respond promptly and adequately to audit queries.

Audit fees and updated Auditing Standards

Audit fees are set by PSAA as part of their national procurement exercise. In 2021, PSAA awarded a contract of audit for Northamptonshire Pension Fund to begin with effect from 2021/22. This contract was re-tendered in 2023 and Grant Thornton have been re-appointed as your auditors. This contract was re-tendered in 2023 and Grant Thornton have been re-appointed as your auditors. The scale fee set out in the PSAA contract for the 2023/24 audit is £123,818.

This contract sets out four contractual stage payments for this fee, with payment based on delivery of specified audit milestones:

- Production of the final auditor's annual report for the previous Audit Year (exception for new clients in 2023/24 only)
- Production of the draft audit planning report to Audited Body
- 50% of planned hours of an audit have been completed
- 75% of planned hours of an audit have been completed

Any variation to the scale fee will be determined by PSAA in accordance with their procedures as set out here https://www.psaa.co.uk/appointing-auditors-and-fees/fee-variations-overview/'

Assumptions

In setting these fees, we have assumed that the Pension Fund will:

- prepare a good quality set of accounts, supported by comprehensive and well-presented working papers which are ready at the start of the audit
- provide appropriate analysis, support and evidence to support all critical judgements and significant judgements made during the course of preparing the financial statements
- provide early notice of proposed complex or unusual transactions which could have a material impact on the financial statements
- maintain adequate business processes and IT controls, supported by an appropriate IT infrastructure and control environment.

Updated Auditing Standards

The FRC has issued updated Auditing Standards in respect of Quality Management (ISQM 1 and ISQM 2). It has also issued an updated Standard on quality management for an audit of financial statements (ISA 220). We confirm we will comply with these standards.

Audit fees

	Proposed fee 2023/24
Northamptonshire Pension Fund Audit	£123,818
ISA 315	£7,530
Potential impact of delayed 2021/22 and 2022/23 administering authority audit opinions and work required on 2021/22 opening balances now that audit opinions have been issued	£1,500
IAS 19 letters for employer body auditors*	TBC
Total audit fees (excluding VAT)	£132,848 (+£TBC)

*Note that fees for IAS 19 letters for employer body auditors were classed as non-audit fees prior to 2022/23. The National Audit Office have confirmed that the provision of IAS 19 assurances to auditors of local government and NHS bodies should be considered work undertaken under the Code of Audit Practice for 2022/23 onwards. Provision of IAS 19 assurances to auditors of any other type of entity remains non-Code work.

Previous year

In 2022/23 the scale fee set by PSAA was £55,250. The actual fee charged for the audit was £58,250.

If the opinion on the 2022/23 and 2021/2022 audit is disclaimed due to the imposition of a backstop date, we will need to undertake further audit work in respect of opening balances. We will discuss the practical implications of this with you should this circumstance arise.

Relevant professional standards

In preparing our fees, we have had regard to all relevant professional standards, including paragraphs 4.1 and 4.2 of the FRC's Ethical Standard (revised 2019) which stipulate that the Engagement Lead (Key Audit Partner) must set a fee sufficient to enable the resourcing of the audit with partners and staff with appropriate time and skill to deliver an audit to the required professional and Ethical standards.

Independence and non-audit services

Auditor independence

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant facts and matters that may bear upon the integrity, objectivity and independence of the firm or covered persons. relating to our independence. We encourage you to contact us to discuss these or any other independence issues with us. We will also discuss with you if we make additional significant judgements surrounding independence matters.

We confirm that we have implemented policies and procedures to meet the requirements of the Financial Reporting Council's Ethical Standard and we as a firm, and each covered person, are independent and are able to express an objective opinion on the financial statements.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Financial Reporting Council's Ethical Standard and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements. Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in September 2022 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

We confirm that we have implemented policies and procedures to meet the requirements of the Ethical Standard. For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Pension Fund.

Other services

No other services provided by Grant Thornton were identified.

Any changes and full details of all fees charged for audit related and non-audit related services by Grant Thornton UK LLP and by Grant Thornton International Limited network member Firms will be included in our Audit Findings report at the conclusion of the audit.

Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	•	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks and Key Audit Matters	•	
Confirmation of independence and objectivity of the firm, the engagement team members and all other indirectly covered persons	•	•
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	•	•
Significant matters in relation to going concern	•	•
Significant findings from the audit		•
Significant matters and issue arising during the audit and written representations that have been sought		•
Significant difficulties encountered during the audit		•
Significant deficiencies in internal control identified during the audit		•
Significant matters arising in connection with related parties		•

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Plan, outlines our audit strategy and plan to deliver the audit, while the Audit Findings will be issued prior to approval of the financial statements and will present key issues, findings and other matters arising from the audit, together with an explanation as to how these have been resolved.

We will communicate any adverse or unexpected findings affecting the audit on a timely basis, either informally or via an audit progress memorandum.

Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Identification or suspicion of fraud(deliberate manipulation) involving management and/or which results in material misstatement of the financial statements		•
Non-compliance with laws and regulations		•
Unadjusted misstatements and material disclosure omissions		•
Expected modifications to the auditor's report, or emphasis of matter		•

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

Grant Thornton

grantthornton.co.uk

West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL AUDIT AND GOVERNANCE COMMITTEE

27 March 2024

Report Title	**Update Report - Regulation of Investigatory Powers Act 2000 (as amended)**
Report Author	**Sarah Hall, Deputy Director Law and Governance** Sarah.Hall@westnorthants.gov.uk

Contributors/Checkers/Approvers		
DSO	Sarah Hall	19/03/2024
Assistant Director Finance-Accountancy	Audra Statham	19/03/2024

List of Appendices

Appendix 1: Proposed amended Policy - *Surveillance Policy - Regulation of Investigatory Powers Act 2000 (as amended)*

1. Purpose of Report

1.1 This report:

a) provides an update on the Council's use of powers available to it under the Regulation of Investigatory Powers Act 2000 (as amended) ('RIPA');
b) proposes amendments to the RIPA Policy;
c) updates Members on officer training undertaken and scheduled following the last report to the Audit and Governance Committee (25 January 2023); and
d) updates Members on other actions being undertaken to strengthen the Council's RIPA framework.

2. Executive Summary

2.1 RIPA governs how public bodies use surveillance methods. The Council may use covert surveillance for the purpose of preventing or detecting crime or preventing disorder.

2.2 In May 2022 the Council underwent an inspection from the IPCO (Investigatory Powers Commissioner's Office). The results of that inspection were reported to Cabinet, and Cabinet

designated the Audit and Governance Committee as the responsible statutory committee to oversee the operation of RIPA policies.

2.3 This report advises the Committee about the Council's use of RIPA powers, proposes the RIPA Policy be updated, and provides an update on training and other actions being undertaken to strengthen the Council's RIPA framework.

3 Recommendation

3.1 It is recommended that the Audit and Governance Committee:

a) Approves the proposed amended RIPA Policy as set out at Appendix 1.
b) Endorse the training scheduled for relevant officers as detailed in paragraphs 6.8 to 6.10 of this report.
c) Note the update at paragraph 6.12 of this report on use of RIPA powers in 2023.

4 Reason for Recommendation

4.1 To ensure the Committee receives an annual update on the Council's use of RIPA powers and development of the Council's RIPA Framework.

4.2 Keeping the RIPA Policy and supporting provisions under regular review helps to ensure that the Policy is up to date and effective, and that any covert surveillance is carried out in compliance with the law.

5 Report Background

Summary of RIPA Provisions

5.1 The origin of RIPA lies in the Human Rights Act 1998 which gave effect in UK law to the rights set out in the European Convention on Human Rights (ECHR). This places restrictions on the extent to which public bodies may interfere with a person's right to respect for his or her home and private life and correspondence during the course of an investigation into suspected criminal activities.

5.2 RIPA sets out the authorisation requirements for all covert surveillance carried out by public authorities where that surveillance is likely to result in the obtaining of private information about a person. It is mandatory for the Council to have a policy which applies to all surveillance carried out by the Council.

5.3 Surveillance, for the purposes of RIPA, 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. It may also be obtained by using a covert human intelligence source (CHIS) to acquire information covertly where it is appropriate and legal to do so. A CHIS is an individual

who covertly uses a relationship to obtain information or to provide access to any information to another person.

5.4 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. The provisions of RIPA ensure (in summary) that any such interferences are in accordance with the law and are necessary and proportionate (i.e. the seriousness of the suspected crime or disorder must outweigh any possible interferences with the personal privacy of the persons being investigated and of persons who associate with them). Part II of RIPA provides a lawful mechanism for public bodies such as the Council to use covert surveillance and covert human intelligence sources compatibly with Article 8 of the ECHR and the Data Protection Act 2018, where it is for the purpose of the detection or prevention of crime.

5.5 Local authorities may authorise the use of Directed Surveillance under RIPA. Directed surveillance is covert surveillance that is not intrusive (see paragraph 5.6 below) but is carried out in relation to a specific investigation or operation in such a manner as is likely to result in the obtaining of private information about any person (other than by way of an immediate response to events or circumstances such that it is not reasonably practicable to seek authorisation under RIPA).

5.6 Intrusive surveillance is covert surveillance that is carried out in relation to anything taking place on residential premises or in any private vehicle (and that involves the presence of an individual on the premises or in the vehicle or is carried out by a means of a surveillance device). Local authorities cannot authorise intrusive surveillance.

5.7 The grounds on which local authorities can rely to authorise directed surveillance are narrower than those available to the police or security services. Local authorities in England and Wales can only authorise use of directed surveillance under RIPA to prevent or detect criminal offences that are either punishable, whether on summary conviction or indictment, by a maximum term of at least 6 months' imprisonment or are related to the underage sale of alcohol and tobacco or nicotine inhaling products. Local authorities cannot authorise directed surveillance for the purpose of preventing disorder unless this involves a criminal offence punishable by a maximum term of at least 6 months' imprisonment.

5.8 Following the amendments made to RIPA by the Protection of Freedoms Act 2012 the use of Directed Surveillance or CHIS by a local authority are subject to judicial approval.

5.9 The Investigatory Powers Act 2016 provided powers to local authorities to access communications data to carry out their statutory functions as a Competent Authority under the Data Protection Act 2018.

5.10 The Investigatory Powers Commissioner (IPCO), Sir Brian Leveson, is responsible for overseeing the application of RIPA and the use of investigatory powers by public authorities. The Commissioner has a statutory obligation to inspect the use of investigatory powers as part of his oversight. Inspections are carried out approximately once every three years. The Council is also required to submit an annual return to the IPCO detailing the Council's use of RIPA.

The Council's RIPA Arrangements

5.11 The Council must have a RIPA Surveillance Policy which applies to all surveillance carried out by the Council. The Council has a RIPA Surveillance Policy in place.

5.12 In September 2022, Cabinet designated the Audit and Governance Committee as the responsible statutory committee to oversee the operation of RIPA policies.

5.13 The Council's Senior Information Responsible Officer (SIRO) is the Director of Law and Governance. The SIRO is responsible for the implementing of the RIPA policy and for ensuring that relevant staff are adequately trained. Relevant staff includes Executive Directors (Authorising Officers) and also employees of the Council who may use surveillance.

5.14 The Council's Executive Directors are designated Authorising Officers. These Officers review the applications that are completed by operational officers who are requesting authorisation to undertake covert surveillance. (The Magistrates Court is responsible for considering the applications approved by the Authorising Officers and determining the request to undertake surveillance).

6 Issues and Choices

RIPA Policy Update

6.1 Minor draft amendments have been made to the Council's RIPA Policy for the consideration and approval of the Committee. The effect of these amendments are to clarify the introduction to the Policy, highlight the fact that the Council is not authorised to conduct intrusive surveillance, clarify the reference to noise nuisance monitoring given in the Policy (to ensure it does not suggest intrusive surveillance) and to include authorisation durations in relation to CHIS authorisations. These amendments will ensure that the Policy is user friendly, clearly reflects the legal position and takes account of all comments made by the Inspector during the last IPCO Inspection in May 2022.

6.2 The Audit and Governance Committee is therefore recommended to approve the amended draft RIPA Surveillance Policy at Appendix 1.

Monitoring Officer Guidance

6.3 The Policy must be supported by guidance and material to assist operational officers in understanding how and when RIPA applies to ensure compliance with the law.

6.4 The potential use of internet research in investigations, including the use of information from social media is an area where it is advisable to have specific practical guidance in place for Officers in addition to the guidance contained within the Home Office Covert Surveillance and Property Interference Practice Guide. Therefore, a Monitoring Officer Guidance document on this topic has been developed and will be made available to staff, as it will be placed on a RIPA resources area of the intranet alongside the formal RIPA Policy.

6.5 The Monitoring Officer Guidance document covers some of the practical issues surrounding use of the internet in a covert manner as part of investigations. For example, the Guidance expressly states that Officers must not use their own social media profiles to carry out investigative work. It is important that only profiles established by, and equipment owned by the Council are used in Council investigations. The importance of this is in part to ensure that staff do not compromise their own safety through the possibility of being digitally traced back to their personal accounts/devices.

6.6 The Monitoring Officer can update practical guidance from time to time. If a need for other guidance documents arises, these will be developed and added to the intranet resources.

Training

6.7 Corporate RIPA Training was last delivered in tranches between September 2022 and February 2023 by an external organisation. The training was delivered to Officers whose job roles require them to have an awareness of RIPA and other legislation relevant to covert surveillance. The Executive Leadership Team ('ELT') also had a RIPA training session specifically tailored towards Authorising Officers because the Council's designated Authorising Officers sit on the Council's ELT and must understand their role and how to consider applications to undertake directed surveillance / approve the use of a CHIS.

6.8 It was reported to Audit Committee in January 2023 that annual training would be delivered to all operational officers undertaking or who may potentially undertake covert surveillance and that Authorising Officers would also receive annual refresher training.

6.9 This year's annual training will be delivered in-house by the Council's Legal Services department, who themselves will have received detailed training/refresher training prior to training operational staff and Authorising Officers.

6.10 To ensure that the training is tailored to the current requirements of operational staff, members of the officer Enforcement Group will be consulted about the type of investigations they undertake or may wish to undertake in the future, and their training requirements. (Membership of the Enforcement Group covers the following Council service areas; Legal Services, Environmental Protection and Environmental Crime, Trading Standards and Licensing, Planning Enforcement, Private Sector Housing, Counter Fraud, Internal Audit and Risk, Community Safety, Transport and Highways, Strategic Housing, Early Help, Safeguarding and Childrens Services, Health Protection and Business Support, and Information Governance).

6.11 It is also proposed that going forwards the Enforcement Group be used as a forum where RIPA Policy/Guidance issues be raised, so that Legal Services can ensure that the resources put on the intranet remain up to date and useful. Specific operational queries requiring advice on RIPA implications will continue to need to be the subject of a request for legal advice made to the in-house Legal Services Department.

Use of RIPA powers in 2023

6.12 In January 2024, the Council responded to IPCO's annual survey enquiring about the Council's use of powers to conduct directed surveillance and employ CHISs under RIPA. After the survey was circulated to all Officers involved in undertaking investigations, a nil response was returned indicating that there had been no use of RIPA powers during the previous year.

7 Implications (including financial implications)

7.1 Resources and Financial

7.1.1 There will be a small cost attached to provision of training for the nominated staff. Costs will be met from within existing operational budgets.

7.2 Legal

7.2.1 The RIPA 2000 requires the Council to have processes for authorising, recording and reviewing any covert surveillance that it carries out that it is regulated by the Act. The processes must comply with the Act, relevant regulations and any statutory codes of practice. In accordance with the statutory Code of Practice, a local authority must have a policy covering its use of covert surveillance. Further, the Council must report its RIPA activity to the Investigatory Powers Commissioner's Office on an annual basis and provide an update on its activity to members.

7.3 Risk

7.3.1 Failure to comply with the RIPA Surveillance Policy and procedural guidance could result in evidence being inadmissible in court proceedings and potential claims that an individual's right to privacy has been breached. However, the Council will have a clear policy in place and officers will have received the necessary training to ensure compliance. Information on the RIPA Policy and procedures will be shared with relevant officers to ensure that they understand the requirements.

7.4 Consultation

7.4.1 Consultation is not required in relation to the RIPA Surveillance Policy. As stated above, operational Officers will be consulted about their RIPA training requirements.

7.5 Consideration by Overview and Scrutiny

7.5.1 RIPA is a statutory matter and has therefore not been referred to overview and scrutiny.

7.6 Climate Impact

7.6.1 There are no immediate climate implications arising from this report.

7.7 Community Impact

7.7.1 The RIPA Surveillance Policy contains safeguards to protect individuals and businesses from unfair or inappropriate surveillance, minimising as far as possible any adverse impact on the community. Proportionate enforcement activity will also have a positive impact upon local communities.

8 Background Papers

8.1 None

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Surveillance Policy

Introduction

1.1 The Human Rights Act 1998 gave effect in UK law to the rights set out in the European Convention on Human Rights (ECHR). Amongst the qualified rights is a person's right to respect for their private and family life, home and correspondence, as provided for by Article 8 of the ECHR. It is Article 8 that is most likely to be engaged when public authorities seek to obtain private information about a person by means of surveillance.

1.2 Part II of the Regulation of Investigatory Powers 2000 Act (as amended) ('RIPA') provides a statutory framework under which covert surveillance activity undertaken by the Council can be authorised and conducted compatibly with Article 8 and the Data Protection Act 2018.

1.3 Surveillance, for the purpose of the RIPA, 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.

1.4 The Employment Practices Code provides a framework under which surveillance activity of employees can be authorised and conducted compatibly with Article 8 and the Data Protection Act 2018.

1.5 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.

1.6 The Council may authorise the use of Directed Surveillance or the use of Covert Human Intelligence Sources (CHISs) pursuant to RIPA.

- **Directed Surveillance** is covert surveillance that is not intrusive* but is carried out in relation to a specific investigation or operation in such a manner as is likely to result in the obtaining of private information about any person (other than by way of an immediate response to events or circumstances such that it is not reasonably practicable to seek authorisation under the 2000 Act.

  * *Intrusive surveillance is covert surveillance that is carried out in relation to anything taking place on residential premises or in any private vehicle (and that involves the presence of an individual on the premises or in the vehicle or is carried out by a means of a surveillance device).* ***West Northamptonshire Council is not empowered to authorise or undertake intrusive surveillance.***

- In summary, a person is a **Covert Human Intelligence Source** ('CHIS') if they establish or maintain a personal or other relationship and they covertly use the relationship to obtain information or provide access to any information to another person, or they covertly disclose information obtained through that relationship or as a consequence of the existence of that relationship.

1.7 Use of Directed Surveillance or deployment of a CHIS could potentially be used by the Council in an investigation as a means of obtaining information. Use of Directed Surveillance or deployment of a CHIS must be authorised. There are designated officers within the Council ('Authorising Officers') who are able to authorise such activity. The Authorising Officer must consider the detailed legal tests when deciding whether to authorise the covert activity. If the Authorising Officer does authorise the activity, it is still subject to a judicial approval process. This means that an application must be made to the Magistrates Court for approval of the authorisation and it cannot take effect until such approval is obtained.

1.8 In practical terms, if you consider that you might wish to carry out directed surveillance or deploy a CHIS as part of an investigation, (or even if you are not certain whether the activities that you are proposing require a RIPA authorisation), please ensure that you seek legal advice from Legal Services early on. If you do require a RIPA authorisation for your proposed activity, you will then need to contact the Authorising Officer.

1.9 It is important to be aware that once a RIPA authorisation has been granted by the Authorising Officer and approved by the Magistrates Court, and you are carrying out the activity, you must still adhere to this Policy. There are ongoing requirements concerning review of the authorisation for example and record keeping requirements.

1.10 The grounds on which local authorities can rely to authorise directed surveillance are narrower than those available to the police or security services. A local authority can only authorise directed surveillance of a member of the public if the designated person believes such surveillance is necessary and proportionate for the purpose of preventing or detecting crime.

1.12 The Protection of Freedoms Act 2012 amended s28 of RIPA and brought in the requirement for a magistrate to approve a RIPA authorisation when the crime threshold was met (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).

1.13 The Investigatory Powers Act 2016 (IPA 2016) provided powers to local authorities to access communications data in order to carry out their statutory functions as a Competent Authority under the Data Protection Act 2018.

1.14 The Council must have a policy in place to ensure that such directed surveillance is carried out in compliance with the law and does not breach the human rights of any of the surveillance subjects, and that surveillance in or around the workplace is also carried out in compliance with the law.

Scope

2.1 The policy applies to all surveillance carried out by The Council, including external surveillance covered by RIPA authorisations, communication data acquisitions covered by the IPA 2016 and internal surveillance covered by the Employment Practices Code.

Aim

2.1 To ensure all legal obligations on the Council are met, in particular, the Human Rights Act 1998.

2.2 To provide a framework for the carrying out of covert surveillance of the public and staff by the Council.

Applicability to investigations carried out by or on behalf of West Northamptonshire Council

This policy applies to covert surveillance activities carried out by or on behalf of the Council and includes, but is not limited to, the following:

- the taking of photographs of someone in a public place or;
- the recording by video cameras of someone in a public place;
- the deployment of noise monitoring equipment
- the taking of photographs of staff in the workplace or;
- the recording by video cameras of staff in the workplace;
- acquisition of communications data e.g. telephone call logs, subscriber details.

Review & Maintenance

3.1 This policy is agreed and distributed for use across the Council by the Director of Legal and Democratic Services and Monitoring Officer on behalf of the Executive Leadership Team. It will be reviewed every two years by the Director of Legal and Democratic Services and Monitoring Officer who will make any recommendations for change to the Executive Leadership Team for consideration and distribution.

Legal Requirements

4.1 The Council is obliged to comply with all relevant UK and EU information legislation. This requirement to comply is devolved to Elected Members, staff,

contractors or others permitted to carry out surveillance on behalf of the Council, who may be held personally accountable for any breaches of Article 8 of the Human Rights Act 1998 (Right to Privacy).

4.2 The Council shall comply with the following legislation and other legislation as appropriate:

- The Data Protection Act (2018) and
- The General Data Protection Regulation (2016)
- Human Rights Act (1998)
- Regulation of Investigatory Powers Act 2000
- Protection of Freedoms Act 2012
- The Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000
- The Investigatory Powers Act 2016

4.3 The acquisition of a RIPA authorisation will equip the Council with the legal protection (The RIPA 'Shield') against accusations of a breach of Article 8.

Policy Statement

5.1 West Northamptonshire Council supports the objectives of the Human Rights Act 1998, the Regulation of Investigatory Powers Act 2000, the Investigatory Powers Act 2016 and the Protection of Freedoms Act 2012. This policy aims to assist staff with meeting their statutory and other obligations which covers the issues of Information Governance.

Objectives

6.1 The policy is intended to provide a framework for carrying out surveillance activities in compliance with the law by:

- Creating and maintaining within the organisation an awareness of the Right to Privacy (Article 8, Human Rights Act 1998) as an integral part of the day-to-day business;
- Ensuring that all staff are aware of and fully comply with the relevant legislation as described in policies and fully understand their own responsibilities when undertaking surveillance activities;
- Ensuring that all staff acquire the appropriate authorisations when undertaking surveillance activities;
- Storing, archiving and disposing of sensitive and confidential surveillance information in an appropriate manner.

6.2 The Council will achieve this by ensuring that:

- Regulatory and legislative requirements are met;

- RIPA and surveillance training is provided;
- All breaches of privacy, actual or suspected, are reported, investigated and any resulting necessary actions taken;
- Standards, guidance and procedures are produced to support this policy.

Responsibilities

7.1 The Director of Legal and Democratic Services and Monitoring Officer is the Senior Information Risk Owner and has overall responsibility for Information Governance within the Council.

7.2 The Director of Legal and Democratic Services and Monitoring Officer is responsible for:

- Acting as the Council's RIPA Monitoring Officer
- Developing, implementing and maintaining the relevant corporate Information Governance policies, procedures and standards that underpin the effective and efficient surveillance processes;
- Support and advice to staff and managers on Surveillance;
- The production, review and maintenance of Surveillance policies and their communication to the whole Council;
- Provision of professional guidance on all matters relating to Surveillance;
- Oversight management of all privacy breaches and suspected breach investigations;
- Provision of corporate training;
- Provision, via the Intranet, of Surveillance briefing materials and, through ILearn, of on-line training;
- Management and recording of RIPA authorisations;
- Providing returns to national inspectors e.g. Investigatory Powers Commissioner's office (IPCO)
- Liaising with national inspection regimes, IPCO and the CCTV commissioner to organise inspections;
- Production of an annual Information Governance Report.

7.3 The RIPA Authorising Officers will assess and authorise RIPA applications.

7.4 The Senior Officer, who will be a service manager or above, will be made aware of IPA Communications data requests via the National Anti-Fraud Network (NAFN) process.

7.5 The Director of Legal and Democratic Services will authorise all internal intercept requests

7.6 The in-house Legal Services Team will advise and assist in staff investigations.

7.7 All Executive Directors will:

- Implement this policy within their business areas;

- Ensure compliance with it by their staff;
- Sign off applications for surveillance of staff;
- Where appropriate take steps to protect the Health and Safety of investigators and third parties.Surveillance Principles

7.8 West Northamptonshire Council is committed to a surveillance framework that ensures:

- Requests for Authorisations are assessed to ensure the privacy of the individual is not breached unless it is necessary and proportionate to do so.
- All requests are monitored, and performance indicators made available to demonstrate compliance with the legislation.

The surveillance process is regularly audited to ensure compliance with statutory requirements and that relevant national codes of practice are followed.

Intrusive Surveillance

8.1 Intrusive surveillance is covert surveillance carried out by an individual or a surveillance device in relation to anything taking place on residential premises or in any private vehicle. The Council is not permitted to carry out intrusive surveillance in any circumstances.

Directed Surveillance

8.2 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.

8.3 The Council will use Directed Surveillance to acquire information covertly where it is appropriate and legal to do so.

8.4 The appropriate Directed Surveillance application form, which will be available on the Council's intranet site, should be completed and submitted to the Authorising Officer.

8.5 Any officer completing the Directed Surveillance RIPA application form must contact Legal Services so that they can be authorised to attend the magistrate's court on behalf of the Council. This authorisation to act on behalf of the Council

at the court remains valid as long as the applying officer is employed by the Council.

8.6 The applying officer must submit the signed Directed Surveillance RIPA application, once it is signed by the Authorising Officer, to the local Magistrate for approval.

8.7 At the start of an investigation, council officers applying for a RIPA authorisation must satisfy themselves that what they are investigating is a criminal offence and passes the criminal threshold test.

8.8 If confidential information or matters subject to legal privilege are to be acquired, the Directed Surveillance may only be authorised by the Head of Paid Service or their deputy in their absence.

8.9 The Director of Legal and Democratic Services and Monitoring Officer will ensure there is always a minimum of three (3) trained Authorising Officers at the Council. These will be at Assistant Director level or above, and their names published on the Council's intranet.

8.10 The Director of Legal and Democratic Services and Monitoring Officer will comply with requests from the IPCO in relation to the organisation of inspections of the Council

8.11 Statistical returns for directed surveillance data acquired using RIPA will be submitted to the IPCO by the Director of Legal and Democratic Services and Monitoring Officer upon request.

8.12 A Directed Surveillance RIPA authorisation may also be used if the crime threshold is not met but the offence is a criminal offence under:

(i) sections 146, 147 or 147A of the Licensing Act 2003; or
(ii) section 7 of the Children and Young Persons Act 1933

(Underage sales of alcohol and tobacco).

8.13 A RIPA authorisation is not needed when it is not reasonably practicable for an authorisation to be sought for the carrying out of the surveillance in an immediate response to events.

Covert Human Intelligence Sources

9.1 Under the 2000 Act, a person is a CHIS if:

1. a) 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);
2. b) he covertly uses such a relationship to obtain information or to provide access to any information to another person; or

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

9.2 A relationship is established or maintained for a covert purpose if and only if it is conducted in a manner that is calculated to ensure that one of the parties to the relationship is unaware of the purpose.

9.3 The Council may use a covert human intelligence source (CHIS) to acquire information covertly where it is appropriate and legal to do so. A CHIS covertly uses a relationship to obtain information or to provide access to any information to another person.

9.4 The crime threshold does not apply to the authorisation of a CHIS.

9.5 The appropriate CHIS application form, which will be available on the Council's intranet site, should be completed and submitted to the Authorising Officer.

9.6 The applying officer must submit the signed CHIS RIPA application, once it is signed by the Authorising Officer, to the local Magistrate for approval.

9.7 The Council will never authorise the use of a CHIS under the age of 18 without carrying out a special risk assessment in relation to any risk of physical injury or psychological distress to the source that may arise.

9.8 The Council will never authorise the use of a CHIS under the age of 16 to gather evidence against his parents or carers.

9.9 If confidential information or matters subject to legal privilege are to be acquired by the CHIS, or the CHIS is a juvenile or a vulnerable individual, the Directed Surveillance may only be authorised by the Chief Executive (Head of Paid Service).

9.10 Monitoring of internet and/or social media sites as part of investigations or enforcement activity must be carried out in compliance with the relevant Code of Practice. Please refer to the Council's separate *Guidance on using social media and other online research to seek intelligence or to pursue investigations.*

Communications Data

10.1 Communications data is generated, held or obtained in the provision, delivery and maintenance of communications services, those being postal services or telecommunications services. The term 'communications data' embraces the 'who', 'when' and 'where' of a communication but not the content, not what was said or written. It includes the manner in which, and by what method, a person or machine communicates with another person or machine external to the Council.

10.2 Applications can be made for entity data (data that associates or links people, identifies people) or event data (data that identifies or describes events).

10.3 Local Authorities must not apply for access to internet connection records. It is a criminal offence to unlawfully access such internet data and any staff doing so may be subject to disciplinary procedures.

10.4 The crime threshold will apply only to the acquisition of communications data by local authorities for event data and not entity data.

10.5 The Council will appoint a Single Point of Contact (SPoC) known as the Senior Officer, who will be a service manager or above, responsible for the acquisition of external communications data. If the National Anti-Fraud Network (NAFN) SPoC system is not used, a trained and accredited member of Council staff must undertake this role.

10.6 NAFN will submit the request to the Office for Communications Data Authorisations (OCDA) on the Council's behalf if the NAFN service is subscribed to. Any application returned by OCDA for re-work must be completed within 14 days or a new request submitted.

10.7 Any application rejected by OCDA can be appealed within 7 days. Any appeal must be re-submitted via the Senior Officer.

10.8 If the National Anti-Fraud Network (NAFN) SPoC system is not used, the appropriate application form, which will be available on the Council's intranet site, should be completed and submitted to the Senior Officer.

10.9 Statistical returns for communications data acquired using IPA will be submitted to the Investigatory Powers Commissioner by the Director of Legal and Democratic Services and Monitoring Officer upon request.

10.10 The Director of Legal and Democratic Services and Monitoring Officer will comply with requests from the Investigatory Powers Commissioner and the National Anti-Fraud Network (NAFN) in relation to the organisation of inspections of the Council.

10.11 Council staff will refer to the statutory Codes of Practice issued by the government and guidance issued by the Council when applying for communications data.

Reviews, Renewals and Cancellations of RIPA Authorisations

11.1 The applying officer must review the authorisation monthly to decide if the operation needs to continue.

11.2 RIPA authorisations must be cancelled as soon as they are no longer required. Cancellations must be authorised by the Council's Authorising Officer.

11.3 RIPA authorisations for directed surveillance are only valid for 3 months. A CHIS authorisation remains valid for 12 months (or four months if a juvenile CHIS is used).

11.4 If a renewal is required, it must be applied for prior to the deadline. Renewals must be authorised by the Council's Authorising Officer and the Magistrate.

Reporting Errors in RIPA Authorisations

12.1 All errors in RIPA authorisations must be reported immediately by the applying manager or Authorising Officer to the Director of Legal and Democratic Services and Monitoring Officer

RIPA Requests from Third Parties

Requests from third parties to use Council equipment, facilities or buildings quoting RIPA authorisations must be made in writing, including a copy of the RIPA authorisation (redacted if necessary) and referred to the Director of Legal and Democratic Services and Monitoring Officer or in the case of CCTV, the CCTV Manager.

CCTV

13.1 The Council operates CCTV systems, the use of which is subject to the national CCTV code of practice, as adopted by the Council.

13.2 The Council will keep its CCTV protocol up to date.

13.3 Where CCTV cameras are used covertly as part of an operation to observe a known individual or group, an appropriate authorisation must be applied for.

13.4 Any statistical returns required by the CCTV Commissioner will be supplied to him by the Director of Legal and Democratic Services and Monitoring Officer upon request.

13.5 The Director of Legal and Democratic Services and Monitoring Officer will comply with requests from the CCTV Commissioner in relation to the organisation of inspections of the Council.

Surveillance of Employees and Non-RIPA Surveillance

14.1 All managers must consider the impact on the human rights of the staff member(s) under formal surveillance and complete one of the appropriate forms which can be found on the Council's intranet.

14.2 The Council will follow the ICO's 'Employment Practices Code' to ensure employees' personal information is respected and properly protected under the Data Protection Act 2018.

14.3 The Council may use Surveillance and the acquisition of internal communications data where there are grounds to do so. Procedures must be followed in relation to its staff where it is appropriate and legal to do so to protect the Council against claims of a breach of Article 8. A RIPA authorisation is not available in these circumstances. It is good practice to apply the same process however to address Article 8 considerations.

14.4 For the acquisition of communications data (including but not limited to cryptag logs, email accounts, computer access, printing logs, internet use logs and telephone call logs) and CCTV footage (overt or covert) managers must complete the separate form for the Interception of Data which can be obtained from the legal services team at legalservices@westnorthants.gov.uk.

14.5 For all other directed surveillance of staff, managers must submit a request to the Legal Services Team (email above).

RIPA does not grant powers to carry out surveillance. It simply provides a framework that allows the Council to authorise and supervise a defined category of surveillance in a manner that ensures compliance with the Human Rights Act 1998. Equally RIPA does not prevent surveillance from being carried out in other circumstances that fall outside the RIPA framework.

- There may be times when it will be necessary to carry out covert Directed Surveillance or use a CHIS other than by using RIPA. For example, in relation to an investigation into an allegation that a contractor is not carrying out their work as contracted, a serious disciplinary offence by a member of staff is alleged e.g., gross misconduct, or children are at risk where Court Orders are not being respected, then a RIPA authorisation is not usually available because "*criminal proceedings*" are not normally contemplated.

- Similarly, there may be serious cases of neighbour nuisance or involving anti-social activity which involve potential criminal offences for which the penalty is below the thresholds which would enable use of a RIPA authorisation. Nonetheless in such cases there may be strong grounds for carrying out

Directed Surveillance or use of a CHIS. Indeed, there may be circumstances in which Directed surveillance or use of CHIS is the only effective means of efficiently obtaining significant information to take an investigation forward.

14.6 Officers should be particularly careful to ensure that individuals who are not a CHIS at the outset of an investigation do not inadvertently become a CHIS by a process of "status drift". If, for example a complainant volunteers to obtain further information about a person being investigated, care should be taken to consider whether the proposed action would involve the complainant becoming a CHIS and if so whether that is appropriate and in accordance with RIPA and the CHIS Code of Practice. Advice should be sought from the Head of Information Governance & Risk if such conduct is suspected.

14.7 In the circumstances outlined above, a RIPA application may be completed in accordance with this Policy and the application must be clearly endorsed in red "NON-RIPA SURVEILLANCE" along the top of the first page. The application must be submitted in the normal fashion to the Authorising Officer who must considered it under the necessity and proportionality test in the same way they would a RIPA application. The normal procedure of timescales, review and cancellations must also be followed.

14.8 The authorisation, regular review, the outcome of any review, renewal applications and eventual cancellation must be notified to the RIPA Monitoring Officer in the normal way and using the same timescales as would be applicable to a RIPA investigation. However, for non RIPA surveillance the requirement to seek approval from the Magistrates Court is inapplicable. The authorisation for non RIPA surveillance takes effect from the date that it is authorised by the Authorising Officer.

Social Media

15.1 In some investigations, social media sites can form a useful source of intelligence. Usually, a review of open-source sites will not require authorisation. However, if reviews are carried out in respect of the same individual with some regularity, this may amount to directed surveillance and authorisation should be obtained.

15.2 If it is necessary and proportionate for the Council to covertly breach privacy controls (e.g., by becoming an account holder's "friend" using a false identity) to conduct an investigation, then a directed surveillance authorisation will be required.

15.3 If the surveillance involves more than merely reading the sites contents, then an authorisation for the use and conduct of a CHIS will be required.

15.4 Such activities may be monitored by the Council.

15.5 Please refer to the section in the Home Office Covert Surveillance and Property Interference Code of Practice on 'Online Covert Activity'. Please also refer to the Council's own *Guidance on using social media and other online research to seek intelligence or to pursue investigations*.

Storage & Destruction of Surveillance Data

16.1 The Director of Legal and Democratic Services and Monitoring Officer will store all signed authorisations electronically centrally in a secure manner.

16.2 All electronic copies of the signed authorisations, will be retained for three years and then disposed of securely, unless it is believed that the records could be relevant to pending or future criminal proceedings, where they must be retained for a suitable further period, commensurate to any subsequent review.

16.3 The Council will ensure that all material acquired during covert surveillance is held in secure locations, with clear handling instructions in place when material exchanges hands, and a clear retention, review, destruction (RRD) schedule will be applied to all copies made.

16.4 Standard Operating Procedures will be followed within teams producing covert material to support officers at a tactical level outlining wider safeguarding requirements (security, access, information sharing) and all relevant staff will be trained on these procedures.

Compliance with the Legislation

17.1 The Council recognises the need to make the contents of this Policy known and ensure compliance by every employee.

17.2 The Director of Legal and Democratic Services and Monitoring Officer will notify relevant staff of changes to RIPA and surveillance legislation, how these changes will affect them, when they will occur and what is needed to stay within the law.

17.3 The Council also recognises the need to make their policies known and accessible to the public. This policy will be published on the Council's website.

17.4 RIPA statistics, suitably redacted as to not reveal specific operations, will be published on the Council's website annually via the open data site.

21.5 West Northamptonshire Council expects all employees to comply fully with this policy. Disciplinary action may be taken against any Council employee who knowingly breaches any instructions contained in, or following from, this policy.

Complaints

22.1 Complaints relating to any surveillance matters must be made in writing and addressed to:

Director of Legal and Democratic Services and Monitoring Officer, West Northamptonshire Council, The Guildhall, St Giles Square, Northampton, NN1 1DE, or via email to:

legalservices@westnorthants.gov.uk

If the complainant is still unhappy following the Director of Legal and Democratic Services and Monitoring Officer response, they must be advised to write to:

The Investigatory Powers Tribunal, PO Box 33220, London, SW1H 9ZQ.

Tel.: 0207 035 3711

West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL
AUDIT & GOVERNANCE COMMITTEE

27 MARCH 2024

Report Title	**Governance Update - Corporate Health Monitoring**
Report Author	**Sarah Hall – Deputy Director of Law and Governance** **Sarah.Hall@westnorthants.gov.uk**

Contributors/Checkers/Approvers

DMO	Sarah Hall	19/03/2024
On behalf of S151 Officer	Audra Statham	19/03/2024

List of Appendices

Appendix A – Corporate Health Monitoring Indicator slides

1. Purpose of Report

1.1. To provide the Committee with an update and overview of the Corporate Health Monitoring work being undertaken across the Council.

2. Executive Summary

2.1 Working together the Director of Legal and Democratic, Deputy Director of Law and Governance and the Council's Head of Audit and Risk Management have developed a suite of Corporate Health Monitoring indicators as part of the Governance Framework which have been presented to the Executive Leadership Team and the Executive Programme Board and which are now presented to this Committee for information and oversight.

3. Recommendation

3.1 It is recommended that the Audit and Governance Committee consider the Corporate Health Monitoring indicators presented, identifying any additional indicators it feels would assist the Committee having oversight of the corporate health of the Council and assurance of effective governance across the Council.

4. Reason for Recommendation

4.1 The Corporate Health Monitoring indicators have been developed as part of the Governance Framework at the Council to monitor how the Council performs in the areas identified. This provides assurance of effective governance across the Council and helps to identify any trends or areas for improvement.

5. Report Background

5.1 The Information/Data contained within the attached Appendix 1 provides information relating to the Council's performance in the following areas:

- Risk Management
- Information Governance
- Upheld Ombudsman Complaints
- Code of Conduct complaints – WNC Councillors
- Internal Audit
- Insurance
- Health & Safety
- HR : Disciplinary cases, employment tribunals

5.2 Future reports will set out previous data as well as current data in order to identify any trends or areas for development.

5.3 Reports will be presented quarterly to the Executive Leadership Team, Executive Programme Board and this Committee in order to effectively monitor the indicators.

5.4 Effective governance is the responsibility of everyone across the Council. By monitoring a suite of indicators, greater understanding of what good governance looks like and how all Officers and Members can participate in ensuring effective governance can be achieved.

6. Issues and Choices

6.1 The Committee is asked to review the indicators presented and identify whether any additional data / information may be of use in providing assurance of good governance.

7. Implications (including financial implications)

7.1 Resources and Financial

7.1.1 There are no financial implications associated with the proposal.

7.2 **Legal**

7.2.1 There are no legal implications associated with the proposal.

7.3 **Risk**

7.3.1 There are no significant risks arising from the proposed recommendations in this report.

7.4 **Consultation**

7.4.1 The Executive Leadership Team and other relevant senior managers have been consulted on the Corporate Health Monitoring Indicators.

7.5 **Climate Impact**

7.5.1 None identified.

7.6 **Community Impact**

7.6.1 None identified.

7.7 **Communications**

7.7.1 None identified.

8. Background Papers

8.1 None.

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West Northamptonshire Council

CORPORATE HEALTH MONTORING FEBRUARY 2024

Contents

- Introduction

  Information/Data for:
- Risk Management
- Information Governance
- Upheld Ombudsman Complaints
- Code of Conduct complaints – WNC Councillors
- Internal Audit
- Insurance
- Health & Safety
- HR : Disciplinary cases, employment tribunals

Introduction

It has been agreed by the Statutory Officers that we will introduce quarterly monitoring, as part of regular scheduled ELT/AD meetings, to review a suite of key corporate health, governance and assurance data.

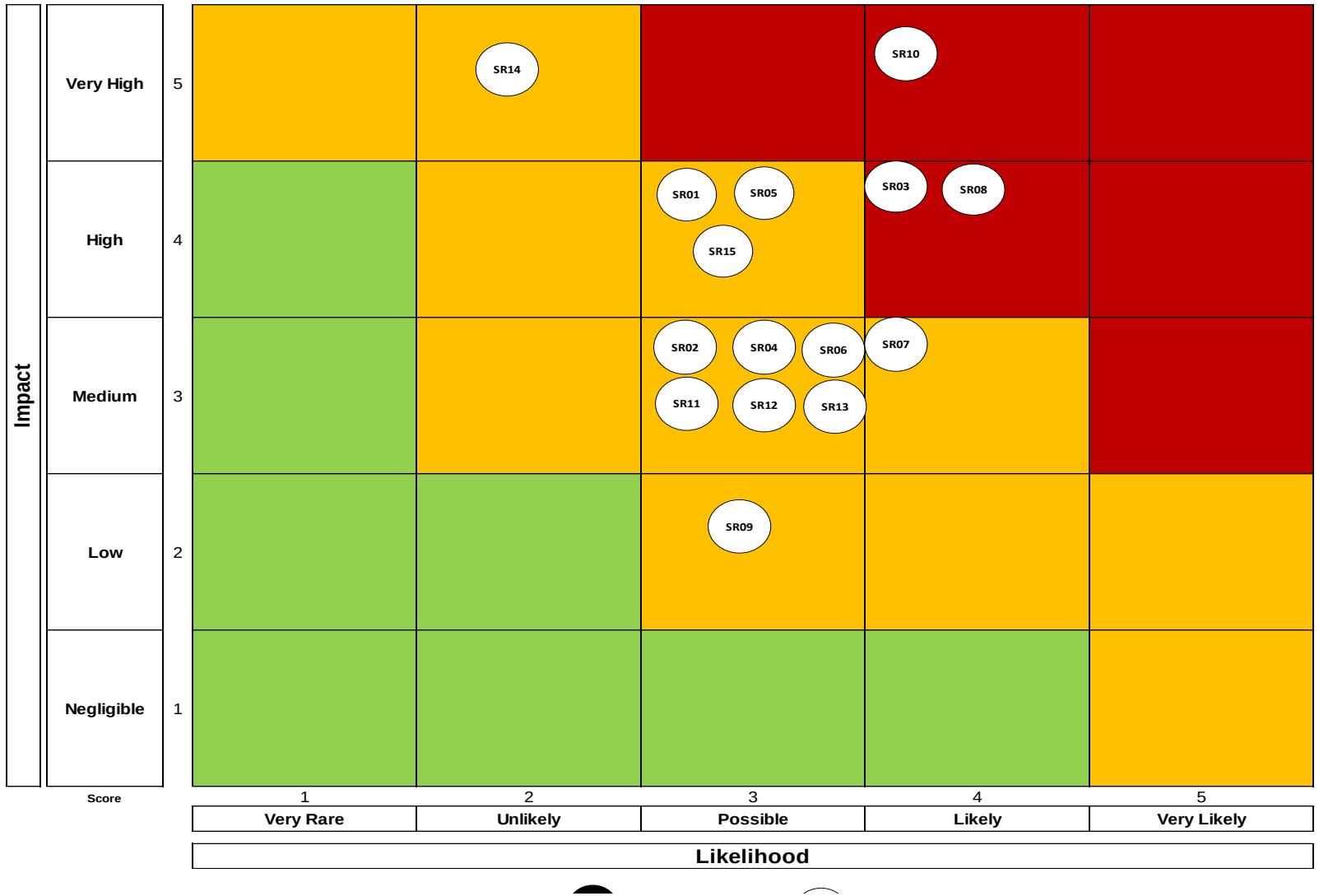
This will assist in raising awareness of any developing corporate concerns, horizon scanning for new risks and issues, and promptly identifying any emerging patterns / trends indicating concerns or problems.

This information will then be shared with the Audit and Governance Committee for oversight.

Risk Management (1)

- There has been a full refresh of the Strategic Risk Register that is in the process of being finalised.
- Final step in the process is for the Strategic Register and Risk Management Strategy to be presented at Cabinet on 12th March 2024.
- On approval the refreshed register will become the official WNC Strategic Risk Register.
- The register will be published on the Intranet and WNC Website.
- Next slide shows the proposed risks for WNC and the scoring on the risk map as at 31 December 2023.

Risk Management (2)



Risks

SR01	Cyber Security
SR02	NPH Residential - Change in Regulations
SR03	Cost of living impact - increased demand for services
SR04	Availability of affordable rental accommodation
SR05	Health and Safety of WNC properties
SR06	Inability to recruit and therefore deliver
SR07	Political risk
SR08	Inter authority agreements
SR09	NCT - relationships management (WNC / NNC / NCT)
SR10	NCT - Financial pressures
SR11	Strategic communications and reputational risk
SR12	RAAC (Reinforced Aerated Autoclaved Concrete)
SR13	Cladding
SR14	Financial Sustainability
SR15	Disaggregation and other disputes

Information Governance (1)

The following table shows the number of FOI/SAR requests received, the service has just recently started to collect the data and will be developed over the coming months. The percentages below for Q3 are indicative for each service.

FOI requests by directorate 2023/24	2023-2024			
	Q1	Q2	Q3	Total
B Chief Executives Office			4	4
B Corporate Services			37	37
B Finance			39	39
B People Services			33	33
B Place			113	113
				226

Information Governance (2)

Data for responses to requests; for two thirds of the cases responses outside the deadlines is lack of response from the service

	Q1	Q2	Q3	Total	%
FOI request responses (all)	349	306	359	1014	
FOI's responded to outside of 20WD	50	41	32	123	12%
EIR request responses (all)	97	126	82	305	
EIR's responded to outside of 20WD	6	13	4	23	8%
SAR (and other data rights) (all requests)	62	71	48	181	
SAR's responded to outside of the 1 month	8	3	2	13	7%
Data incidents reported to DPO	82	65	44	191	
ICO breach reports submitted	3	0	4	7	

Ombudsman Complaints

Summary of WNC Complaints By Directorate 1st April 2023 to 31st March 2024

Directorate	Number of complaints received	Complaints upheld	Closed after initial enquiries
Place, Economy & Environment	8	0	8
Communities & Opportunities	4	1	3
Childrens Safeguarding (ChildrensTrust NCT)	4	1	3
Corporate Parenting (ChildrensTrust NCT)	3	0	3
Childrens Trust	3	0	3
Finance & Resources	8	1	7
Education Services WEST	9	7	2
Corporate Services WEST	2	2	0

Code of Conduct Councillor Complaints

Councillor Complaints 1st April 2023 to 31 December 2023:

Council	Number of complaints	Active	Closed
Parish Council	15	6	9
WNC	10	1	9
WNC/Parish Council	1	1	0
PFCP	2	2	0

Internal Audit (1)

Total number of recommendation: **237**
Total outstanding **96**
% Outstanding **41%**

Classification		Essential	Important		Standard
Not yet due (this would include recommendations where an extension has been agreed)	53	6	39		8
Completed	132	25	89		18
Transferred to follow up audit (all limited assurance audits to have a follow up planned, usually within 12 months)	9	1	8		0
Overdue - management response received but not verified	0	0	0		0
Overdue - no management response received	43	15	26		2
Total	237	47	162		28

% Not due	22%
% Completed	56%
% Transferred	4%
% Overdue	18%

Insurance (1)

West Northamptonshire claims 1 April 2021 to 31 December 2023

Liability Summary	Received
Highways	1789
Adults	1
Corporate	12
Country Parks	2
Education Services	1
Grounds Maintenance	17
Car Parks	8
Parks and Open Spaces	16
Property / Estates	20
Public Health	2
Waste Management	15

Insurance (2)

Material Damage Summary	Received
Environment	1
Housing	4
Car Parks	3
Parks and Open Spaces	1
Property / Estates	17

Motor Vehicle Summary	Received
Adults	1
Environment	4
Fleet / Lease	5
Fleet / General	61
Waste Management	25

Health & Safety (1)

WNC WORKER INCIDENTS by SERVICE 1st April - 31st December 2023							
Education	People Directorate	Communities and Opportunities	NEAR MISS/PROPERTY	Corporate Services	Place, Economy & Environmental	NCT	Grand Total
139	72	49	46	38	34	6	384

WNC NON-WORKER INCIDENTS by SERVICE 1st April - 31st December 2023						
People Directorate	Communities and Opportunities	Education	Place, Economy & Environmental	NCT	Corporate Services	Grand Total
187	43	36	18	6	6	296

ALL WNC INCIDENTS 1st April - 31st December 2023							
People Directorate	Education	Communities and Opportunities	Place, Economy & Environmental	NEAR MISS/PROPERTY	Corporate Services	NCT	Grand Total
259	175	92	52	46	44	12	680

West Northamptonshire Council

Health & Safety (2) Incidents by type April – Dec 2023

Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Slip, trip, fall same level	43	51	34	7	8	9	10	14	6	182
Another kind of accident	15	20	27	10	7	12	16	12	18	137
Physical assault	5	10	20	6	2	13	24	32	7	119
Verbal abuse, threat & aggression	14	10	7	18	11	19	9	15	9	112
Property Damage	3	2	2	1	5	3	4	1		21
Struck by object	4	4	1	1	1	1	1	1		14
Ill-health contributing to an incident	2	1	2	2	2	1		2	1	13
Lifting and handling injuries		1	4	2			1	5		13
Struck against	3	2	1	1	1		1		1	10
Fall from height	1	1	2	2			1	1	1	9
Exposure to a hot surface or substance		1			1	1	1	3		7
Fire	2	1	2		1				1	7
Fall on stairs	2		1	1				1	1	6
Equipment Failure			1	1	1	1			2	6
Theft	1		2				2			5
Trespass / Unauthorised Access						2		1		3
Road Traffic Collision				1			1		1	3
Injured by an animal		1		1	1					3
Exposed to fire	1				1					2
Trapped by something collapsing							1			1
Vandalism			1							1
10 - Diving operations incidents									1	1
Contact with machinery		1								1
Struck by moving vehicle									1	1
21 - Accidental release or escape of substances liable to cause harm								1		1
18 - Unintended collapse, partial collapse of building or structure		1								1
Contact with electricity			1							1
Grand Total	**96**	**107**	**108**	**54**	**42**	**62**	**72**	**89**	**50**	**680**

Health & Safety (3)

RIDDOR Incidents 1 April 2023 to 31 January 2024

Incident Type	People	Education	Place , Economy & Environmental
Lifting and handling injuries	1		2
Slip, trip, fall same level	2		1
Fall on stairs			1
Another kind of accident	1	1	

HR

1 September to 31 December 2023:

Employment Pre-Tribunal Cases:
1 x Conciliation Agreement (COT3)
Serious HR Disciplinary Cases:
1 x suspension and subsequent dismissal
1 x dismissal
Any Independent / external assurance reports – main issues:
None

West Northamptonshire Council

WEST NORTHAMPTONSHIRE COUNCIL AUDIT & GOVERNANCE COMMITTEE

27 March 2024

Report Title	Work Programme

1. Purpose

1.1. The purpose of this report is to provide an updated work programme for consideration by the Committee

2. Recommendations

2.1. It is recommended that the Committee considers and approves the work programme.

3. Issues and Choices

Information

3.1 Attached at Appendix A is an updated work programme for the Committee.

3.2 The work programme will evolve over time and the Committee is requested to consider the attached programme and highlight any other areas where they may wish to receive further reports.

4. Implications (including financial implications)

4.1. Policy

4.1.1. There are no significant policy implications associated with this report.

4.2. Resources and Risk

4.2.1. There are no financial and risk implications associated directly with this report.

West Northamptonshire Council

4.3. Legal

4.3.1. There are no specific legal risks associated with this report.

4.4. Equality and Health

4.4.1. There are no specific equality and health issues associated with this report.

Report Author: Martin Henry
Executive Director – Finance
S151 Officer

Audit and Governance Committee

Appendix A

Work Programme

	27 March 2024	05 June 2024	25 July 2024	25 September 2024	19 November 2024	22 January 2025	12 March 2025
Minutes from the previous meeting	x	x	x	x	x	x	x
Internal Audit Plan 2024/25	x						x
Internal Audit Progress report	x	x	x	x	x	x	x
Public Sector Internal Audit Standards (PSIAS)	x						
Compliance with the CIPFA Position Statement on Audit Committees	x						
Strategic Risk Register and Risk Management Strategy	x	x	x	x	x	x	x
External Audit - Progress report	x	x	x	x	x	x	x
Northamptonshire Pension Fund 2023-24 - External Audit Plan	x						x
Regulation of Investigatory Powers Act (RIPA)	x	x	x	x	x	x	x
Update on Governance	x	x	x	x	x	x	x
Update on Budget Setting and Revenue and Capital Medium Term Capital Programme	x	x	x	x	x	x	x
Review of Committee Work programme	x	x	x	x	x	x	x

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