Notice of Meeting

Audit & Governance Committee

Date & time
Monday, 27 March 2017
at **10.00 am**

Place
Members Conference Room, County Hall, Kingston upon Thames, Surrey KT1 2DN

Contact
Angela Guest
Room 122, County Hall
Tel 020 8541 9075

angela.guest@surreycc.gov.uk

Chief Executive
David McNulty

We're on Twitter: @SCCdemocracy

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Angela Guest on 020 8541 9075.

Members

Mr Stuart Selleck (Chairman), Mr Denis Fuller (Vice-Chairman), Mr W D Barker OBE, Mr Will Forster, Mr Tim Hall and Mr Saj Hussain

Ex Officio:

Mr David Hodge CBE (Leader of the Council), Mr Peter Martin (Deputy Leader and Cabinet Member for Economic Prosperity), Mrs Sally Ann B Marks (Chairman of the County Council) and Mr Nick Skellett CBE (Vice-Chairman of the County Council)

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING - 20 FEBRUARY 2017 (Pages 1 - 8)

To agree the minutes as a true record of the meeting.

3 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter

(i) Any disclosable pecuniary interests and / or

(ii) Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner)
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS AND PETITIONS

To receive any questions or petitions.

Notes:

1. The deadline for Member's questions is 12.00pm four working days before the meeting (*21 March 2017)*.
2. The deadline for public questions is seven days before the meeting (*20 March 2017)*.
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 RECOMMENDATIONS TRACKER (Pages 9 - 14)

To review the Committee's recommendations tracker.

6 LEADERSHIP RISK REGISTER (Pages 15 - 24)

The purpose of this report is to present the latest Leadership risk register and update the committee on any changes made since the last meeting.

7 PENSION FUND ACCOUNTS EXTERNAL AUDIT 2016/17 (Pages 25 - 40)

This report provides the Audit and Governance Committee with the Audit Plan for the external audit of the 2016/17 financial statements of the Surrey Pension Fund.

8 BREACHES POLICY FOR THE FIREFIGHTERS PENSION SCHEME (Pages 41 - 74)

This report provides details of a written policy statement and guidance for breaches of the law in respect of all activities of the Surrey Fire & Rescue Authority (SF&R) in respect of the Firefighter's Pension Scheme (FFPS).

9 INTERNAL AUDIT PLAN (Pages 75 - 110)

The purpose of this report is to present the Annual Internal Audit Plan for 2017/18 to the Committee.

10 COMPLETED INTERNAL AUDIT REPORTS (Pages 111 - 118)

The purpose of this report is to inform Members of the Internal Audit reports that have been completed since the last meeting.

11 DATE OF NEXT MEETING

The next meeting of Audit & Governance Committee will be on 12 June 2017.

David McNulty
Chief Executive
Published: 16 March 2017

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

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MINUTES of the meeting of the **AUDIT & GOVERNANCE COMMITTEE** held at 10.00 am on 20 February 2017 at Members Conference Room, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its next meeting.

Elected Members:
(*Present)

*Mr Stuart Selleck (Chairman)
*Mr Denis Fuller (Vice-Chairman)
Mr Bill Barker
*Mr Will Forster
*Mr Tim Hall
*Mr Saj Hussain

1/17 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

An apology was received from Mr Bill Barker.

2/17 MINUTES OF THE PREVIOUS MEETING [5 DECEMBER 2016] [Item 2]

The Minutes of the previous meeting were approved as an accurate record.

3/17 DECLARATIONS OF INTEREST [Item 3]

There were none.

4/17 QUESTIONS AND PETITIONS [Item 4]

There were none.

5/17 RECOMMENDATIONS TRACKER AND BULLETIN [Item 5]

Declarations of interest:
None

Witnesses:
None

Key points raised during the discussion:

1. Tracker A11/16 – A response from the cabinet member for business services and resident experience had been received by the Chairman and emailed to all members of the committee. The council's position with Babcock 4s was still unclear. It was agreed to invite the cabinet member to the next meeting of the committee.
2. Tracker A13/16 – The project Horizon report was on track to come to the next meeting of this committee.
3. Tracker A14/16 – A response from the Chief Executive had been received regarding parking end of year statement deadlines.
4. Tracker A3/16 – Completed and therefore can be deleted from the tracker.

5. Tracker A18/15 – SEND – to keep this on the tracker to inform new members.
6. The committee gave thanks to Sue Lewry-Jones, Chief Internal Auditor, who was leaving the Council. The committee valued her support and professionalism in presenting reports and carrying out any actions.

Action/Further information to note:

1. To invite the cabinet member for business services and resident experience to the next meeting to discuss and clarify further the future with Babcock 4s - Tracker A11/16
2. To request that the Audit Performance Manager chase whether or note the financial position had been sorted out with Reigate - Tracker A14/16
3. Delete Tracker A3/16.
4. Send a copy of the notes from the first SEND Multi Board meeting to members of the committee – Tracker A18/15.

Resolved:

That the committee noted the tracker and information bulletin.

6/17 STATUTORY RESPONSIBILITIES NETWORK [Item 7]

Declarations of interest:
None

Witnesses:
David McNulty, Chief Executive

Key points raised during the discussion:

1. In response to a question about how the committee should be assisting with savings and structure of budgets the Chief Executive explained that the committee regularly review the risk register in terms of sustainability, specific strategic responses and that services were being delivered as they should. It was thought that the Statutory Responsibilities Network (SRN) consisted of the right people.
2. The SRN focus was now on further savings needed following council's budget decision and ensuring requirements were met with regards to consultation and mitigating any consequences.
3. In response to a query regarding lessons learned from the implementation of the Multi-Agency Safeguarding Hub (MASH) the Chief Executive explained that the project planning was done according to Prince 2 and nothing was to be learned from this as it went as it should. However, there were lessons to be learned from the impact of MASH and other services in the system. There was ongoing work with partners ensuring that referrals to the MASH were appropriate. The SRN had not signed off the Project Implementation Document (PID) yet as there was still work needed to ensure the project was working as it should be. A report was expected by SRN within the next few weeks. It was stated that children were safer now the MASH was in place.

Actions/ further information to be provided:
None.

Resolved:
That the Audit & Governance Committee Chairman continues to meet with the Network Chairman, the Chief Executive, in order to keep up-to-date with network activity.

7/17 ETHICAL STANDARDS - ANNUAL REVIEW [Item 6]

Declarations of interest:
None

Witnesses:
Ann Charlton, Monitoring Officer and Director of Legal & Democratic Services

Key points raised during the discussion:

1. The Monitoring Officer introduced the report and stated that the highest number of complaints were regarding lack of timely response to the public. Whilst this was not an ethical standards issue it may be a performance issue and group leaders were notified. It was advised that if Members did not want to respond to any particular communication they should politely explain this in order to close it down. She also reported that officers keep any code of conduct complaints confidential unless proven.
2. One member queried whether there should be specific training for councillors on social media and how to behave around it. The Monitoring officer replied that if the council were promoting members to use social media then they should be given advice on its use.
3. The Monitoring Officer explained that it was proving difficult to get all members to update their Register of Interests (RoI) forms and one member stated that they were unable to print from an ipad which was becoming a more general problem for members and paperwork.
4. Some members suggested that examples be given on the RoI form and maybe list potential organisations that may need to be considered. The Committee were informed that organisation needed to be listed where members had a managerial or a role of influence in that organisation. Whilst it was agreed that a list of organisations may not be helpful, in case some were missed, it was requested that a list of types of organisations would be useful to members.

Actions/ further information to be provided:
None

Resolved:

1. That the Monitoring Officer provides training and guidance to new and returning members as outlined in paragraph 17 of the report.

2. The Monitoring Officer's report on recent activity in relation to the Code of Conduct and complaints made in relation to member conduct was noted.

8/17 2016/17 EXTERNAL AUDIT PLAN AND KEY PERFORMANCE INDICATORS [Item 8]

Declarations of interest:
None

Witnesses:
Thomas Ball, Grant Thornton
Geoffrey Banister, Grant Thornton

Key points raised during the discussion:

1. Grant Thornton (GT) introduced the audit plan for 2016/17 and highlighted the two focus areas for the Value for Money conclusion: an update on the Ofsted opinion in relation to Children's' Services and the Council's financial position. The report had been written before the Council's decision not to increase Council Tax by 15%, but the need to review the Councils financial position remained.
2. In response to a question about why GT needs to review the pension liability calculation when it is carried out by a specialist actuary, GT said that it needed specific review due to its size and that small changes in the calculation or assumptions used could have a large effect on the accounts. GT also responded that fees for this work were set by the regulator but that GT decided what work to do in that financial envelope. Pensions were complex and if something was missed the committee would have cause to complain about the work of GT.
3. GT explained how they met with the leadership team and the Leader on an annual basis and regularly met with audit officers to look at key issues. There was also regular meetings with the S151 officer and key finance officers. The committee discussed the deferring of the changes in the valuation of highways. CIPFA have deferred this for a year. GT stated that the valuation size and scale would require additional audit work and they were awaiting a decision from CIPFA about whether this implementation would be deferred further.
4. The Finance Manager assured the committee that a report would come to committee before the implementation of these changes, when more clarity was reached.

Actions/ further information to be provided:
None.

Resolved:
The Audit Plan and proposed Key Performance Indicators for 2016/17 as attached to the report were approved.

9/17 2015/16 AUDIT FINDINGS REPORT FOR SURREY CHOICES LTD [Item 9]

Declarations of interest:
None

Witnesses:
Geoffrey Banister, Grant Thornton
David John, Audit Performance Manager

Kevin Kilburn, Deputy Chief Finance Officer

Key points raised during the discussion:

1. Grant Thornton introduced the report and explained that whilst it was an improvement on the previous year, it was a very difficult audit and that process had been put in place to make this easier in the future.
2. The Audit Performance Manager explained that audit work had been undertaken with Surrey Choices and it would be looked at again this year.
3. There had been a part 2 report discussed at the Council Overview Board (COB) at which a member of the Shareholder Board had attended. The Committee wished for that report and a member of the Board to attend the next meeting of the Audit & Governance Committee to discuss governance issues. The Deputy Chief Finance Officer reiterated that the committee needed to be sure they were not duplicating the work of COB.
4. Clarification was requested in relation to the description of page 15 of the financial statements which the Deputy Chief Finance Officer would take up with the company.

Actions/ further information to be provided:

1. Committee Manager to send copy of the part 2 report and minutes of Council Overview Board.
2. The Deputy Chief Finance Officer to raise the description on page 15 of the financial statements document.

Resolved:

To invite the Chairman of the Shareholder Board to the next meeting of the committee to discuss governance issues.

10/17 MINIMUM REVENUE PROVISION CALCULATION [Item 10]

Declarations of interest:
None

Witnesses:
Nicola O'Connor, Finance Manager Assets and Accounting

Key points raised during the discussion:

1. The Finance Manager introduced the report and in response to a query, confirmed that the external auditors had been presented with a technical paper regarding these changes and the Finance Manager was not expecting any issues during the audit in relation to these changes.

Actions/ further information to be provided:
None

Resolved:
The report was noted.

2

11/17 COMPLETED INTERNAL AUDIT REPORTS [Item 11]

Declarations of interest:
None

Witnesses:
David John, Audit Performance Manager

Key points raised during the discussion:

1. The Audit Performance Manager introduced the report which set out seven audit reports that had been completed since the last meeting of the committee.
2. Three of these reports had an audit opinion of significant improvement needed. All of these were programmed for follow up. They were each discussed in detail by the committee.
3. In response to a question it was reported that there was not consistency in understanding the difference between accident and incident and whether or not it should be reported. Steps were being taken to improve the logging of what should be logged.
4. There was some discussion around agency staff and in particular those that were here for some time and whether or not they received health and safety training. Even those that worked for Surrey CC for very short periods should have the basics covered. The Audit Performance Manager stated that assurances were coming from managers but this was not evidence based.
5. There was much discussion about the highways contract with regards to problems of standards, management not holding to account or taking the issues seriously enough. It was recognised that the contract was small to the contractor and some members spoke of the wish that it come back in-house.
6. The Audit Performance Manager reported that the new manager, Andrew Milne, was addressing the issues and ensuring that the top level had a grasp of the problems.
7. It was reported that the Economic, Prosperity, Environment and Highways Board was due to review the highways contract.
8. Members asked why the contract had been renewed when 25% of gulleys checked had not been cleaned and that local highways teams were effectively doing the work that should be done by Kier as contract manager.
9. The Audit Performance Manager reported that a follow up audit would be undertaken as soon as practicable after the agreed date for implementing recommendations.

Actions/ further information to be provided:

1. To include the following issues on the tracker:
   - Feedback to committee from meeting with officers in March to discuss cyber security (Tracker A2/17)
   - Update to the March committee meeting on improvements in Health & Safety (Tracker A3/17)
2. Chairman to write to the Chairman of People, Performance and Development Committee raising the concerns of this committee regarding health and safety. (Tracker A3/17)

3. Chairman to write to the Cabinet Member, copy to the Leader, regarding the committee's concerns on the renewal of the highways contract. (Tracker A4/17)

Resolved:

The Committee noted the report.

12/17 2016/17 REVIEW OF THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL AUDIT [Item 12]

Declarations of interest:
None

Witnesses:
David John, Audit Performance Manager

Key points raised during the discussion:

1. The Audit Performance Manager went through each section of annex 1 to the report and reported that the Charter had been approved by the Strategic Responsibilities Network and that new KPI's will be part of the Orbis-IA agreed governance arrangements.
2. He also reported that the reports would look different in future. The opinion may use the word 'assurance' but the phrase 'significant improvement' could still be used within the management summaries and conclusions.
3. and would be exceptional reports rather than narrative.
4. There was further discussion regarding the proposed changes to the reports which the committee felt uneasy about. The committee all agreed that they would prefer to keep the word 'improvement' as to change this would mean a dilution of importance and it was understood by the public. The Audit Performance Manager explained that the stakeholder could ask for a review.

Actions/ further information to be provided:
None.

Resolved:

1. The report was noted.

2. The committee requested that the term 'significant improvement' not be replaced by 'assurance' in future audit reports.

13/17 ANNUAL REPORT OF THE AUDIT & GOVERNANCE COMMITTEE [Item 13]

Declarations of interest:
None

Witnesses:
None

Key points raised during the discussion:

1. Saj Hussain pointed out that he was not a Member of the Resident Experience Board.
2. It was requested that in future there was more detail around the work of the committee and skills of committee members be included in the report.

Actions/ further information to be provided:
To correct the report and publish.

Resolved:
The report was noted.

14/17 TREASURY MANAGEMENT STRATEGY [Item 14]

Declarations of interest:
None

Witnesses:
Phil Triggs, Strategic Manager Pensions & Treasury

Key points raised during the discussion:

1. The Strategic Manager Pension Fund & Treasury introduced the report stating that full Council had already approved the treasury management strategy. He went through table 2.1: current and projected portfolio position and table 2.2: prospects for interest rates within the report.
2. There was discussion around the levels of cash before borrowing took place as the previous minimum cash limit was £47m but this requirement had not been kept in the new strategy. The Strategic Manager Pension Fund & Treasury explained the current financial advantages of short term borrowing, which would be beneficial on a temporary basis. Temporary was defined as over the next one to three years and if economic conditions changed, the strategy would be adapted accordingly after taking advice from the council's treasury consultant.

Actions/ further information to be provided:
None

Resolved:

The content of the Treasury Management Strategy for 2017/18 was approved.

15/17 DATE OF NEXT MEETING [Item 16]

The date of the meeting was NOTED.

Meeting ended at: 12.32 pm

_____

Chairman

Audit & Governance Committee
27 March 2017

Recommendations Tracker

PURPOSE OF REPORT:

For Members to consider and comment on the Committee's recommendations tracker. To note the Information Bulletin.

INTRODUCTION:

A recommendations tracker recording actions and recommendations from previous meetings is attached as Annex A, and the Committee is asked to review progress on the items listed.

RECOMMENDATION:

The Committee is asked to monitor progress on the implementation of recommendations from previous meetings in Annex A.

REPORT CONTACT: Angela Guest, Regulatory Committee Manager
020 8541 9075
angela.guest@surreycc.gov.uk

Sources/background papers: None

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Annex A

Audit & Governance Committee Recommendations Tracking

Recommendations (ACTIONS)

Number	Meeting Date	Item	Recommendation / Action	Action by whom	Action update
A4/17	20/02/17	Completed Internal Audit reports - Highways	Chairman to write to the Cabinet Member, copy to the Leader, regarding the committee's concerns on the renewal of the highways contract.	Chairman	**Letter sent to CM on 13 March.**
A3/17	20/02/17	Completed Internal Audit reports – health & safety	Verbal update to the March committee meeting on improvements in Health & Safety	Internal Audit	
A2/17	20/02/17	Completed Internal Audit reports – cyber security	Feedback to committee from meeting with officers in March to discuss cyber security	Internal Audit	
A1/17	20/02/17	Audit for Surrey Choices	1. To send copy of the part 2 report and minutes of Council Overview Board. 2. To invite Shareholder Board to next meeting of A&G	Committee manager Chairman	1. **Posted to Members 1/3/2017**
A14/16	5/12/16	Completed Internal Audit reports	Chairman to write to the Chief Executive regarding the committee's concerns on boroughs and districts not passing on their end of year statements to parking enforcement and requesting that deadlines are enforced.	Chairman	Response received from Chief Executive 24/1/2017 - **To request that the Audit Performance Manager chase whether or not the financial position had been sorted out with Reigate**

Annex A

Audit & Governance Committee Recommendations Tracking

Number	Meeting Date	Item	Recommendation / Action	Action by whom	Action update
A13/16	5/12/16	Internal Audit half year report	The chief internal auditor was requested to enquire about the resources to do the expected monitoring for operation horizon.	Chief Internal Auditor	**The project Horizon report was on track to come to the March 2017 meeting of this committee.**
A11/16	5/12/16	Babcock 4S – directors report & financial statement	The Chairman to write a letter to the cabinet member for business services and resident experience regarding the committee's concerns	Chairman	A response from the cabinet member for business services and resident experience had been received by the Chairman and emailed to all members of the committee. The council's position with Babcock 4s was still unclear. **It was agreed to invite the cabinet member to the March 2017 meeting of the committee.**
A8/16 Merged A20/15 A43/15 -Dec 2016	28/05/150 7/12/15	Completed Internal Audit Reports Internal Audit Half Year Report 2915/16	record keeping for accounts relating to individuals' care charges be moved from Adult Social Care to Business Services. management response to an Internal Audit recommendation regarding outstanding financial assessments.	Chairman	Members from Audit & Governance Committee were invited to attend the Social Care Services Board on 26 October to take part in discussions on this item. Denis Fuller and Tim Hall attended as did Saj Hussain who is a member of SCSB. **Jan 2017 – Committee agreed to keep on the tracker for the new committee.**

Number	Meeting Date	Item	Recommendation / Action	Action by whom	Action update

Annex A

Audit & Governance Committee Recommendations Tracking

Number	Meeting Date	Item	Recommendation / Action	Action by whom	Action update
A18/15	09/04/15	SEND Strategy	Assistant Director for Schools and Learning to share a summary work programme for developing the SEND Strategy with the committee.	Assistant Director for Schools and Learning	SEND Strategy 2020 and development plan agreed and published. A formal multi-board group set up to monitor the four workstreams of the plan. The Boards involved will be SCS, ESB and REB. The Education & Skills Board and the Social Care Services Board and the Wellbeing & health Scrutiny Board have submitted a task group scoping document to COB for approval at its September meeting. At the July meeting of A&G it was agreed to keep this on the tracker and to monitor the four workstreams of the multi board. The first meeting of the multi-Board task group takes place on 15 December 2016. 5/12/16 – A&G agreed to keep this on the tracker in order to inform the post-election members. **A copy of the notes from the first SEND Multi Board meeting were sent to members of the committee 1/3/2017**

Annex A

Audit & Governance Committee Recommendations Tracking

COMPLETED RECOMMENDATIONS/REFERRALS/ACTIONS – TO BE DELETED

Number	Meeting Date	Item	Recommendation / Action	Action by whom	Action update

Audit & Governance Committee
27 March 2017

Leadership Risk Register

Purpose of the report:

The purpose of this report is to present the Leadership risk register as at 28 February 2017 and update the committee on any changes made since the last meeting to enable the committee to keep the council's strategic risks under review.

Recommendations:

It is recommended that the committee:

1. Review the Leadership risk register; and

2. Determine whether there are any matters that they wish to draw to the attention of the Chief Executive, Cabinet, specific Cabinet Member or relevant Scrutiny Board.

Leadership risk register:

3. The Leadership risk register (Annex 1) is owned by the Chief Executive and shows the council's key strategic risks. The register is regularly reviewed by strategic risk leads from across the council, senior management and members.

4. Since it was last presented to the committee in December 2016, the risk register has been reviewed by the Strategic Risk Forum[1] (chaired by the Director of Finance) and the Statutory Responsibilities Network[2].

Changes to the Leadership risk register

5. The key changes to the risks are:
   - Updates to the processes and controls to reflect the current financial situation (Medium Term Financial Plan – L5); and

[1] Strategic Risk Forum membership – Director of Finance (Chair), strategic risk leads, Chief Internal Auditor, Head of Emergency Management, Risk and Governance Manager.
[2] Statutory Responsibilities Network membership – Chief Executive (Chair), statutory officers for Social Care and Public Health, Education, Fire, Director of Finance, Director of Legal, Democratic and Cultural Services, Chief Internal Auditor.

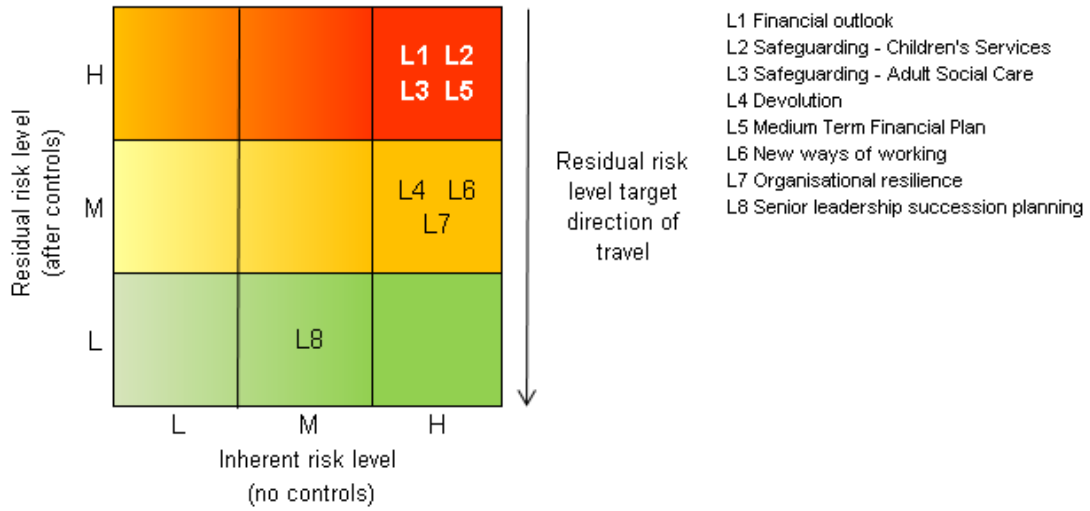
6

- Additional references to staff resilience, capacity and workload; and Member induction (Organisational Resilience – L7).

Residual risk level

6. The Leadership risk register includes both the inherent and residual risk levels for each risk. Inherent risk is the level of risk before any control activities are applied. The residual risk level takes into account the controls that are already in place, detailed on the risk register as both 'processes in place' and 'controls.'

7. There are eight risks on the Leadership risk register, seven of which have a high inherent risk level, as illustrated in the table below. Despite mitigating actions, four of these risks continue to have a high residual risk level (L1,L2,L3,L5), three have a medium residual risk level (L4,L6,L7) and one has a low residual risk level (L8): showing the significant level of risk that the council is facing despite the processes and controls being put in place to manage the risks.



Implications:

Financial and value for money implications

8. There are no direct financial implications relating to the Leadership risk register.

Equalities and Diversity Implications

9. There are no direct equalities implications but any actions taken need to be consistent with the council's policies and procedures.

Risk Management Implications

10. Effective management of risks and financial controls supports the council to meet its objectives and enable value for money.

Report contact: Rawdon Phillips, Risk Manager, Finance

Contact details: 01273 481593 or Rawdon.Phillips@eastsussex.gov.uk

Leadership risk register as at 28 February 2017 *(covers rolling 12 months)*

Owner: David McNulty

Strategic risks – have the potential to significantly disrupt or destroy the organisation

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
L1	CSF7 EAI1 FN1 ORB10	**Financial outlook** Lack of funding, due to constraints in the ability to raise local funding and/or distribution of funding, results in significant adverse long term consequences for sustainability and service reductions leading to significant implications for residents.	**High**	• Structured approach to ensuring Government understands the council's Council Tax strategy and unsustainable impact of current funding mechanism. • Targeted focus with Government to secure a greater share of funding for specific demand led pressures (in particular Adult Social Care). • Proactive engagement with Government departments to influence Government policy changes (especially relative needs assessment, 100% business rate retention strategy, learning disabilities and Better Care Fund). • Continued horizon scanning of the financial implications of existing and future Government policy changes. • Development of alternative / new sources of funding (e.g. bidding for grants). Notwithstanding actions above, there is a significant risk of Central Government policy changes /austerity measures due to changes in ministerial responsibilities impacting on the council's long term financial sustainability.	- Members make decisions to stop new spending, reduce spending and or generate alternative sources of funding, where necessary, in a timely manner. - Officers unable to recommend MTFP unless a credible sustainable budget is proposed. - Members proactively take the opportunities to influence central Government. - Officers continue to analyse events and create budget scenarios. - The organisation uses external expertise to confirm the facts relating to its sustainability.	Director of Finance	**High**
L2	CSF3,4,9	**Safeguarding – Children's Services** Avoidable failure in Children's Services, through action or inaction, including child sexual exploitation, leads to serious harm, death or a major impact on well	**High**	• Working within the frameworks established by the Children's Safeguarding Board and the Social Care Services Board ensures the council's policies and procedures are up to date and based on good practice. • The Adult Social Care and Children, Schools and Families Multi-Agency Safeguarding Hub	- Timely interventions by well recruited, trained, supervised and managed professionals ensures appropriate actions are taken to safeguard and promote the well being of children in Surrey. - Actively respond to feedback	Deputy Chief Executive and Strategic Director of Children's Schools and Families	**High**

Key to references:
ASC = Adult Social Care risk
CSF = Children, Schools and Families risk
C&C = Customers and Communities risk
EAI = Environment and Infrastructure risk
FN = Finance Service risk
ORB = Orbis risk

Leadership risk register as at 28 February 2017 *(covers rolling 12 months)* Owner: David McNulty

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
		being.		went live on 5 October 2016. • The Children's Services Improvement Plan was refreshed in October 2016 and is being delivered to address the improvement notice dated 26 January 2016 and strengthen service and whole system capability and capacity. Ofsted visit on a quarterly basis to monitor progress. • Assistant Director roles and responsibilities have been reshaped to strengthen leadership and governance. Appointees are now all in place.	from regulators. - Robust quality assurance and management systems in place to identify and implement any key areas of learning so safeguarding practice can be improved. - The Children's Safeguarding board (chaired by an independent person) comprises senior managers from the County Council and other agencies facilitating prompt decision making and ensuring best practice. - An Improvement Board (chaired by the Deputy Leader) oversees progress on the Improvement Plan and agrees areas of action as required.		
L3	ASC6,7 ,13,14	**Safeguarding – Adult Social Care** Avoidable failure in Adult Social Care, through action or inaction, leads to serious harm, death or a major impact on wellbeing.	**High**	• Working within the framework established by the Surrey Safeguarding Adults Board ensures that the council's policies and procedures are up to date and based on good practice. • The Adult Social Care and Children, Schools and Families Multi Agency Safeguarding Hub went live on 5 October 2016. • Established a locality safeguarding advisor to assure quality control. • Strong leadership, including close involvement by Associate Cabinet Member for Adult Social Care in safeguarding functions.	- Continue to work with the Independent Chair of the Surrey Safeguarding Adults Board to ensure feedback and recommendations from case reviews are used to inform learning and social work practice. - Actively respond to feedback from regulators. - One year on from the implementation of the Care Act, a new strategic plan for safeguarding within ASC will	Strategic Director of Adult Social Care & Public Health	**High**

Key to references:
ASC = Adult Social Care risk
CSF = Children, Schools and Families risk
C&C = Customers and Communities risk
EAI = Environment and Infrastructure risk
FN = Finance Service risk
ORB = Orbis risk

Leadership risk register as at 28 February 2017 *(covers rolling 12 months)* Owner: David McNulty

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
					be implemented.		
L4		**Devolution** Failure to achieve a devolution deal leaves Surrey County Council without a coherent response to the strategic infrastructure challenges facing the county.	**High**	• 3SC internal governance arrangements agreed - including a Strategic Oversight Group which manages 3SC risks (and 3SC risk register developed/approved). • Programme office and workstream sponsors and leads agreed with roles and responsibilities defined. • Regular meetings of local authority Leaders and Chief Executives. • Regular engagement with 3SC partners. • Regular engagement with central government at both political and official level. Negotiation with Government underway – Heads of Terms sent to officials as basis for negotiations: draft deal document to follow. • Establishment of a shadow Sub National Transport Body to support the delivery of major strategic transport infrastructure.	- Keep all processes under active review. - Strategic Oversight Group reviewing risk register quarterly. - Next 3SC Leaders' Board in July 2017	Chief Executive	**High**

Cross cutting risks – high level risks that can be mitigated more effectively through cross working.

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
L5	ASC1,2, 12,16,17 C&C4 CSF1,2, 7 EAI1,3 FN2	**Medium Term Financial Plan (MTFP) 2017-20** Failure to achieve the MTFP, which could be a result of: • Not achieving savings • Additional service	**High**	• Monthly reporting to Continuous Improvement and Productivity Network and Cabinet on the forecast outturn position is clear about the impacts on future years and enables prompt management action (that will be discussed informally with Cabinet). • Weekly review of the in year financial position	- Prompt management action taken by Directors / Leadership Teams to identify correcting actions for any in year overspends or failure to deliver service reductions (evidenced by robust action	Director of Finance	**High**

Key to references:
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Leadership risk register as at 28 February 2017 *(covers rolling 12 months)* Owner: David McNulty

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
	ORB01, 10	demand and/or • Over optimistic funding levels. As a consequence, lowers the council's financial resilience and could lead to adverse long term consequences for services if Members fail to take necessary decisions.		at Chief Executives Direct Reports meeting. • Budget planning discussions held with Cabinet and Scrutiny Boards. • Early conversations are undertaken with all relevant stakeholders to ensure consultations about service changes are effective and completed in a timely manner (savings tracker developed for use during 2017/18 to identify necessary consultations, milestones, Equality Impact Assessments). • Cross service networking and timely escalation of issues to ensure lawfulness and good governance. • Increased challenge and rigour on cost control. • Chief Executive's Direct Reports meeting agreement to focus capacity on three key priorities – information management in CSF, health and social care integration and assets. • Member led Sustainability Review Board established to focus on ensuring all service reductions are clearly identified, planned and monitored during 2017/18.	plans). - Members (Council, Cabinet, Scrutiny Boards) make the necessary decisions to implement action plans in a timely manner. - Members have all the relevant information to make necessary decisions.		
L6	ASC2, 16 CSF1,2, 5,6,8 ORB01, 02,07, EMT3, 12, EA13	**New ways of working** Failure to identify and manage the impacts / consequences of implementing a range of new models of delivery leads to severe service disruption and reputational damage.	**High**	• Shared and aligned strategies to ensure no unintended consequences. • Robust governance arrangements (eg. Inter Authority Agreements, Health and Social Care Integration Board, Health and Wellbeing Board, financial governance framework) in place with early warning mechanisms. • Regular monitoring of progress and risks against transformation programmes. • Effective transition arrangements with continuous stakeholder engagement.	- Leadership and managers recognise the importance of building and sustaining good working relationships with key stakeholders and having early discussions if these falter. - Work with Clinical Commissioning Groups on models of integrated care. - Members continue to endorse approaches to integration across the council.	Chief Executive	**Medium**

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Leadership risk register as at 28 February 2017 *(covers rolling 12 months)* Owner: David McNulty

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
				• Continuous focus on building and maintaining strong relationships with partners through regular formal and informal dialogue. • Close liaison and communication with customers.			
L7	ASC4, 5,8 CSF5 EAI2,3 ,4 ORB0 2,03,0 8, EMT1, 10,11	**Organisational resilience** Failure to plan for and/or respond effectively to a significant event and or strains on workforce capacity or resilience, results in severe and prolonged service disruption and loss of trust in the organisation.	**High**	• Developing an employment framework that supports flexibility in service delivery and organisational resilience. • Robust governance framework (including codes of conduct, IT security policies, health and safety policies, complaints tracking). • Information Governance Board monitors information governance requirements and changes and reviews information governance risks. • Review of third party information governance risks. • External risks are regularly assessed through the Local Resilience Forum and reviewed by the Statutory Responsibilities Network. • Active learning by senior leaders from external experiences / incidents informs continual improvement within the council. • Close working between key services and the Emergency Management Team to proactively update and communicate business continuity plans and share learning. • High Performance Development Programme in place to increase skills, resilience and effectiveness of leaders. • Career conversations built into appraisal process looking forward five years • Shaping leaders programme. • Ensure a clear Induction Programme is	- Regular monitoring of effectiveness of processes is in place and improvements continually made and communicated as a result of learning. - Robust change management processes.	Chief Executive	**Medium**

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ASC = Adult Social Care risk
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Leadership risk register as at 28 February 2017 *(covers rolling 12 months)*

Owner: David McNulty

Ref	Risk ref.	Description of the risk	Inherent risk level (no controls)	Processes in place *(ie the 'how' risks are being mitigated)*	Controls *(i.e. decisions needed)*	Lead risk owner	Residual risk level (after existing controls)
				developed and delivered in a timely manner for new Members following local elections in May 2017 (to recognise that new members will have to learn quickly about the challenges facing the county and be in a position to make key decisions).			
L8		**Senior Leadership Succession Planning** A significant number of senior leaders leave the organisation within a short space of time and cannot be replaced effectively resulting in a reduction in the ability to deliver services to the level required.	**High**	• Enhance distributed leadership by focus on organisational goals and scorecard for organisational performance. • Workforce planning linked to business continuity plans. • Senior leadership appraisal process incorporates feedback (shaping leaders) and succession planning into appraisal process.	- Transparent and effective succession plans.	Chief Executive	**Medium**

Key to references:
ASC = Adult Social Care risk
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Movement of risks

Ref	Risk	Date added	Inherent risk level when added	Movement in residual risk level		Current residual risk level
L1	Financial outlook	Aug 12	High	Jan 16	⇧	High
L2	Safeguarding – Children's Services	May 10	High	Jan 15	⇧	High
L3	Safeguarding – Adult Social Care	May 10	High	Jan 15	⇧	High
L4	Devolution	Jan 16	High	Nov 16	⇧	High
L5	Medium Term Financial Plan	Aug 12	High	-	-	High
L6	New ways of working	Jan 16	High	-	-	Medium
L7	Organisational resilience	May 10	High	Aug 12	⇩	Medium
L8	Senior Leadership Succession Planning	Mar 15	High	Nov 16	⇧	Medium

Risks removed from the register in the last 12 months

Risk	Date added	Date removed
National policy development	*Feb 13*	*Jan 16*
Waste	*May 10*	*Jan 16*
Comprehensive Spending Review 2015	*Sept 14*	*Jan 16*
Reputation	*Oct 14*	*Jan 16*
Staff resilience	*May 10*	*Jan 16*
Information governance	*Dec 10*	*Jan 16*
Supply chain / contractor resilience	*Jan 14*	*Jan 16*

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Leadership level risk assessment criteria

Due to their significance, the risks on the Leadership risk register are assessed on their inherent risk level (no controls) and their residual risk level (after existing controls have been taken into account) by high, medium or low.

Risk level	Financial impact	Reputational impact	Performance impact	Likelihood
	(% of council budget)	*(Stakeholder interest)*	*(Impact on priorities)*	
Low	< 1%	Loss of confidence and trust in the council felt by a small group or within a small geographical area	Minor impact or disruption to the achievement of one or more strategic / directorate priorities	Remote / low probability
Medium	1 – 10%	A sustained general loss of confidence and trust in the council within the local community	Moderate impact or disruption to the achievement of one or more strategic / directorate priorities	Possible / medium probability
High	10 – 20%	A major loss of confidence and trust in the council within the local community and wider with national interest	Major impact or disruption to the achievement of one or more strategic / directorate priorities	Almost certain / highly probable

SURREY
COUNTY COUNCIL

AUDIT and GOVERNANCE COMMITTEE

27 March 2017

GRANT THORNTON: 2016/17 EXTERNAL AUDIT PLAN

SUMMARY AND PURPOSE:

This report provides the Audit and Governance Committee with the Audit Plan for the external audit of the 2016/17 financial statements of the Surrey Pension Fund.

RECOMMENDATION:

It is recommended that the Committee approves the attached external audit plan.

BACKGROUND:

1. The Audit Plan (attached as Annex 1) outlines the risks identified by Grant Thornton, the Council's external auditors, for the audit of the Pension Fund's 2016/17 financial statements and their planned response to these risks.

2016/17 FINANCIAL STATEMENT RISKS

2. The Audit Plan has identified a series of 'significant' risks and 'other' risks. These risks are not specific to Surrey County Council but are risks in existence for all Local Authority Pension Fund financial statements.

3. The 'significant' risks comprise:

- Fraudulent transactions
- Management override of controls
- Inappropriate valuation of Investments

4. The 'other' risks comprise:

- Invalid investment purchases and sales
- Incorrect recording of contributions
- Incorrect calculation of benefits
- Incorrect member data

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- Going concern assumptions
- Inaccuracies in admin expenses, cash balances, current assets and liabilities, investment income, actuarial statements, financial instrument disclosures, related party transaction disclosures

IMPLICATIONS:

A) Financial
There are no direct financial implications.

B) Equalities
There are no direct equality implications.

C) Risk
The external audit process will help manage areas of risk.

WHAT HAPPENS NEXT:

i. Following agreement with the Director of Finance, the Audit Plan is presented to this committee for discussion and approval.

ii. The external audit process will start on the conclusion of the accounts closure.

iii. The completed external audit process and financial statements will be presented to the Audit and Governance Committee later this year.

REPORT AUTHOR:
Phil Triggs, Strategic Manager (Pension Fund & Treasury)

CONTACT DETAILS:
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Sources/background papers:
None

DRAFT

This version of the report is a draft. Its contents and subject matter remain under review and its contents may change and be expanded as part of the finalisation of the report.

The Audit Plan for Surrey Pension Fund

Year ended 31 March 2017

27th March 2017

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Surrey County Council
County Hall
Penrhyn Road
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KT1 2DN

27th March 2017

Dear Members of the Audit and Governance Committee

Audit Plan for Surrey Pension Fund for the year ending 31 March 2017

This Audit Plan sets out for the benefit of those charged with governance (in the case of Surrey Pension Fund, the Audit and Governance Committee), an overview of the planned scope and timing of the audit, as required by International Standard on Auditing (UK & Ireland) 260. This document is to help you understand the consequences of our work, discuss issues of risk and the concept of materiality with us, and identify any areas where you may request us to undertake additional procedures. It also helps us gain a better understanding of the Fund and your environment. The contents of the Plan have been discussed with management.

We are required to perform our audit in line with Local Audit and Accountability Act 2014 and in accordance with the Code of Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General in April 2015. Our responsibilities under the Code are to give an opinion on the Fund's financial statements.

As auditors we are responsible for performing the audit, in accordance with International Standards on Auditing (UK & Ireland), 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 for the preparation of the financial statements which give a true and fair view.

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. In particular we cannot be held responsible to you for reporting all of the risks which may affect the Fund or all weaknesses in your internal controls. This report has been prepared solely for your benefit. 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.

We look forward to working with you during the course of the audit.

Yours sincerely

Ciaran McLaughlin

Engagement Lead

Contents

Understanding your business and key developments

Developments

Investment Regulations

The new investment regulations came into force on 1 November 2016 and require administering authorities to publish new Investment Strategy Statements by 1st April 2017. The statement must be in accordance with guidance issued by the Secretary of State and include a variety of information. This will include the authority's assessment of the suitability of particular investments and types of investments, the authority's approach to risk, including the ways in which risks are to be measured and managed and the authority's approach to pooling investments, including the use of collective investment vehicles and shared services. These regulations also provide the Secretary of State with the power to intervene in the investment function of a fund if he/she is satisfied that the authority is failing to act in accordance with the regulations.

Triennial actuarial valuation of the fund

The results of the triennial review as at 31 March 2016 have now been reported. Members will need to consider the outcome of this review and the impact this will have on the fund in future investment decisions.

Key challenges

Pooling Governance

Arrangements for pooling of investments continue to develop, with DCLG expecting administering authorities to be transferring liquid assets from April 2018. The structure and governance of these arrangements will need to be implemented before this date. These arrangements are likely to have a significant impact on how the investments are managed, who makes decisions and how investment activities are actioned and monitored. Although much of this operational responsibility will move to the investment pool operator, it is key that administering authorities (through Pension Committees and Pension Boards) continue to operate strong governance arrangements, particularly during the transition phase where funds are likely to have a mix of investment management arrangements.

Surrey Pension Fund has been instrumental in setting up the Borders to Coast Pensions Partnership (BCCP) consisting of 12 administering authorities. On 10th February 2017 your Pension Fund Committee endorsed this pooling option and approved your legal entry in to the partnership along with the outline governance arrangements. The collective assets of the pool are approximately £36 billion.

Managing the transition to the new pooling arrangements effectively is a key operational priority for management. In the longer term, the new arrangements will require changes in how Surrey County Council and its officers discharge their duties to provide governance over management of the Fund's assets.

Financial reporting changes

CIPFA Code of Practice 2016/17 (the Code)

The main change to the Code for Pension Funds is the extension of the fair value disclosures required under the Code from 2016/17.

The greatest impact is expected to be for those Funds holding directly owned property and/or shares and Level 3 investments. These are reflected in CIPFA's pension fund example accounts alongside further changes including an analysis of Investment Management expenses in line with CIPFA's Local Government Pension Scheme Management Costs guidance, a realignment of investment classifications , and an additional disclosure note covering remuneration of key management personnel which has been included in related party transactions.

Earlier closedown

The Accounts and Audit Regulations 2015 require councils to bring forward the approval and audit of financial statements to 31 July by the 2017/2018 financial year. This will impact not only upon the production of the Fund accounts but also on earlier requests for information from employers within the Fund.

Our response

- We will discuss with you your progress in implementing the requirements of the new investment regulations, highlighting any areas of good practice or concern which we have identified.
- We will discuss your progress in implementing revised governance structures, and share our experiences gained nationally.
- We aim to complete all our substantive audit work of your financial statements the end of September 2017.
- As part of our opinion on your financial statements, we will consider whether your financial statements accurately reflect the changes in the 2016/17 Code

Materiality

In performing our audit, we apply the concept of materiality, following the requirements of International Standard on Auditing (UK & Ireland) (ISA) 320: Materiality in planning and performing an audit. 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. 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, for example, when greater precision is required (e.g. senior manager salaries and allowances).

We determine planning materiality (materiality for the financial statements as a whole determined at the planning stage of the audit) in order to estimate the tolerable level of misstatement in the financial statements, assist in establishing the scope of our audit engagement and audit tests, calculate sample sizes and assist in evaluating the effect of known and likely misstatements in the financial statements.

We have determined planning materiality based upon professional judgement in the context of our knowledge of the Fund. In line with previous years, we have calculated financial statements materiality based on a proportion of net assets for the Fund. For purposes of planning the audit we have determined overall materiality to be £32,236k (being 1% of net assets as at 31 March 2016). Our assessment of materiality is kept under review throughout the audit process and we will advise you if we revise this during the audit.

Under ISA 450, auditors also set an amount below which misstatements would be clearly trivial and would not need to be accumulated or reported to those charged with governance because we would not expect that the accumulation of such amounts would have a material effect on the financial statements. "Trivial" matters are clearly inconsequential, whether taken individually or in aggregate and whether judged by any criteria of size, nature or circumstances. We have defined the amount below which misstatements would be clearly trivial to be £1,611k.

ISA 320 also requires auditors to determine separate, lower, materiality levels where there are 'particular classes of transactions, account balances or disclosures for which misstatements of lesser amounts than materiality for the financial statements as a whole could reasonably be expected to influence the economic decisions of users'. We have identified no areas where separate materiality levels are required.

Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; Judgments about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both; and Judgments about matters that are material to users of the financial statements are based on a consideration of the common financial information needs of users as a group. The possible effect of misstatements on specific individual users, whose needs may vary widely, is not considered. (ISA (UK and Ireland) 320)

Significant risks identified

An audit is focused on risks. Significant risks are defined by ISAs (UK and Ireland) as risks that, in the judgment 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.

Significant risk	Description	Audit procedures
The revenue cycle includes fraudulent transactions	Under ISA (UK and Ireland) 240 there is a presumed risk that revenue streams 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 Surrey Pension Fund, we have determined that the risk of fraud arising from revenue recognition can be rebutted, because: • there is little incentive to manipulate revenue recognition • opportunities to manipulate revenue recognition are very limited • the culture and ethical frameworks of local authorities, including Surrey County Council, mean that all forms of fraud are seen as unacceptable Therefore we do not consider this to be a significant risk for Surrey Pension Fund.
Management over-ride of controls	Under ISA (UK and Ireland) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities.	• Review of accounting estimates, judgments and decisions made by management • Review of journal entry process and selection of unusual journal entries for testing back to supporting documentation • Review of unusual significant transactions
Level 3 Investments Valuation is incorrect	Under ISA 315 significant risks often relate to significant non-routine transactions and judgemental matters. Level 3 investments by their very nature require a significant degree of judgement to reach an appropriate valuation at year end.	• We will update our understanding of your process for valuing level 3 investment through discussions with relevant personnel from the Pension Fund during the interim audit. • For a sample of private equity investments, test valuations by obtaining and reviewing the audited accounts at latest date for individual investments and agreeing these to the fund manager reports at that date. Reconciliation of those values to the values at 31st March 2016 with reference to known movements in the intervening period. • To review the nature and basis of estimated values and consider what assurance management has over the year end valuations provided for these types of investments.

"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 and Ireland) 315) . In making the review of unusual significant transactions "the auditor shall treat identified significant related party transactions outside the entity's normal course of business as giving rise to significant risks." (ISA (UK and Ireland) 550)

Other risks identified

Reasonably possible risks (RPRs) are, in the auditor's judgment, other risk areas which the auditor has identified as an area where the likelihood of material misstatement cannot be reduced to remote, without the need for gaining an understanding of the associated control environment, along with the performance of an appropriate level of substantive work. The risk of misstatement for an RPR or other risk is lower than that for a significant risk, and they are not considered to be areas that are highly judgmental, or unusual in relation to the day to day activities of the business.

Reasonably possible risks	Description of risk	Audit procedures
Investment purchases and sales	Investment activity not valid. Investment valuation not correct.	• We will perform substantive testing of material purchases and sales up to the time of our interim visit and agreed these to supporting documentation • We will review the reconciliation of information provided by the fund managers, the custodian and the Pension Fund's own records and seek explanations for variances • Complete a predictive analytical review for different types of investments
Investment values – Level 2 investments	Valuation is incorrect. (Valuation net)	• We will review the reconciliation of information provided by the fund managers, the custodian and the Pension Fund's own records and seek explanations for variances • If deemed necessary for additional assurance, we will test a sample of level 2 investments prices from the custodian/ fund manager to independently obtained prices
Contributions	Recorded contributions not correct (Occurrence)	• Controls testing over occurrence, completeness and accuracy of contributions to the scheme from employees of Surrey County Council • Test a sample of contributions from Scheduled and Admitted bodies to source evidence to gain assurance over their accuracy and occurrence • Trend analysis of scheme contributions across the year to assess the completeness of scheme contributions • Rationalise contributions received with reference to changes in member body payrolls and numbers of contributing pensioners to ensure that any unexpected trends are satisfactorily explained

Other risks identified (continued)

Reasonably possible risks	Description of risk	Audit procedures
Benefits payable	Benefits improperly computed/claims liability understated (Completeness, accuracy and occurrence)	• Walkthrough of controls identified and controls testing over completeness, accuracy and occurrence of benefit payments • Substantive testing of a sample of individual pensions in payment by reference to member file. • Trend analysis of benefit payments across the year to assess the completeness of benefit payments • We will rationalise pensions paid with reference to changes in pensioner numbers and increases applied in the year to ensure that any unusual trends are satisfactorily explained
Member Data	Member data not correct. (Rights and Obligations)	• We will perform a walkthrough of the controls identified in the cycle • Controls testing over reconciliations and verifications with individual members • Sample testing of changes to member data made during the year to source documentation

Other risks identified (continued)

Going concern

As auditors, we are required to "obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern" (ISA (UK and Ireland) 570). We will review the management's assessment of the going concern assumption and the disclosures in the financial statements.

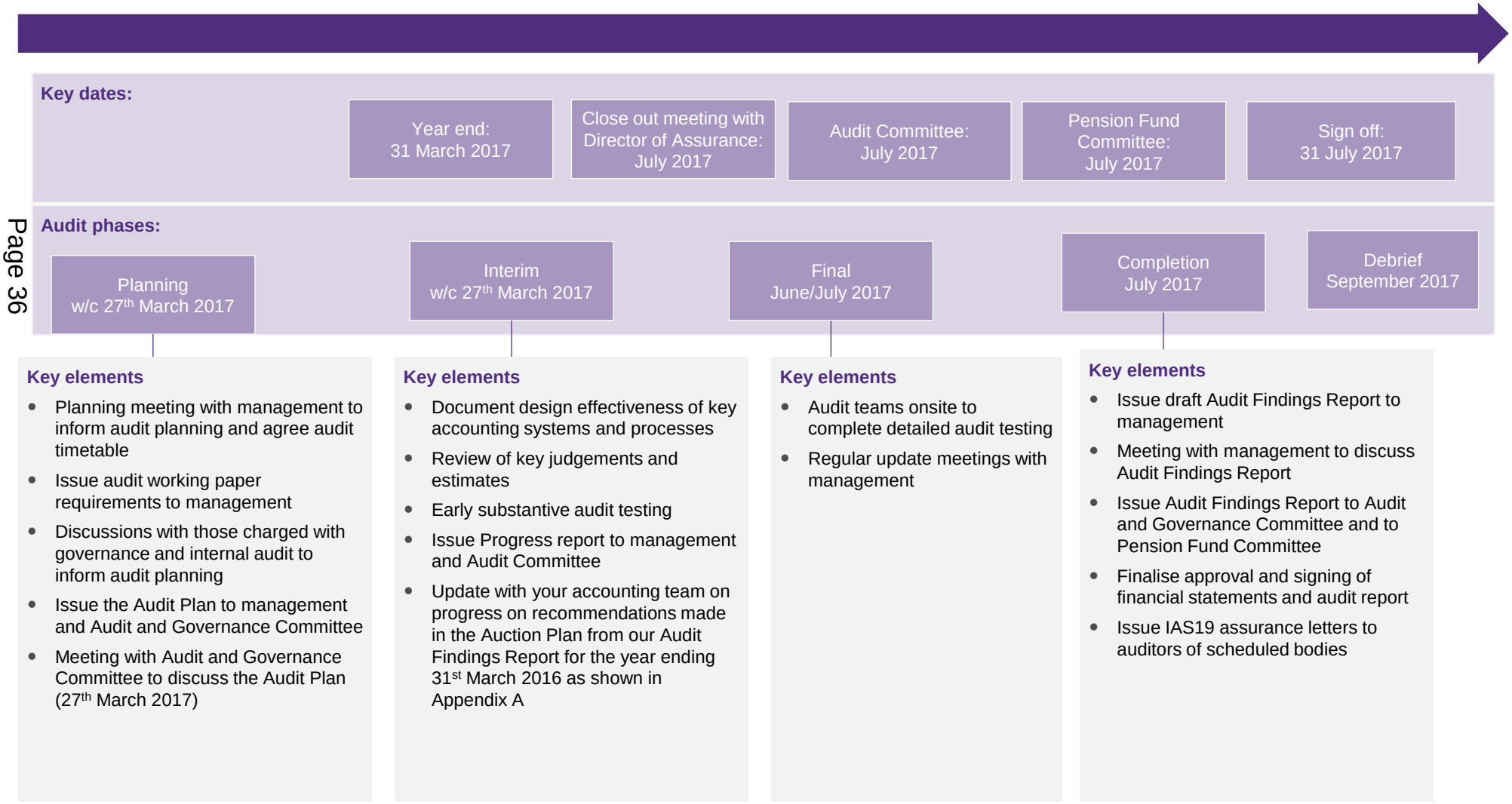
Other material balances and transactions

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 the previous sections but will include:

- Administrative expenses
- Cash deposits
- Current assets
- Current liabilities
- Investment Income
- Actuarial Valuation and Actuarial Present Value of Promised Retirement Benefits
- Financial Instruments disclosures
- Related Party Transactions disclosures

The audit cycle

The audit timeline



Audit Fees

Fees

	£
Pension fund audit	27,105
Total audit fees (excluding VAT)	**27,105**

Our fee assumptions include:

- Supporting schedules to all figures in the accounts are supplied by the agreed dates and in accordance with the agreed upon information request list
- The scope of the audit, and the Fund and its activities, have not changed significantly
- The Fund will make available management and accounting staff to help us locate information and to provide explanations
- The accounts presented for audit are materially accurate, supporting working papers and evidence agree to the accounts, and all audit queries are resolved promptly.

Fees for other services

We provide no other services to Surrey Pension Fund.

Independence

Ethical Standards and ISA (UK and Ireland) 260 require us to give you timely disclosure of matters relating to our independence. 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 Auditing Practices Board's Ethical Standards and we confirm that we are independent and are able to express an objective opinion on the financial statements.

What is included within our fees

- A reliable and risk-focused audit appropriate for your business
- Invitations to events hosted by Grant Thornton in your sector, as well as the wider finance community
- Ad-hoc telephone calls and queries
- Technical briefings and updates
- A review of accounting policies for appropriateness and consistency

Communication of audit matters with those charged with governance

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

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 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 a report to the Fund.

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK and Ireland), 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.

This plan has been prepared in the context of the Statement of Responsibilities of Auditors and Audited Bodies issued by Public Sector Audit Appointments Limited (http://www.psaa.co.uk/appointing-auditors/terms-of-appointment/)

We have been appointed as the Fund's independent external auditors by the Audit Commission, the body responsible for appointing external auditors to local public bodies in England at the time of our appointment. As external auditors, we have a broad remit covering finance and governance matters.

Our annual work programme is set in accordance with the Code of Audit Practice ('the Code') issued by the NAO and includes nationally prescribed and locally determined work (https://www.nao.org.uk/code-audit-practice/about-code/). Our work considers the Fund's key risks when reaching our conclusions under the Code.

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

It is the responsibility of the 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 Fund is fulfilling these responsibilities.

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	✓	
Views about the qualitative aspects of the entity's accounting and financial reporting practices, significant matters and issues arising during the audit and written representations that have been sought		✓
Confirmation of independence and objectivity	✓	✓
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	✓	✓
Material weaknesses in internal control identified during the audit		✓
Identification or suspicion of fraud involving management and/or others which results in material misstatement of the financial statements		✓
Non compliance with laws and regulations		✓
Expected modifications to the auditor's report, or emphasis of matter		✓
Uncorrected misstatements		✓
Significant matters arising in connection with related parties		✓
Significant matters in relation to going concern	✓	✓

Appendix 1: Action plan from 2015/16

Priority
High - Significant effect on control system
Medium - Effect on control system
Low - Best practice

Rec No.	Recommendation	Priority	Management response	Implementation date & responsibility
1	New starter letters should be sent to all new members of the pension scheme and a full review of those instances where this did not take place during 2015/16 should be undertaken.	Medium	A process review has been undertaken and an automated bulk process for generating new joiner letters has been initiated - process maps have been recorded as part of the Audit. The missing cases for 2015/16 have been identified as part of the process review and will be contacted as part of the bulk processing.	Pension Services Manager, September 2016
2	Given the potential sensitivity of cash balances, unreconciled differences on cash balances should be fully adjusted on at least an annual basis.	High	Fund manager and custodian cash balances are currently monitored on a quarterly basis. Management will ensure that any variances will be fully adjusted as part of a quarterly reconciliation.	Senior Accountant, December 2016

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SURREY
COUNTY COUNCIL

AUDIT & GOVERNANCE COMMITTEE

27 March 2017

SURREY FIREFIGHTER'S PENSION SCHEME - BREACHES OF LAW POLICY AND GUIDANCE

SUMMARY AND PURPOSE:

This report provides details of a written policy statement and guidance for breaches of the law in respect of all activities of the Surrey Fire & Rescue Authority (SF&R) in respect of the Firefighter's Pension Scheme (FFPS).

RECOMMENDATION:

It is recommended that the Committee approves the Breaches of Law Policy and Guidance, included as Annexes 1 to 5.

REASONS FOR RECOMMENDATION

1. A Breaches Policy is a crucial tool for the SF&R in reducing risk and providing an early warning of possible malpractice. The proposed Breaches of Law Policy and accompanying guidance provides the framework for the identification and reporting of breaches and when it is appropriate to inform the Pensions Regulator (tPR).

DETAILS

2. As of 1 April 2015, the regulations of public sector pension schemes, including the FFPS, became the responsibility of the Pensions Regulator (tPR).

3. As a result there is now a legal requirement under the Pensions Act 2004 for groups and individuals (reporters) involved in the management of the pension scheme to report any significant breaches of the law to the tPR where they are likely to be of material significance: Examples of these reporters are:

- Members of the Local Pension Board.
- Any person who is otherwise involved in the administration of the scheme: including officers of the Pension Services Team.
- All participating employers in the scheme.
- Professional advisers.
- Any other person otherwise involved in advising the managers of the scheme.

4. The tPR Code of Practice no 14 (Governance and administration of public service pension schemes) states there should be a procedure in place within each Fund to identify and assess these breaches (a "Breaches Policy").

5. Where a breach of the law is identified the SF&R will need to take all necessary steps to consider the breach and, if necessary, report to tPR. It is stressed that, as set out in the Breaches Policy, all suspected breaches will be registered in a breaches log, but only material breaches are required to be reported to tPR.

Content

6. The Breaches Policy contains the following areas:
   - Explanation of the need for a Breaches Policy;
   - Definition of what constitutes a breach;
   - Identification of who is responsible for reporting breaches;
   - Clarification of when to report a breach and when this should be escalated to tPR;
   - The process for reporting breaches including the identification of the Responsible Officer and role of this officer;
   - The procedure for monitoring breaches;
   - Whistleblowing and training requirements.

Reporting breaches

7. All breaches or suspected breaches should be reported to the Responsible Officer in the first instance. However, if the suspicion is around theft, fraud or other serious offences where discussions may alert those implicated or impede the actions of the policy or a regulatory authority, the reporter should report to tPR directly and at the earliest opportunity.

8. The Responsible Officer is responsible for the management and execution of the breaches policy. The Responsible Officer for the SF&R is Lindsey Shaw (Workforce Information Officer).

9. The Responsible Officer will determine whether any breach or likely breach is materially significant, having regard to the guidance set out in tPR Codes of Practice and after consultation with the Head of Fire & Rescue, Director of Finance, the Director of Legal, Cultural and Democratic Services and the Local Firefighter's Pension Board.

RISK MANAGEMENT AND IMPLICATIONS

10. Risk related issues are contained within the report.

LEGAL IMPLICATIONS

11. There is a legal obligation in s70 of the Pensions Act 2004 to report breaches of the law to the Pension Regulator. This obligation was expanded as of 1 April 2015 to specifically include public sector pension boards.

12. The Pensions Regulator has issued non-statutory guidance, referred to in the body of this report, which recommends the adoption of a Breaches Policy by all public sector pension schemes. While not binding, to depart from the recommendations of this guidance without an alternative mitigation in place would expose the SF&R pension scheme to risk of challenge and possible sanction by the Pension Regulator if it failed to meet its underlying legal obligations.

WHAT HAPPENS NEXT:

13. On approval by the Audit & Governance Committee, the Breaches of Law Policy and Guidance will be published and distributed to interested parties.

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ANNEXES:
Annex 1: Surrey FFPS Breaches Policy & Guidance
Annex 2: Surrey FFPS Breaches Policy & Guidance Appendix 1
Annex 3: Surrey FFPS Breaches Policy & Guidance Appendix 2
Annex 4: Surrey FFPS Breaches Policy & Guidance Appendix 3
Annex 5: Surrey FFPS Breaches Policy & Guidance Appendix 4

SOURCES/BACKGROUND PAPERS:
The Pensions Act 2004
The Pensions Regulator Code of Practice no 14 (Governance and administration of public service pension schemes)

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Surrey Firefighter's pension scheme

Breaches of Law Policy and Guidance

8

Breaches of Law Policy and Guidance

The Surrey Fire & Rescue Authority (SF&R) seeks to conduct its affairs in regards to the Surrey Firefighter's Pension Scheme in a responsible manner, to ensure that all its activities are open and effectively managed, and that the SF&R integrity and principles of public interest disclosure are sustained.

This document and its appendices sets out the SF&R policy and procedures for identifying, monitoring and, where appropriate, reporting breaches of the law as required in the Pensions Act 2004 (the Act) and detailed in the Pensions Regulator's (tPR) Code of Practice no 14 - Governance and administration of public service pension schemes (the Code).

The following appendices accompany this Breaches policy and guidance:

Appendix 1: *The legal requirement to report a breach.*
Appendix 2: *Examples of what may be considered a breach, whether it may be considered material, and how to make a submission to tPR*
Appendix 3: *Example breaches applying tPR Traffic Light System*.
Appendix 4: *Template breaches report document.*

1. Why have a breaches policy?

- It is a crucial tool for the SF&R in reducing risk and providing an early warning of possible malpractice.
- It provides an opportunity to learn from mistakes and review and improve processes in the areas where the breach occurred.
- It represents an important addition to the SF&R suite of policies that make up its risk framework.
- The identification, management and reporting of material breaches to tPR is a requirement of the Code.
- Failure to report a breach without a *reasonable excuse* is a civil offence that can result in civil penalties.

2. What is a breach?

A breach of the law is:

- When a legal duty which is relevant to the administration of the scheme has not been, or is not being, complied with.

It can encompass many aspects of the management and administration of the scheme, including failure:

- To do anything required under overriding legislation, applicable statutory guidance or codes of practice.
- To maintain accurate records.
- To act on any fraudulent act or omission that is identified.
- Of an employer to pay over member and employer contributions on time.
- To pay member benefits either accurately or in a timely manner.
- To issue annual benefit statements on time or non-compliance with the Regulator's Code of Practice No 14.

Non-compliance with the Firefighter's Pension Scheme (FFPS) regulations can encompass many aspects of the management and administration of the scheme, including failure:

- To abide with the FFPS Regulations.
- To comply with the SF&R policies and procedures.

It is important that the *Responsible Officer* is satisfied that a breach has actually occurred, rather than acting on a suspicion of such an event.

3. Who is responsible for reporting breaches?

The following are responsibility to report breaches (known as *Reporters*):

- Members of the Local Pension Board.
- Any person who is otherwise involved in the administration of the scheme: including officers of the Pension Services Team.
- All participating employers in the scheme.
- Professional advisers.
- Any other person otherwise involved in advising the managers of the scheme.

Reporters are required to take a pro-active approach to the identification, management and reporting of all breaches that have occurred, or are likely to occur.

4. When to report a suspected breach

Reporters should refer to Appendix 2 for guidance on whether to report a suspected breach. If Reporters are in any doubt they should contact the *Responsible Officer*.

5. Reporting a breach to tPR?

Breaches of the law which affect pension schemes should be considered for reporting to tPR if it is considered that the breach is likely to be of material significance to tPR.

A material breach must be notified to tPR as soon as is reasonably practicable and no later than one month after becoming aware of the breach or likely breach.

Where it is considered that a breach is of such significance that tPR is required to intervene as a matter of urgency (for example, serious fraud) the matter should be brought to the attention of tPR immediately.

Not all breaches identified will need to be reported to tPR. Where prompt and effective action is taken to investigate and correct the breach and its causes and, where appropriate, notify any affected members, tPR will not normally consider this to be materially significant.

6. Who to report a suspected breach to

All breaches or suspected breaches should be reported to the [Responsible Officer] in the first instance. **However, if the suspicion is around theft, fraud or other serious offences where discussions may alert those implicated or impede the actions of the policy or a regulatory authority, the *Reporter* should go to tPR directly and at the earliest opportunity.**

7. Role of the responsible officer

The *Responsible Officer* is responsible for the management and execution of the breaches policy. The Responsible Officer for the SF&R is Lindsey Shaw (Workforce Information Officer).

The *Responsible Officer* will be responsible for recording and reporting breaches and likely breaches as follows:

- Record all identified breaches and likely breaches of which they are aware in the SF&R pension breaches log.
- Investigate the circumstances of all reported breaches and likely breaches.
- Ensure, where necessary that an action plan is put in place and acted on to correct the identified breach and also ensure further breaches of a similar nature do not reoccur.
- Report to the Local Pension Board:
    - All materially significant breaches will require reporting to tPR as soon as is practicable, but no later than within 30 days (if the next scheduled meeting of the Local Pension Board is in excess of 30 days the *Responsible Officer* will consult with the Chairman of the Local Pension Board within the 30 day period (verbally if necessary) prior to reporting to tPR; and after consultation with the *Head of Fire & Rescue, Director of Finance, the Director of Legal, Cultural and Democratic Services).*
    - All other breaches to the next scheduled meeting of the Local Pension Board.

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- Report all materially significant breaches identified to tPR as soon as practicable but not later than 30 days after becoming aware of the breach.

The *Responsible Officer* will determine whether any breach or likely breach is materially significant, having regard to the guidance set out in tPR Codes of Practice and after consultation with the *Head of Fire & Rescue, Director of Finance, the Director of Legal, Cultural and Democratic Services* and Local Pension Board.

Where uncertainty exists as to the materiality of any identified breach the *Responsible Officer* will be required to informally notify tPR of the issue and the steps being taken to resolve the issue.

8. How are records of breaches maintained?

All breaches or suspected breaches will be recorded in the SF&R Breaches Log. *Responsible Officer* will maintain the SF&R Breaches Log. The SF&R Breaches Log will include the following information:

- Date the breach or likely breach was identified.
- Name of the employer (where appropriate).
- A description of the breach:
    - Cause.
    - Effect
    - Reaction.
    - Implications.
- Whether the breach is considered to be red, amber or green with reference to tPR traffic light system (hyperlink and appendix).
- Whether the concern has been reported before.
- Whether the suspected breach is considered materially significant to tPR and reasons for this consideration.
- Date of report to tPR (if applicable).
- Recommended action to rectify the breach.
- Evidence that these recommendations have been implemented.
- Confirmation that *the Head of Fire & Rescue, Director of Finance, the Director of Legal, Cultural and Democratic Services* and Local Pension Board have been consulted.

Updates to the breaches log will be reported to the Local Pension Board at its next meeting.

9. Whistleblowing

It is a statutory duty to report breaches of the law. In rare cases this may involve a duty to whistle blow on the part of an employee of the SF&R. The duty to report does not override any other duties a *Reporter* may have, such as confidentiality. Any such duty is not breached by reporting to tPR. Given the statutory duty that exists, in exercising this breaches policy the SF&R will ensure it adheres to the requirements of the Employment Rights Act 1996 in protecting an employee making a whistleblowing disclosure to tPR.

The duty to report, however, does not override 'legal privilege', so oral and written communications between the SF&R service and the Local Pension Board and a professional legal adviser do not have to be disclosed.

10. Training

The *Responsible Officer* will ensure that all *Reporters*, receive appropriate training on this policy as appropriate.

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Surrey Firefighter's pension scheme

Breaches of Law Policy and Guidance

Appendix 1:
The legal requirement to report a breach

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The legal requirement to report a breach

Breaches of the law which affect pension schemes should be considered for reporting to the Pensions Regulator.

The decision whether to report requires two key judgements:

- Is there reasonable cause to believe there has been a breach of the law.
- If so, is the breach likely to be of material significance to the Pensions Regulator?
-

The requirement to report breaches of the law arises when a duty which is:

- Imposed by or by virtue of an enactment or rule of law; and
- Relevant to the administration of a scheme.

Imposed by or by virtue of an enactment or rule of law

'Enactment' covers Acts of Parliament and regulations or statutory instruments. For example, the Pensions Act 2004 is an enactment as are regulations made under that Act:

Pensions Act 2004 (70 (2)):

"(2) Where the person has reasonable cause to believe that –

(a) A duty which is relevant to the administration of the scheme in question, and is imposed by or virtue of an enactment or rule of law, has not been or is not being complied with, and

(b) The failure to comply is likely to be of material significance to the Regulator in the exercise of its functions,

he must give a written report of the matter to the Regulator as soon as reasonably practicable."

Breaches of criminal law, such as an offence of dishonesty under the Theft Act, would also come within the term enactment.

'Rule of law' covers law laid down by decisions of the courts. It would, for example, include trust law and common law.

When considering breaches of trust law, reporters should bear in mind the basic principle that the Surrey Fire & Rescue Authority (SF&R) is holding property on behalf of others. The SF&R should act in good faith and within the terms of the Firefighter's Pension Scheme Regulations for the benefit of all of the beneficiaries of the scheme. If they fail to do so, they are in breach of law. A very basic rule of thumb in considering whether an action or failure to act is, or may be, a breach is if the SF&R

has acted in a way which would appear unfair or wrong to a reasonable and objective person.

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‘Relevant to the administration of the scheme’

In view of its statutory objectives, the Pensions Regulator interprets ‘administration’ widely in the context of the need to report breaches. It is much wider than just those tasks normally associated with the administrative function such as keeping records, dealing with membership movements, calculating benefits and preparing accounts, though all these are included within it. The Pensions Regulator interprets administration to include such matters as the consideration of funding in defined benefit schemes, investment policy and investment management, as well as the custody of invested assets; indeed anything which could potentially affect members’ benefits or the ability of members and others to access information to which they are entitled.
There are two key judgements required:

- First, does the reporter have reasonable cause to believe there has been a breach of the law?
- If so, then, secondly, does the reporter believe the breach is likely to be of material significance to the Pensions Regulator?

Reasonable cause to believe

Having a reasonable cause to believe that a breach has occurred means more than merely having a suspicion that cannot be substantiated.

Where the reporter does not know the facts or events around the suspected breach, it will usually be appropriate to check with the *Responsible Officer*, or with others who are in a position to confirm what has happened. However, it would not be appropriate to check with the t *Responsible Officer* or others in cases of theft, or if the reporter is concerned that a fraud or other serious offence might have been committed and discussion with those persons might alert those implicated or impede the actions of the police or a regulatory authority.

If the reporter is unclear about the relevant legal provision, they should clarify their understanding of the law to the extent necessary to form a view.

In establishing that there is reasonable cause to believe that a breach has occurred, it is not necessary for a reporter to gather all the evidence which tPR would require before taking legal action.

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Surrey Firefighter's pension scheme

Breaches of Law Policy and Guidance

Appendix 2:
When a breach may be considered material and how to make a submission to The Pensions Regulator

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When a breach may it be considered material and how to make a submission to The Pensions Regulator

The Pensions Regulator (tPR) has produced guidance to assist schemes in identifying the severity of a breach and whether it should then be reported. When determining materiality of any breach or likely breach *Reporters* will in all cases consider the following:

- Cause.
- Effect.
- Reaction; and
- Wider implications.

Cause

The breach is likely to be of material significance to tPR where it was caused by:

- Dishonest.
- Poor governance or administration.
- Slow or inappropriate decision making practices.
- Incomplete or inaccurate advice, or
- Acting (or failing to act) in deliberate contravention of the law.

When deciding whether a breach is of material significance, those responsible should consider other reported and unreported breaches of which they are aware. However, historical information should be considered with care, particularly if changes have been made to address previously identified problems.

A breach will not normally be materially significant if it has arisen from an isolated incident, for example resulting from teething problems with a new system or procedure, or from an unusual or unpredictable combination of circumstances. But in such a situation, it is also important to consider other aspects of the breach such as the effect it has had and to be aware that persistent isolated breaches could be indicative of wider scheme issues.

Effect

Reporters need to consider the effects of any breach, but with the regulator's role in relation to public service pension schemes and its statutory objectives in mind, the following matters in particular should be considered likely to be of material significance to tPR:

- Local Pension Board members not having the appropriate degree of knowledge and understanding, which may result in pension boards not fulfilling their roles,

the scheme not being properly governed and administered and/or scheme managers breaching other legal requirements.

- Local Pension Board members having a conflict of interest, which may result in them being prejudiced in the way that they carry out their role, ineffective governance and administration of the scheme and/or scheme managers breaching legal requirements.
- Adequate internal controls not being established and operated, which may lead to schemes not being run in accordance with their scheme regulations and other legal requirements, risks not being properly identified and managed and/or the right money not being paid to or by the scheme at the right time.
- Accurate information about benefits and scheme administration not being provided to scheme members and others, which may result in members not being able to effectively plan or make decisions about their retirement.
- Appropriate records not being maintained, which may result in member benefits being calculated incorrectly and/or not being paid to the right person at the right time.
- Any misappropriation of assets of the scheme or being likely to do so, which may result in scheme assets not being safeguarded, and
- Any other breach which may result in the Surrey Firefighter's Pension Scheme being poorly governed, managed or administered.

Reporters need to take care to consider the effects of the breach, including any other breaches occurring as a result of the initial breach and the effects of those resulting breaches.

Reaction

Where prompt and effective action is taken to investigate and correct the breach and its causes and, where appropriate, notify any affected members, tPR will not normally consider this to be materially significant.

A breach is likely to be of concern and material significance to the regulator where a breach has been identified and those involved:

- Do not take prompt and effective action to remedy the breach and identify and tackle its cause in order to minimise risk of recurrence.
- Are not pursuing corrective action to a proper conclusion, or
- Fail to notify affected scheme members where it would have been appropriate to do so.

8

Wider implications

Reporters should consider the wider implications of a breach when they assess which breaches are likely to be materially significant to the regulator. For example, a breach is likely to be of material significance where the fact that the breach has occurred makes it appear more likely that other breaches will emerge in the future. This may be due to the scheme manager or pension board members having a lack of appropriate knowledge and understanding to fulfil their responsibilities or where other pension schemes may be affected. For instance, public service pension schemes administered by the same organisation may be detrimentally affected where a system failure has caused the breach to occur.

tPR "traffic light" framework

tPR provides a "traffic light" system of categorising an identified breach:

Green – not caused by dishonesty, poor governance or a deliberate contravention of the law and its effect is not significant and a plan is in place to rectify the situation. In such cases the breach may not be reported to tPR, but should be recorded in the SF&R 's breaches log.

Amber – does not fall easily into either green or red and requires further investigation in order to determine what action to take. Consideration of other recorded breaches may also be relevant in determining the most appropriate course of action. The SF&R or local pension board will need to decide whether to informally alert tPR to the likely breach, formally reporting the breach if it is subsequently decided to categorise the breach as red.

Red - caused by dishonesty, poor governance or a deliberate contravention of the law and having a significant impact, even where a plan is in place to rectify the situation. The SF&R or local pension board must report all such breaches to tPR in all cases.

If it is unclear as to whether the breach or likely breach is significant, in the first instance full details should always be reported to the *Responsible Officer* to determine the appropriate course of action.

It should be noted that failure to report a significant breach or likely breach is likely, in itself, to be a significant breach (examples of tPR "Traffic Light" framework are included as appendix 3).

The *Responsible Officer* will use tPR "traffic light" framework as a means of identifying whether any breach is to be considered as materially significant and so reported to tPR.

Any failure of a scheme employer to pass over employee contributions that are considered to be of material significance must be reported to tPR immediately.

In order to determine whether failure to pay over employee contributions is materially significant or not the SF&R will seek from the employer:

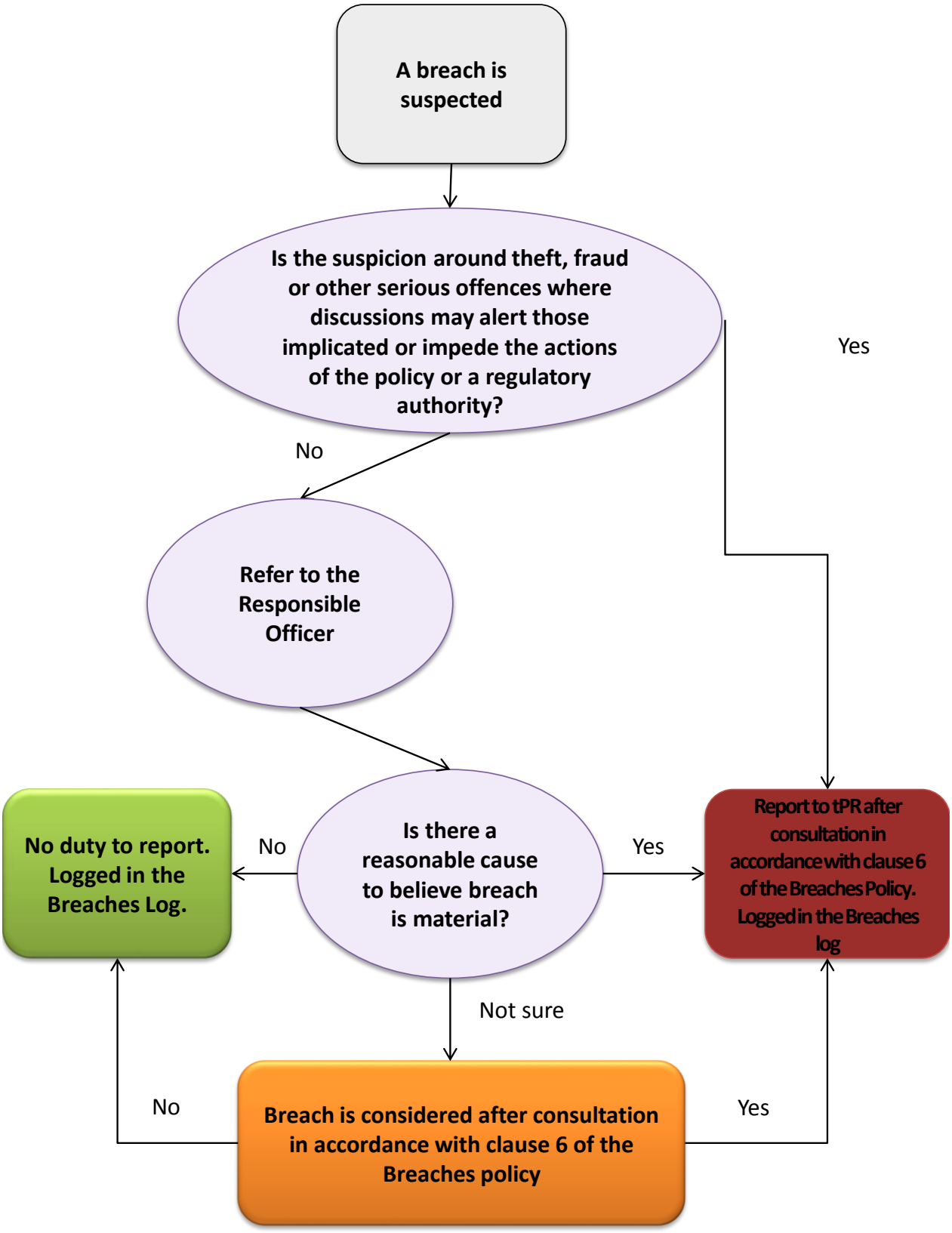
- The cause and circumstances of the payment failure.
- What action the employer has taken as a result of the payment failure, and
- The wider implications or impact of the payment failure.

Where a payment plan is agreed with the employer to recover outstanding contributions and it is being adhered to or there are circumstances of infrequent one-off late payments or administrative failures the late payment will not be considered to be of material significance.

All incidences resulting from the unwillingness or inability of the employer to pay over the employee contributions, dishonesty, fraudulent behaviour or misuse of employee contributions, poor administrative procedures or the failure to pay over employee contributions within 90 days from the due date will be considered to be of material significance and reported to tPR.

Once a breach or likely breach has been identified, regardless of whether it needs to be reported to tPR, the *Responsible Officer*, must review the circumstances of the breach in order to understand why it occurred, the consequences of the breach and agree the corrective measures required to prevent re-occurrence, including an action plan where necessary. All breaches must be recorded in the SF&R's breaches log.

8 Reporting decision tree



Submitting a report to tPR

Reports must be submitted in writing and can be sent by post or electronically, including by email or by fax. Wherever possible reporters should use the standard format available via the Exchange online service on the regulator's website :

http://www.thepensionsregulator.gov.uk/trustees/exchange.aspx

The report should be dated and include as a minimum:

- Full name of the scheme.
- Description of the breach or breaches.
- Any relevant dates.
- Name of the employer or scheme manager (where known).
- Name, position and contact details of the reporter, and
- Role of the *reporter* in relation to the scheme.

Additional information that would help the regulator includes:

- The reason the breach is thought to be of material significance to the regulator.
- The address of the scheme.
- The contact details of the scheme manager (if different to the scheme address).
- The pension scheme's registry number (if available), and
- Whether the concern has been reported before.

Reporters should mark urgent reports as such and draw attention to matters they consider particularly serious. They can precede a written report with a telephone call, if appropriate.

Reporters should ensure they receive an acknowledgement for any report they send to the regulator. Only when they receive an acknowledgement can the reporter be confident that tPR has received their report.

tPR will acknowledge all reports within five working days of receipt, however it will not generally keep a reporter informed of the steps taken in response to a report of a breach as there are restrictions on the information it can disclose.

Reporters should provide further information or reports of further breaches if this may help the regulator to exercise its functions. tPR may make contact to request further information.

Breaches should be reported as soon as reasonably practicable, which will depend on the circumstances. In particular, the time taken should reflect the seriousness of the suspected breach.

8 In cases of immediate risk to the scheme, for instance, where there is any indication of dishonesty, the regulator does not expect *Reporters* to seek an explanation or to assess the effectiveness of proposed remedies. They should only make such immediate checks as are necessary. The more serious the potential breach and its consequences, the more urgently reporters should make these necessary checks. In cases of potential dishonesty the *Reporter* should avoid, where possible, checks which might alert those implicated. In serious cases, reporters should use the quickest means possible to alert tPR to the breach.

Example breaches of the law and the traffic light framework

Introduction

Certain people involved with the governance and administration of a public service pension scheme must report certain breaches of the law to The Pensions Regulator. These people include scheme managers, members of pension boards, employers, professional advisers and anyone involved in administration of the scheme or advising managers. You should use the traffic light framework when you decide whether to report to us. This is defined as follows:

- Red breaches must be reported.
- Amber breaches are less clear cut: you should use your judgement to decide whether it needs to be reported.
- Green breaches do not need to be reported.

All breaches should be recorded by the scheme even if the decision is not to report.

When using the traffic light framework you should consider the content of the red, amber and green sections for each of the cause, effect, reaction and wider implications of the breach, before you consider the four together.

As each breach of law will have a unique set of circumstances, there may be elements which apply from one or more of the red, amber and green sections. You should use your own judgement to determine which overall reporting traffic light the breach falls into.

By carrying out this thought process, you can obtain a greater understanding of whether or not a breach of the law is likely to be of material significance and needs to be reported.

You should not take these examples as a substitute for using your own judgement based on the principles set out in the draft public service code of practice as supported by relevant pensions legislation. They are not exhaustive and are illustrative only.

The Pensions Regulator

Knowledge and understanding required by pension board members

Example scenario: The scheme manager has breached a legal requirement because pension board members failed to help secure compliance with scheme rules and pensions law.

	Potential investigation outcomes			
	Cause	**Effect**	**Reaction**	**Wider implications**
Red	Pension board members have failed to take steps to acquire and retain the appropriate degree of knowledge and understanding about the scheme's administration policies	A pension board member does not have knowledge and understanding of the scheme's administration policy about conflicts of interest. The pension board member fails to disclose a potential conflict, which results in the member acting improperly	Pension board members do not accept responsibility for their failure to have the appropriate knowledge and understanding or demonstrate negative/non-compliant entrenched behaviours The scheme manager does not take appropriate action to address the failing in relation to conflicts	It is highly likely that the scheme will be in breach of other legal requirements. The pension board do not have an appropriate level of knowledge and understanding and in turn are in breach of their legal requirement. Therefore, they are not fulfilling their role to assist the scheme manager and the scheme is not being properly governed
Amber	Pension board members have gaps in their knowledge and understanding about some areas of the scheme's administration policies and have not assisted the scheme manager in securing compliance with internal dispute resolution requirements	Some members who have raised issues have not had their complaints treated in accordance with the scheme's internal dispute resolution procedure (IDRP) and the law	The scheme manager has failed to adhere precisely to the detail of the legislation where the breach is unlikely to result in an error or misunderstanding or affect member benefits	It is possible that the scheme will be in breach of other legal requirements. It is possible that the pension board will not be properly fulfilling their role in assisting the scheme manager
Green	Pension board members have isolated gaps in their knowledge and understanding	The scheme manager has failed to adhere precisely to the detail of the legislation where the breach is unlikely to result in an error or misunderstanding or affect member benefits	Pension board members take action to review and improve their knowledge and understanding to enable them to properly exercise their functions and they are making quick progress to address gaps in their knowledge and understanding. They assist the scheme manager to take prompt and effective action to remedy the breach	It is unlikely that the scheme will be in breach of other legal requirements. It is unlikely that the pension board is not fulfilling their role in assisting the scheme manager

Scheme record-keeping

Example scenario: An evaluation of member data has identified incomplete and inaccurate records.

	Potential investigation outcomes			
	Cause	**Effect**	**Reaction**	**Wider implications**
Red	Inadequate internal processes that fail to help employers provide timely and accurate data, indicating a systemic problem	All members affected (benefits incorrect/not paid in accordance with the scheme rules, incorrect transactions processed and poor quality information provided in benefit statements)	Action has not been taken to identify and tackle the cause of the breach to minimise the risk of recurrence nor to notify members	It is highly likely that there are wider scheme issues caused by inadequate processes and that the scheme will be in breach of other legal requirements
Amber	A failure by some – but not all – participating employers to act in accordance with scheme procedures, indicating variable standards of implementing those procedures	A small number of members affected	Action has been taken to identify the cause of the breach, but progress to tackle it is slow and there is a risk of recurrence	It is possible that there are wider scheme issues and that the scheme may be in breach of other legal requirements
Green	A failure by one participating employer to act in accordance with scheme procedures, indicating an isolated incident	No members affected at present	Action has been taken to identify and tackle the cause of the breach and minimise the risk of recurrence	It is unlikely that there are wider scheme issues or that the scheme manager will be in breach of other legal requirements

Providing information to members

Example scenario: An active member of a defined benefit (DB) public service scheme has reported that their annual benefit statement, which was required to be issued within 17 months of the scheme regulations coming into force, has not been issued. It is now two months overdue. As a consequence, the member has been unable to check:

- personal data is complete and accurate
- correct contributions have been credited
- what their pension may be at retirement

	Potential investigation outcomes			
	Cause	**Effect**	**Reaction**	**Wider implications**
Red	Inadequate internal processes for issuing annual benefit statements, indicating a systemic problem	All members may have been affected	Action has not been taken to correct the breach and/or identify and tackle its cause to minimise the risk of recurrence and identify other members who may have been affected	It is highly likely that the scheme will be in breach of other legal requirements
Amber	An administrative oversight, indicating variable implementation of internal processes	A small number of members may have been affected	Action has been taken to correct the breach, but not to identify its cause and identify other members who may have been affected	It is possible that the scheme will be in breach of other legal requirements
Green	An isolated incident caused by a one off system error	Only one member appears to have been affected	Action has been taken to correct the breach, identify and tackle its cause to minimise the risk of recurrence and contact the affected member	It is unlikely that the scheme will be in breach of other legal requirements

Internal controls

Example scenario: A DB public service scheme has outsourced all aspects of scheme administration to a third party, including receiving contributions from employers and making payments to the scheme. Some contributions due to the scheme on behalf of employers and members are outstanding.

	Potential investigation outcomes			
	Cause	**Effect**	**Reaction**	**Wider implications**
Red	The administrator is failing to monitor that contributions are paid to them in time for them to make the payment to the scheme in accordance within the legislative timeframes and is therefore not taking action	The scheme is not receiving the employer contributions on or before the due date nor employee contributions within the prescribed period	The administrator has not taken steps to establish and operate adequate and effective internal controls and the scheme manager does not accept responsibility for ensuring that the failure is addressed	It is highly likely that the administrator is not following agreed service level standards and scheme procedures in other areas. The scheme manager is likely to be in breach of other legal requirements such as the requirement to have adequate internal controls
Amber	The administrator has established internal controls to identify late payments of contributions but these are not being operated effectively by all staff at the administrator	The scheme is receiving some but not all of the employer contributions on or before the due date and employee contributions within the prescribed period	The scheme manager has accepted responsibility for ensuring that the failure is addressed, but the progress of the administrator in training their staff is slow	It is possible that the administrator is not following some of the agreed service level standards and scheme procedures in other areas. It is possible that the scheme manager is in breach of other legal requirements
Green	Legitimate late payments have been agreed by the scheme with a particular employer due to exceptional circumstances	The employer is paying the administrator the outstanding payments within the agreed timescale	The scheme has discussed the issue with the employer and is satisfied that the employer is taking appropriate action to ensure future payments are paid on time	It is unlikely that the employer is failing to adhere to other scheme processes which would cause the scheme manager to be in breach of legal requirements

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Surrey Firefighter's pension scheme

Breaches of Law Policy and Guidance

Appendix 4:

Form to report a suspected breach to the Responsible Officer

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Form to report a suspected breach to the Responsible Officer

Reporter name	
Reporter position	
Telephone contact	
Email address	
Address	
Date of suspected breach	
Description of suspected breach and why you consider it to be a breach (please provide all relevant details)	

Signed	
Date of submission	
Report no (internal use)	

Please submit this form to:

The Responsible Officer
Lindsey Shaw
Surrey Fire and Rescue Service Headquarters
Croydon Road
Reigate
Surrey RH2 0EJ

Telephone - 01737 224084

Email - lindseys@surreycc.gov.uk

8 Email:

AUDIT & GOVERNANCE COMMITTEE
27 MARCH 2017

Internal Audit Plan 2017/18

SUMMARY AND PURPOSE:

The purpose of this report is to present the Annual Internal Audit Plan for 2017/18 to the Committee.

Under-pinning the work of the Internal Audit team in delivering the Annual Internal Audit Plan are the key principles and objectives as set out in the Internal Audit Charter and Strategy. These are presented alongside the Annual Internal Audit Plan for 2017/18 as good practice dictates that these should be updated and reviewed on an annual basis.

Also included in this report are the updated Internal Audit Reporting and Escalation Policy and Quality Assurance and Improvement Programme as required by the Public sector Internal Audit Standards (PSIAS).

RECOMMENDATION:

Members are asked to consider the contents of this report and annexes, and to approve the following:

(i) Internal Audit Charter (Annex A)
(ii) The Internal Audit Strategy (Annex B)
(iii) The Internal Audit Reporting and Escalation Policy (Annex C)
(iv) The Internal Audit Quality Assurance and Improvement Programme (Annex D)
(v) 2017/18 Internal Audit Plan (Annex E)

BACKGROUND:

1. The statutory basis for Internal Audit in local government is provided in the Accounts and Audit Regulations 2015 - which require a local authority to "*undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes".*

2. The Accounts and Audit Regulations contain the expectation that Internal Audit will take into account public sector internal audit standards or guidance. The Audit and Governance Committee recognises the mandatory nature of the Public Sector Internal Audit Standards (PSIAS), which came into effect on 1 April 2013 (and revised 1 April 2016).

3. **Internal Audit Charter (Annex A)**
The PSIAS require Internal Audit to have a Charter that has been formally approved and is regularly reviewed. The Charter attached at Annex A reflects the PSIAS Local

Government Application note which was published in April 2013 and has been refreshed in order to:

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- reflect the changes to the PSIAS (effective from 1 April 2016), notably the inclusion of a "mission statement".
- Ensure a consistent look and feel with OrbisIA partners (East Sussex County Council and Brighton and Hove City Council)

4. **Internal Audit Strategy (Annex B)**

Under the PSIAS there is no longer a requirement to produce an Internal Audit Strategy. However, the Chief Internal Auditor is of the opinion that this is a useful document that links the work of Internal Audit to the Council's vision to be confident in Surrey's future. There have been no significant changes to the Internal Audit Strategy previously approved by this Committee in April 2015.

Through approving the Internal Audit Strategy for 2016-2021 alongside the Internal Audit Plan for 2016/17, the link between the work of Internal Audit and the high level strategic vision of the Council is apparent.

5. **Internal Audit Reporting and Escalation Policy (Annex C)**

The Internal Audit Reporting and Escalation Policy is attached at Annex C. It remains unchanged from 2016/17 although it is anticipated that minor amendments will be made post April 2017 for changes in terminology arising from Orbis-IA joint ways of working.

6. **The Internal Audit Quality Assurance and Improvement Programme (Annex D)**

The PSIAS require the Chief Internal Auditor to develop a Quality Assurance and Improvement Plan (QAIP) which is designed to provide reasonable assurance to its key stakeholders that Internal Audit:

- Performs its work in accordance with its charter
- Operates in an effective and efficient manner; and,
- Is adding value and continually improving the service that it provides

A copy of this QAIP is attached at Annex D for Audit and Governance members to consider.

7. **2017/18 Internal Audit Plan and resources (Annex E)**

<u>Development of the Internal Audit Plan</u>

The Internal Audit Plan for 2017/18, which is a risk based programme of work, is set out at Annex E. There are a number of core elements to the Internal Audit Plan which are likely to feature each year. Certain audit activities are mandatory, e.g.

(i) Reviewing corporate governance arrangements to inform the Annual Governance Statement
(ii) Grant certification
(iii) Irregularity contingency
(iv) Participation in the National Fraud Initiative (NFI)

In addition to these mandatory elements, Internal Audit also carries out testing on an annual basis of many of the Council's key financial systems.

Once these core elements of the Plan and follow up reviews are accounted for, the remaining audits shown in the proposed Plan have been included based on a risk priority which has been assessed following:

(i) Consultation with:
   a. Heads of Service and other senior management
   b. Members of the Cabinet including the Leader of the Council

c. Members of the Audit and Governance Committee
d. S151 Officer
e. The Risk and Governance Manager
f. External Auditor

(ii) Consideration of risk registers
(iii) Areas of concern emerging from liaison with other Local Authority Internal Audit sections

The draft Plan, which attempts to demonstrate a link to the Council's strategic priorities, was also presented at a meeting of the Governance Panel on 23 February and Statutory Responsibilities Network on 27 February.

The Chief Internal Auditor is confident that the draft Internal Audit Plan at Annex E provides comprehensive coverage across the Council's activities and addresses key areas of risk.

Resources

The Internal Audit budget allocation included in the Council's Medium Term Financial Plan is as follows:

	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	£000s	£000s	£000s	£000s	£000s
Audit	**665**	**586**	**598**	**610**	**622**

The Internal Audit team consists of 11 members of staff, although currently only 7 of these posts are filled with permanent members of staff. The budget for 2017/18 does not allow for all 11 auditor positions to be filled with permanent staff and so some agency resourcing will be used during 2017/18 to help deliver the audit plan.

The budget for 2017/18 should be sufficient to cover anticipated costs of employment, and the number of audit days available will decrease slightly (from 2117 days in 2016/17 to 1987 days in 2017/18) to reflect the reduction in available time following the retirement of the Chief Internal Auditor. A decision on the leadership of Orbis-IA is expected to be made in April 2017 by the Director of Finance for Orbis and Surrey County Council.

The Internal Audit team is sufficiently resourced to deliver the programme of work (as shown at Annex E) which will enable the Head of Orbis-IA to provide an opinion on the adequacy of the Council's system of internal control for 2017/18.

IMPLICATIONS:

12. Financial
Equalities
Risk management and value for money

13. There are no direct implications (relating to finance, equalities, risk management or value for money) arising from this report. The Annual Internal Audit plan is designed to focus on key areas of risk and as such should help ensure effective risk management and support the achievement of value for money.

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WHAT HAPPENS NEXT:

14. The Internal Audit team will deliver the 2017/18 Internal Audit Plan and Internal Audit reports will be produced and distributed in line with the Reporting and Escalation Policy.

15. Completed audit reports will continue to be presented to the Committee throughout the year and an update on performance against the 2017/18 Plan will be reported to the Committee in December 2017.

REPORT AUTHOR: **David John, Audit Performance Manager**

CONTACT DETAILS: telephone: 020 8541 7762 e-mail david.john@surreycc.gov.uk

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SURREY

ANNEX A

INTERNAL AUDIT CHARTER

1. Introduction

This Charter describes for the Council the purpose, authority and responsibilities of the Internal Audit function in accordance with the UK Public Sector Internal Audit Standards (PSIAS).

The PSIAS require that the Charter must be reviewed periodically and presented to "senior management" and "the board" for approval. For the purposes of this charter "senior management" will be the Statutory Responsibilities Network and the board will be the Audit & Governance Committee (described generically in this Charter as the Audit Committee)

The Charter shall be reviewed annually and approved by the Statutory Responsibilities Network and the Audit Committee. The Head of Internal Audit is responsible for applying this Charter and keeping it up to date.

2. Internal Audit Purpose

The mission of Internal Audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

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

Internal Audit supports the whole Council to deliver economic, efficient and effective services and achieve the Council's vision, priorities and values.

3. Statutory Requirement

Internal Audit is a statutory service in the context of the Accounts and Audit Regulations 2015, which require every local authority to maintain 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.

orbis

These regulations require any officer or Member of the Council to

- make available such documents and records; and
- supply such information and explanations;

as are considered necessary by those conducting the audit.

This statutory role is recognised and endorsed within the Council's Financial Regulations.

In addition, the Council's S151 Officer has a statutory duty under Section 151 of the Local Government Act 1972 to establish a clear framework for the proper administration of the authority's financial affairs. To perform that duty the Section 151 Officer relies, amongst other things, upon the work of Internal Audit in reviewing the operation of systems of internal control and financial management.

4. Internal Audit Responsibilities and Scope

Annually the Head of Internal Audit is required to provide to the Audit Committee an overall opinion on the Council's internal control environment, risk management arrangements and governance framework to support the Annual Governance Statement.

Internal Audit is not responsible for control systems. Responsibility for effective internal control and risk management rests with the management of the Council.

Internal Audit activity must be free from interference in determining the scope of activity, performing work and communicating results.

The scope of Internal Audit includes the entire control environment and therefore all of the Council's operations, resources, services and responsibilities in relation to other bodies. In order to identify audit coverage, activities are prioritised based on risk, using a combination of Internal Audit and management risk assessment (as set out within Council risk registers). Extensive consultation also takes place with key stakeholders and horizon scanning is undertaken to ensure audit activity is proactive and future focussed.

Internal audit activity will include an evaluation of the effectiveness of the organisation's risk management arrangements and risk exposures relating to:

- Achievement of the organisation's strategic objectives;
- Reliability and integrity of financial and operational information;
- Efficiency and effectiveness of operations and activities;

- Safeguarding of assets; and
- Compliance with laws, regulations, policies, procedures and contracts

5. Independence

Internal Audit will remain sufficiently independent of the activities that it audits to enable auditors to perform their duties in a way that allows them to make impartial and effective professional judgements and recommendations. Internal auditors should have no operational responsibilities.

Internal Audit is involved in the determination of its priorities in consultation with those charged with governance. The Head of Internal Audit has direct access to, and freedom to report in their own name and without fear of favour to, all officers and Members and particularly those charged with governance. This independence is further safeguarded by ensuring that the Head of Internal Audit's formal appraisal/performance review is not inappropriately influenced by those subject to audit. This is achieved by ensuring that both the Chief Executive and the Chairman of the Audit Committee have the opportunity to contribute to this performance review.

All Internal Audit staff are required to make an annual declaration of interest to ensure that objectivity is not impaired and that any potential conflicts of interest are appropriately managed.

6. Reporting Lines

Regardless of line management arrangements, the Head of Internal Audit has free and unfettered access to report to the S151 Officer; the Monitoring Officer; the Chief Executive; the Audit Committee Chairman; the Leader of the Council and the Council's External Auditor.

The Audit Committee will receive reports on a periodic basis – as agreed with the Chairman of the Audit Committee – on the results of audit activity and details of Internal Audit performance including progress on delivering the audit plan.

7. Fraud & Corruption

Managing the risk of fraud and corruption is the responsibility of management. Internal Audit will however be alert in all its work to risks and exposures that could allow fraud or corruption and will investigate allegations of fraud and corruption in line with the Council's Anti Fraud and Corruption Strategy.

The Head of Internal Audit should be informed of all suspected or detected fraud, corruption or irregularity in order to consider the adequacy of the relevant controls and evaluate the implication for their opinion on the control environment.

Internal Audit will promote an anti-fraud and corruption culture within the Council to aid the prevention and detection of fraud.

8. Consultancy Work

Internal Audit may also provide consultancy services, generally advisory in nature, at the request of the organisation. In such circumstances, appropriate arrangements will be put in place to safeguard the independence of Internal Audit and, where this work is not already included within the approved audit plan and may affect the level of assurance work undertaken; this will be reported to the Audit Committee.

In order to help services to develop greater understanding of audit work and have a point of contact in relation to any support they may need, Internal Audit has put in place a set of service liaison arrangements that provide a specific named contact for each service; and, regular liaison meetings. The arrangements also enable Internal Audit to keep in touch with key developments within services that may impact on its work.

9. Resources

The work of Internal Audit is driven by the annual Internal Audit Plan, which is approved each year by the Audit Committee. The Head of Internal Audit is responsible for ensuring that Internal Audit resources are sufficient to meet its responsibilities and achieve its objectives.

Internal Audit must be appropriately staffed in terms of numbers, grades, qualifications and experience, having regard to its objectives and to professional standards. Internal Auditors need to be properly trained to fulfil their responsibilities and should maintain their professional competence through an appropriate ongoing development programme.

The Head of Internal Audit is responsible for appointing Internal Audit staff and will ensure that appointments are made in order to achieve the appropriate mix of qualifications, experience and audit skills. The Head of Internal Audit may engage the use of external resources where it is considered appropriate, including the use of specialist providers.

10. Due Professional Care

The work of Internal Audit will be performed with due professional care and in accordance with the UK Public Sector Internal Audit Standards (PSIAS), the Accounts and Audit Regulations (2015) and with any other relevant statutory obligations and regulations.

In carrying out their work, Internal Auditors must exercise due professional care by considering:

(i) The extent of work needed to achieve the required objectives;

(ii) The relative complexity, materiality or significance of matters to which assurance procedures should be applied; and

(iii) The adequacy and effectiveness of governance, risk management and control processes;

(iv) The probability of significant errors, fraud or non-compliance; and

(v) The cost of assurance in proportion to the potential benefits.

Internal Auditors will also have due regard to the Seven Principles of Public Life – Selflessness; Integrity, Objectivity; Accountability; Openness; Honesty; and Leadership.

11. Quality Assurance

The Head of Internal Audit will control the work of Internal Audit at each level of operation to ensure that a continuously effective level of performance – compliant with the PSIAS is maintained.

A Quality Assurance Improvement Programme (QAIP) is in place which is designed to provide reasonable assurance to its key stakeholders that Internal Audit:

- Performs its work in accordance with its charter
- Operates in an effective and efficient manner; and,
- Is adding value and continually improving the service that it provides

The QAIP requires an annual review of the effectiveness of the system of Internal Audit to be conducted. Instances of non-conformance with the PSIAS, including the impact of any such non-conformance, must be disclosed to the Audit Committee. Any significant deviations must be considered for inclusion in the council's Annual Governance Statement.

April 2017

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Internal Audit Strategy 2016-21

ANNEX B

SURREY

PURPOSE

To provide the statutory Internal Audit function promoting continuous improvement and correct use of public money

VISION

Professional Excellence
Respected Expertise
Independent Assurance

VALUES

- **Listen**
- **Responsibility**
- **Trust**
- **Respect**

Context

The Surrey County Council Internal Audit Charter sets out the purpose, authority and responsibilities of the Council's Internal Audit team. This complementary Strategy provides a framework to ensure the work of Internal Audit is aligned to the Council's Corporate Strategy and upholds and promotes the Council's values. Demands on the Council are increasing while financial resources are decreasing. The Internal Audit team will help meet these challenges by working with Services, Members and partners, sharing data, knowledge and expertise to help improve services and improve outcomes for our residents.

ASSURANCE: We provide an opinion each year on the Council's internal control environment, risk management arrangements and governance framework.

ADVICE: Based on audit findings we make recommendations for improvement and work with Services, Members and partners providing advice on a range of issues.

PROBITY: We take a zero tolerance approach to fraud and corruption. We investigate alleged irregularities and work proactively with Services, Members and partners to fight fraud and protect the public purse.

Our strategic approach

1. Risk based

In 2017/18 we will

- Ensure the Annual Internal Audit Plan supports the Council's strategic goals:
  - Everyone in Surrey has a great start to life and can live and age well
  - Surrey's economy remains strong and sustainable
  - Residents in Surrey experience public services that are easy to use, responsive and value for money

2. Properly resourced

In 2017/18 we will

- Employ a strong mix of people in the Internal Audit team matching technical expertise to audit needs promoting flexibility and living the Council's values
- Encourage and support continuing professional development across the Internal Audit team
- Explore and develop opportunities for wider and more flexible resourcing and intelligence sharing with Internal Audit partners

3. Right profile

In 2017/18 we will

- Share Internal Audit findings promptly with key stakeholders including senior officers and Cabinet Members
- Report publically to the Audit and Governance Committee on implementation of Internal Audit recommendations and attend Overview and Scrutiny Board meetings to discuss audit findings
- Be represented on the Statutory Responsibilities Network and the Continuous Improvement and Productivity Network, drawing attention to governance related matters

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ANNEX C

Internal Audit Reporting and Escalation Policy

Internal Audit
Strategy and Performance
Deputy Chief Executive's Office
April 2016
Version 1.16

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CONTENTS

INTRODUCTION:

1. The Public Sector Internal Audits Standards require that internal audit activity must be free from interference in determining the scope of internal auditing, performing work and communicating results. Timely and appropriate management responses to Internal Audit reports enable the Council to demonstrate that it maintains high standards of internal control and governance in line with corporate objectives.

2. The Audit and Governance Committee have approved this policy in order to ensure that issues are remedied in an appropriate and timely manner.

REPORTING:

3. With the exception of investigations into alleged irregularities (which are subject to separate arrangements not covered in this policy), the following reporting and escalation arrangements apply to all audit reviews undertaken by Internal Audit.

Draft Report

4. Following completion of an audit review the auditor will produce a draft report, which is issued to the responsible manager, (the auditee). The auditee will be asked to comment on the factual accuracy of the report and attend an exit meeting with the auditor within 5 working days. In this context 'factually accurate' means that the auditor's report and recommendations are based on a correct interpretation of the systems or circumstances pertaining to the review.

Exit meeting

5. The exit meeting is held with the auditee and other officers as appropriate. It is during this meeting that key points arising from the audit, factual amendments and recommendations for improvement are discussed. Where possible service actions addressing audit recommendations should be captured for inclusion in a draft management action plan (MAP).

Management Action Plan production

6. Following the exit meeting a draft MAP and revised draft report will be produced for distribution to the auditee, Head of Service and other key officers involved in the audit. Auditees must obtain agreement from their Head of Service as to the proposed actions to be included in the MAP. The relevant Head of Service will be recorded in the MAP as the Responsible Officer and there is an expectation that the Head of Service will have briefed their Director on the findings/recommendations arising from any Internal Audit review in advance of agreeing the MAP. Where actions rest with one or more service, the Head of Service responsible for the business activity reviewed will be deemed the Responsible Officer.

7. The service then has 10 working days to return a completed MAP and any further comments on factual accuracy to the auditor. As part of this process the service is responsible for ensuring that named officers with responsibility for individual actions within the MAP are sufficiently briefed and accepting of such responsibility before the MAP is returned to Internal Audit.

Ownership of the Management Action Plan

8. Whilst individual actions within the MAP may rest with one or more officers, the Head of Service has overall accountability for timely completion of the actions in the MAP, and is

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required to inform Internal Audit if timescales are likely to be missed. In assigning their name to the MAP, Heads of Service are confirming that they accept responsibility for completion of the actions therein.

9. Where MAPs involve recommendations for more than one service, each relevant Head of Service must provide confirmation that they accept responsibility for those actions related to their service area.

10. In either case, the auditor will assume that the auditee has consulted with those officers listed as responsible for individual actions in the MAP, prior to said officers being assigned responsibility for those actions.

Final Report and agreed MAP

12. Upon receipt of the completed MAP the auditor will consider if the actions therein are appropriate. If the auditor is satisfied that all factual points have been addressed; that the service has no outstanding concerns with the report, and that the MAP sufficiently addresses all the findings raised in the audit report, then the final report and MAP can be issued.

13. **Final reports should be issued together with the completed MAP, both of which must be in PDF format.**

MAP Escalation Procedure

14. If the MAP is not returned to deadline, or in the auditor's opinion does not adequately address the issues raised, the Chief Internal Auditor or Audit Performance Managers will discuss their concerns with the Head of Service. If that discussion does not result in a MAP acceptable to Internal Audit the issue will be referred to the relevant Strategic Director for a decision.

15. The Strategic Director's decision will be either to agree an acceptable MAP on behalf of the Head of Service, which must then be implemented within the agreed timescale, or to accept the position and acknowledge that the Strategic Director accepts the risk. Risks tolerated in this manner should be considered for inclusion on the service risk register.

16. If in the opinion of the Chief Internal Auditor the Strategic Director's decision exposes the Council to an unacceptable level of risk, the matter will be referred first to the Chief Executive and then to the Audit and Governance Committee.

17. Depending upon the time taken in escalating MAP completion, the Chief Internal Auditor reserves the right to issue the final report without an agreed MAP.

Distribution list

18. The front cover of the agreed final audit report should list the officers for whom the report has been prepared. This includes the auditee, the Head of Service and other key officers as set out in the agreed Terms of Reference.

19. The inside cover to the report should include a table showing who else the report has been circulated to. If any people in this list are included on the front cover of the report it will not be necessary to include them in the circulation list. **The following distribution list may not apply should the Chief Internal Auditor deem the report to be of a particularly sensitive nature.**

- The External Auditor (through the Lotus Notes group email address)

- Responsible manager's level 4 report;
- Relevant Head of Service;
- Service Finance Manager;
- Risk and Governance Manager;
- Section 151 Officer;
- Relevant Strategic Director(s);
- All members of the Audit and Governance Committee;
- Relevant Cabinet Portfolio Holder;
- Chairman of the relevant select committee; and
- Procurement (if applicable - see 23)

20. There may also be a requirement to circulate the final report to other officers not included in the above list e.g. where that officer is required to action one of the audit recommendations. Where this individual is known at the time of issuing the final report their details should be included in the circulation table.

21. In all cases the Assistant Director of Strategy and Performance and the Chief Internal Auditor should be included in the email circulation of the final audit report - this is for information purposes only, so they do not need to be included in the report distribution table referred to above. The Assistant Director of Strategy and Performance will also ensure that where appropriate to do so, final audit reports will be forwarded onto the relevant Performance Lead managers.

22. The relevant Scrutiny Officer/Assistant should be cc'd in the email circulation of the final audit report.

23. All audit reports for **Procurement,** or reports that have recommendations for Procurement, should be copied to the Procurement and Commissioning Performance and Development Manager.

24. If an audit report has an audit opinion of "Unsatisfactory" or "Significant Improvement Needed" the Chief Internal Auditor will draw this to the attention of the Head of Communications.

Structure and contents

25. Audit reports are generated using a standard reporting template.

26. In order to aid the reader's understanding of the report, a glossary of acronyms should be included as a table on the inside of the front cover under the distribution list.

27. Final audit reports and MAPs should be saved as a PDF document using the format below. Where practical the two documents should be joined as one PDF document.

    Audit name-year-Final Report
    For example: IFRS-09-10-Fin Rep

Protective marking

28. Both draft and final reports should be marked in accordance with the County Council's Security Classifications for Data and Information Policy.

29. The Chief Internal Auditor has determined that of the three levels of marking applicable to local government the third category – OFFICIAL - SENSITIVE – is likely not to be relevant to audit reports. Consequently reports will generally either be marked as 'OFFICIAL' or not marked at all, in accordance with the extract from the Policy below:

[NOT PROTECTIVELY MARKED]

- may have no marking or be marked [NOT PROTECTIVELY MARKED]
- contains no sensitive information
- available to all (internally or externally)
- may be published online or in print

[OFFICIAL]

- many of the council's routine business operations
- policy development, service delivery, statistics
- legal advice, contracts, some administrative data
- contains sensitive information but loss would not cause significant distress

[OFFICIAL - SENSITIVE]

- subject to a heightened risk profile and only available to limited number of users
- contains personal data, commercial confidence or financial information
- loss would cause substantial distress to individuals or damaging consequences for the council

30. If an auditor is in doubt whether a report should be marked “OFFICIAL” or otherwise they should seek guidance from the Chief Internal Auditor or an Audit Performance Manager.

31. Where the “OFFICIAL” marking is used, the following paragraph must be added to the front cover of the draft and final report above the date of issue, and should also be included in the email containing the report:

    *Please note that this report has been prepared by the County Council's Internal Audit team for the use of management in connection with the discharge of the Council's business and has been marked as **OFFICIAL** due to the sensitive nature of its content. A copy is being provided to you on the express understanding that it enables you to carry out your role as an officer or Member of the Council. It is not to be copied or in any way shared with any other person outside the Council.*

Summary of completed audits for Members

32. The Chief Internal Auditor will report on all audits completed since the previous meeting to the Audit and Governance Committee, summarising the reason for the audit, the key findings, the risks resulting from those findings and the recommendations for improvement. The Audit and Governance Committee then considers whether there are any reports that it would like to review in more detail at a future meeting. A list of completed audit reports for the period (together with a link to full copies of those reports) is circulated to all members following the meeting of Audit and Governance Committee.

33. Should the Audit and Governance Committee require an update on completion of actions for a particular audit, the relevant Head of Service is responsible for informing the Chief Internal Auditor of what actions have been completed or providing an explanation for any delay in, or change to, the action being taken.

ESCALATION:

Follow up reviews

34. A formal follow-up review of the progress made in implementing recommendations agreed within the MAP may be programmed into the annual Internal Audit Plan at a time the Chief Internal Auditor considers appropriate. A formal follow-up review is typically carried out for audits that have attracted an audit opinion of "Unsatisfactory" or "Significant Improvement Needed".

35. Upon completion of the follow-up review the auditor will report to the Responsible Officer drawing attention to any actions that have not been completed by the agreed date. A copy of the follow-up report will be sent to the full distribution list set out above.

34. In addition, the Chief Internal Auditor will provide a report, at least bi-annually, to the Audit and Governance Committee on progress in implementing MAPs agreed for audits completed.

Audit and Governance Committee

36. The Head of Service may be required to attend the Audit and Governance Committee to answer questions on the reasons for the non-completion of agreed action or delay in implementation, and the remedial action to be taken.

37. The Audit and Governance Committee having considered the report and the evidence provided by the Head of Service will either agree the remedial actions proposed or, if they consider the position unsatisfactory, may refer the matter to the relevant scrutiny board or to the Cabinet Portfolio holder as necessary.

Select Committee Review of Internal Audit Reports

38. It has been agreed by the Chairmen of the Council's Overview and Scrutiny Boards that any relevant Internal Audit reports that have attracted an audit opinion of either "Significant Improvement Needed" or "Unsatisfactory", and/or those with High Priority recommendations, will be considered for inclusion on the Scrutiny Boards's work programme. The process agreed with Democratic Services to ensure this happens is described at Annex A

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VERSION CONTROL:

1.0	Approved by Audit and Governance Committee 19/11/08	Effective from 01/12/2008
1.1	Amended to include Strategic Director in circulation	Effective from 24/02/2009
1.2	Amended to reflect comments made at Audit and Governance Committee 19/03/09	Effective from 01/04/2009
1.3	Amended to reflect Directorate/ Service Restructure	Effective from 11/01/2010
1.4	Amended to reflect Protect designation, revised timescales for draft and final reporting times, additional distribution requirements, and incorporation of additional guidance on Galileo in this one document	Draft 01/03/10
1.5	As agreed at Audit and Governance Committee 29/03/2010	Effective from 01/04/2010
1.6	Updated following CLT request for MAP ownership to be at Head of Service (or above) level.	Effective from 04/05/2010
1.7	Updated to highlight the requirement to issue the Final Report and MAP together, plus reflect changes to the audit manual.	Effective from 09/07/2010
1.8	Updated to reflect the responsibility of the Head of Service to inform Internal Audit if timescales in the MAP are likely to be missed.	Effective from 20/08/2010

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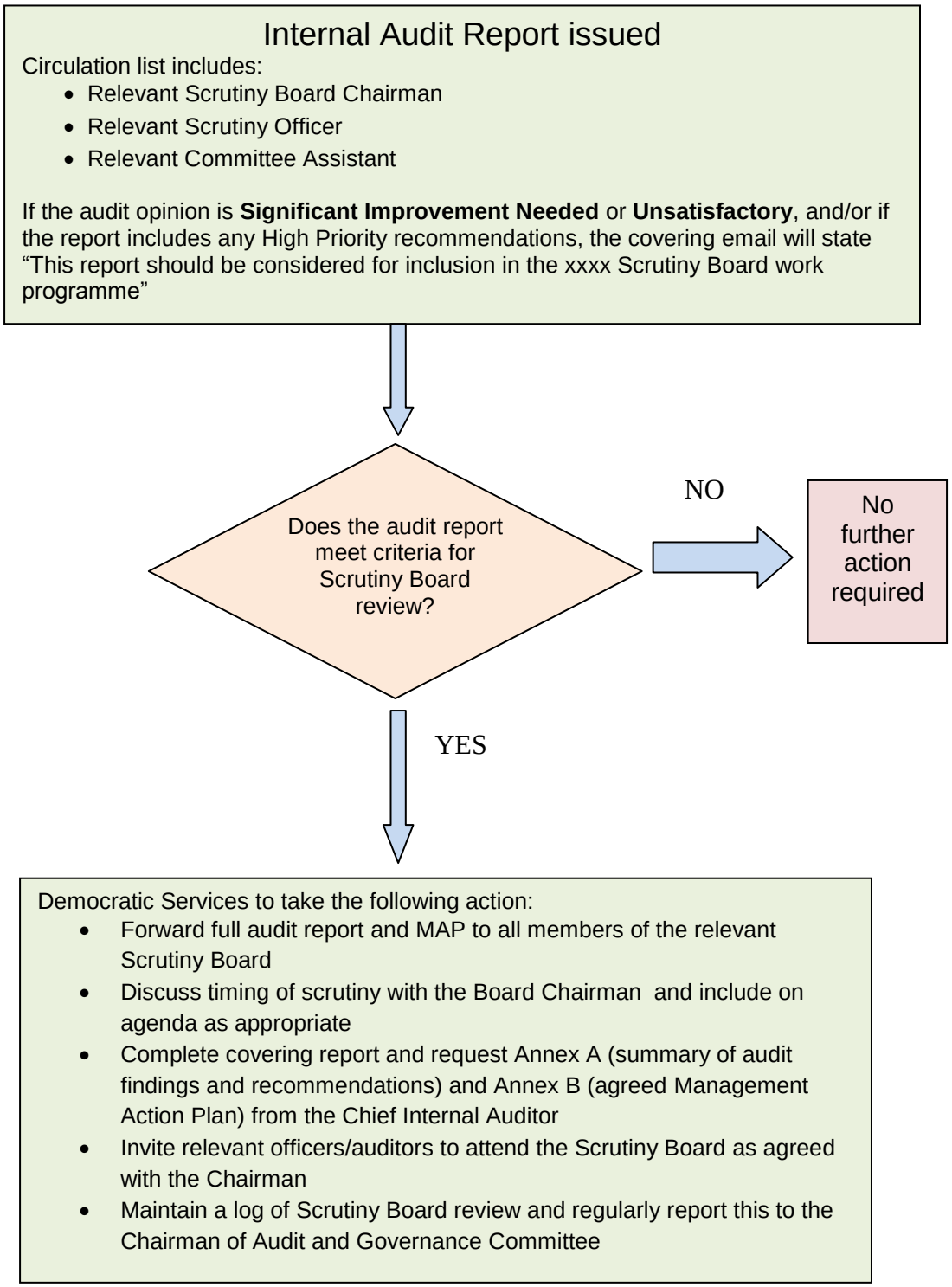
1.9	Revised following Internal Audit team comments.	Effective from 23/09/2010
1.10	Amended to reflect new Service Name	Effective from 01/04/2011
1.11	Amendments as reported to A&G committee on 05/04/2012	Effective from 05/04/2012
1.12	Amendments as reported to and agreed with A&G committee on 18/03/2013	Effective from 18/03/2013
1.13	Amended to reflect the need to include officers from Democratic Services in report circulation	Effective from 11/12/2013
1.14	Amended to reflect agreed process for Select Committee review (note as discussed with Chairman of A&G Committee)	Effective from 25/03/2013
1.15	Amended to reflect the council's new arrangements for the security classification of data and information; and, comments made at A&G Committee on 09/04/2015	Effective from 09/04/2015
1.16	Updated to reflect introduction of Scrutiny Boards and changes to service names and job titles.	Effective from 11/04/2016

SCRUTINY BOARD REVIEW OF INTERNAL AUDIT REPORTS – AGREED PROCESS



Note: The Scrutiny Board is encouraged to seek assurance from officers that appropriate and timely action is being taken to address the audit recommendations made. The agreed Management Action Plan will be available as part of the Scrutiny Board papers, but the supporting audit report will not be included with the public papers. This will have been previously circulated to board members.

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SURREY

ANNEX D

Internal Audit Quality Assurance and Improvement Programme

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PURPOSE:

1. The OrbisIA Quality Assurance Improvement Programme (QAIP) is designed to provide reasonable assurance to its key stakeholders within Orbis Partner Authorities that Internal Audit:

    - Performs its work in accordance with its charter
    - Operates in an effective and efficient manner
    - Is adding value and continually improving the service that it provides

2. The Head of Internal Audit is responsible maintaining this QAIP which covers all aspects of Internal Audit activity. This QAIP seeks to conform with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as such includes both internal and external assessments.

INTERNAL ASSESSMENTS

3. Internal Assessment includes both ongoing and periodic reviews.

Ongoing Reviews

4. Ongoing assessments are conducted through:

    - Supervision of individual audit assignments
    - Applying relevant audit policies and procedures, including those set out on the OrbisIA Sharepoint Site, to ensure applicable audit planning, fieldwork and reporting quality standards are met
    - Review of all audit reports proportionate to the level of sensitivity (as determined by the Head of Internal Audit) prior to formal circulation
    - Feedback from auditees on individual audit assignments

5. The Audit Manager will assign audit work to the Assignment Lead and Assignment Manager giving due regard to their level of skills, experience and competence. The Assignment Manager will have the following responsibilities:

    - Review and contribute to the Terms of Reference
    - Support to, and liaison with, the Assignment Lead throughout the audit
    - Monitoring assignment progress and budget
    - Review working papers and draft reports
    - Review final report

6. Feedback from auditees and reviews of working papers and audit reports will form part of the discussion during monthly 1-2-1 meetings and periodic team review sessions in line with the Orbis approach to Performance and Development; and will help inform formal appraisal discussions as required by the sovereign Authority.

7. OrbisIA team objectives and priorities will be agreed annually and comprehensive performance targets will be agreed with senior management and the board. For Surrey County Council "senior management" is the Executive Leadership Team (ELT) and the "board" is the Audit & Governance Committee. The Head of Internal Audit will measure, monitor and report on progress against these targets to ELT and Audit & Governance Committee at least twice yearly *(as agreed by the sovereign authority's Audit Committee)*. The key performance measures for 2017/18 are set out at Annex A.

Periodic Reviews

8. Periodic assessments are conducted to evaluate conformance with the Definition of Internal Auditing; the Code of Ethics; and, Standards as set out in the PSIAS. These may be conducted through self assessment or by other persons with sufficient knowledge of Internal Audit practices. The PSIAS Local Government Application Note and Checklist will be used as part of this evaluation.

9. An annual review of the effectiveness of the system of Internal Audit will also be conducted. This review is sponsored by the Audit Committee Chairman who will also agree the specific terms of reference for that review. In drafting the Terms of Reference for this annual review the Head of Internal Audit will seek the views of the Section 151 Officer.

EXTERNAL ASSESSMENTS

10. An external assessment will be conducted at least once every five years as required by the PSIAS which came into effect on 1 April 2013 (and revised in April 2016).

11. The Head of Internal Audit will consider what form of external assessment is most appropriate eg a "full" external assessment or a self-assessment with independent validation. The scope of any external assessment will be discussed with the Section 151 Officer and agreed with the Chairman of the Audit Committee and with the appointed external assessor.

12. Before appointing an external assessor, the Head of Internal Audit will have confirmed with the Chairman of the Audit Committee that the assessor is competent in the area of professional internal auditing practices and the external assessment process. In determining competence the Head of Internal Audit will consider the level of experience gained in organisations of similar size and if in doubt will seek advice from CIPFA.

13. For an external assessment to provide a truly independent view, it is important that the appointed assessor has no real or apparent conflict of interest with the Council in general or the Internal Audit team in particular. The Head of Internal Audit will be alert to this risk when appointing the external assessor.

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REPORTING

14. The outcome of any external assessment or periodic internal assessment (notably the annual review of the effectiveness of the system of Internal Auditor) will be reported to Senior Management and to the Audit and Committee on completion. The Head of Internal Audit will not state that the Internal Audit service conforms with the Internal Standards for the Professional Practice of Internal Auditing (ie the PSIAS in the UK Public sector) unless the results of the QAIP (including a completed external assessment) confirm this.

15. The Head of Internal Audit will take appropriate action to ensure that recommendations for improvement identified as a result of periodic internal or external assessments exercises are implemented as appropriate.

16. Progress in implementing agreed improvement plans will be included as part of the Head of Internal Audit's annual report to the Audit Committee.

17. Any significant deviations from the PSIAS will be brought to the attention of the Senior Management and considered for inclusion in the Annual Governance Statement.

VERSION CONTROL:

1.0	As presented to the Audit Committee	March 2017

SURREY

ANNEX A

Aspect of Service	OrbisIA Performance Indicators	Target
Quality	• Annual Audit Plan agreed by Audit Committee • Annual Audit Report and Opinion • Satisfaction levels	• By end April • To inform AGS • 90% satisfied
Productivity and Process Efficiency	• Audit Plan – completion to draft report stage	• 90%
Compliance with Professional Standards	• Public Sector Internal Audit Standards • Relevant legislation such as the Police and Criminal Evidence Act, Criminal Procedures and Investigations Act	• Conforms • Conforms
Outcomes and degree of influence	• Implementation of management actions agreed in response to audit findings	• 95% for high priority
Our Staff	• Professionally Qualified/Accredited	• 80%

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Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Corporate Governance Arrangements Information Governance Risk Management AGS - Internal Audit Opinion CRSA and S151 responsibilities Organisational Ethics	55	(75)
Key Financial and Non Financial Systems SAP Application controls - policy, roles and access Accounts Payable Payroll Accounts Receivable Revenue Budget Control Treasury Management General Ledger Pension Fund Investments Pension Administration	180	(175)
Grants Government Grants EU Grants	40	(54)

ANNEX E

Internal Audit **Surrey County Council**

Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Contract Reviews Compliance with PSO's Procurement Due Diligence Highways Contract Management (Kier Supply Chain) Ethical Procurement Collusion Contract Management Occupational Health Contract	150	(135)
Adult Social Care and Public Health AIS Replacement Better Care Fund Adult Care Assessments Substance Misuse Services Adults & Public Health Transformation & Governance (support)	150	(160)

Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Business Services	265	(225)
3rd Party Services (non-corporate)		
IT Asset Management		
General Data Protection Regulations (GDPR)		
Prioritisation of Disaster Recovery/Service Restoration		
Surrey Choices		
PAMS Income		
Pooling of Pension Fund		
Property Transformation		
Appraisals		
Employee Expenses		
Workplace Travel Allowance		
Blue Badges		
Financial Savings		
(Vendor) Data Management		
Empty Properties (SCC owned)		
Purchasing Cards		

ANNEX E

Internal Audit **Surrey County Council**

Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Customers and Communities Public Consultation Local Committee Petitions Community Improvement Fund/Third Sector Grants	35	(0)
Chief Executive's Office Members' Expenses & Allowances	20	(50)

Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Children's Schools and Families	275	(270)
Children's Improvement Plan (support)		
SEND 2020		
Quality Assurance Framework		
Unaccompanied Asylum Seekers (Children)		
Non-Maintained Independent Schools		
Schools Data Analysis		
Schools Compliance		
Environment and Infrastructure	110	(140)
Integrated Waste Data Management System		
Pavement Horizon		
Grass Cutting (B&D Agency Agreements)		
Highways Asset Valuation		
CIL & S106		

ANNEX E

Internal Audit **Surrey County Council**

Internal Audit Plan 2017/18

	Audit Days 2017/18	(Audit Days 2016/17)
Follow-up Audits including: Premises Security Highways Contract (Lot 5) Health & Safety Contingency	45	(45)
Client Support and Service Liaison	90	(128)
Innovation and New Models of Delivery - Support	30	(50)
Irregularity and Special Investigations including Fraud Prevention Surrey Counter Fraud Partnership Irregularity Contingency Anti Fraud and Data Interrogation NFI Data Matching Exercise	340	(340)
Internal Management, Corporate Support and Organisational Learning	204	(270)

Internal Audit Plan 2017/18

Audit & Governance Support		
Member support		
Audit Planning		
Audit Management		
Corporate Support Activities		
Internal Audit Web Page		
Total Audit Days	**1989**	(2117)

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AUDIT & GOVERNANCE COMMITTEE
27 March 2017

Completed Internal Audit Reports

SUMMARY AND PURPOSE:

The purpose of this report is to inform Members of the Internal Audit reports that have been completed since this Committee last considered a Completed Internal Audit Reports item in February 2017 - as attached at Annex A.

Although it is not the Committee's policy to review all Internal Audit reports in detail during the meeting, full copies of the reports summarised have been provided to Members of the Committee and are available through the Members' on-line library.

RECOMMENDATION:

The Committee is asked to consider whether there are any audit reports or management action plans that it would like to review further and whether there are any matters they wish to refer to the relevant Scrutiny Board.

BACKGROUND:

1 At the conclusion of each audit review a report is issued to the responsible manager who is asked to complete an action plan responding to the recommendations.

2 The return of a management action plan (MAP), which in the auditor's opinion adequately addresses the report findings and recommendations, signals the end of the audit process. Any follow up work required forms part of future audit plans at the appropriate time.

3 There have been four audit reports issued since the last report to this Committee in February 2017. The table below lists those audits and shows the audit opinion and number of high priority recommendations included in the Management Action Plan.

	Audit	Opinion	Number of recommendations rated as High Priority
1	Foster Care Follow-up	Some Improvement Needed	0
2	Risk Management	Some Improvement Needed	0
3	CIF/Member Allocations	Some Improvement Needed	0
4	Safeguarding in Education	Some Improvement Needed	1

10

4 Annex A contains more details of the audits listed above and shows for each the:

- title of the audit
- background to the review
- key findings
- overall audit opinion
- key recommendations for improvement

5 The Committee will be aware that in order to respond to general Member interest in Internal Audit reports it has previously been agreed that a list of completed reports will be circulated to all Members of the County Council on a periodic basis.

6 In order to fully discharge its duties in relation to governance the Committee is asked to review the attached list of recently completed Internal Audit reports and determine whether there are any matters that it would like to review further or if it would like to suggest another Scrutiny Board does so.

IMPLICATIONS:

7 Financial
Equalities
Risk management and value for money

8 There are no direct implications (relating to finance, equalities, risk management or value for money) arising from this report. Any such matters highlighted as part of the audit work referred to in this report, would be progressed through the agreed Internal Audit Reporting and Escalation Policy

WHAT HAPPENS NEXT:

9 See Recommendations above.

REPORT AUTHOR: David John, Audit Performance Manager

CONTACT DETAILS: telephone: 020 8541 7762 e-mail david.john@surreycc.gov.uk

Sources/background papers: Final audit reports and agreed management action plans

Completed Audit Reports (February 2017) Annex A

Audit	Background to review	Key findings	Audit opinion (1)	Recommendations for improvement (Priority) (2)
Foster Care Follow-up	This report follows up the previous review, issued in March 2016, which had provided an audit opinion of Unsatisfactory. The review found numerous control weaknesses. Recommendations were agreed in a Management Action Plan (MAP) in March 2016 and this report sets out the progress made against the MAP.	The East and West Foster Care Teams each hold a local foster carer database on the I Drive which provides information on foster carers approval levels; placements and availability. An enhanced carer database is held within the two separate databases, this is a shared resource for the teams. A test to ensure the consistency of recording across the two databases, which was also conducted in the March review, was repeated and identified that the numbers of enhanced carers differs. Foster carers are responsible for notifying their insurance companies who provide contents, buildings and car insurance that they are approved foster carers. Relevant extract from Foster Carer Handbook: "*There may be occasions when you can make a claim to Surrey County Council for the replacement of property or possessions if there has been wilful damage by a foster child. This will not cover situations where a claim can be made against an existing buildings or contents insurance policy."* The Foster Carer directive regarding insurance claims is unclear and may be subject to local interpretation.	Some Improvement Needed	The service will continue to maintain on-going checks for foster carers as outlined until the Liquidlogic system has been implemented (M) The service will conduct regular reviews as outlined to ensure information contained within the database is accurate and current (M) Legal team will be consulted with regards to the insurance claims directive to ensure the wording is clear and appropriate (M)

Completed Audit Reports (February 2017)

Annex A

Audit	Background to review	Key findings	Audit opinion (1)	Recommendations for improvement (Priority) (2)
Risk Management	The Council's approach to Risk Management (RM) is set out in its Risk Management Strategy. The RM Plan provides an overview of the governance arrangements within the Council and defines the roles and responsibilities of officers and Members who are key in ensuring that governance arrangements support the aims and objectives of the Council.	One SRF representative highlighted that they were not provided with any training or guidance to prepare them for the role. The Auditor looked at the risk registers held on S-Net and found that on the whole risk registers held were in date: however, there were four registers that were in need of updating by the service. A review of the Risk Workshop Guidance and Risk Management Induction Pack available on S-Net and used as a source of guidance by risk representatives, found that project/ programme risk is not specifically covered in these documents.	Some Improvement Needed	An induction checklist should be compiled to maintain a record of the induction process for newly appointed risk representatives. (L) Although status updates on risk registers are presented at all SRF meetings, some services and Directorates are not compliant with the framework guidance on submission of risk registers. A formal escalation process may need to be adopted to progress further (L) Consideration should be given to increasing awareness and understanding of programme and project risk. (M)

Completed Audit Reports (February 2017) Annex A

Audit	Background to review	Key findings	Audit opinion (1)	Recommendations for improvement (Priority) (2)
Community Improvements Fund (CIF) / Members Allocation (MA) Site Visits	Community Partnerships Team (CPT) asked Internal Audit to visit a number of CIF and MA projects to review the evidence the projects could provide to demonstrate how the grant was spent and the outcomes achieved. The grant awards selected for review were mainly those where CPT officers had historically requested evidence of project outcomes but this had not been supplied by the grant recipient.	All of the external projects visited were able to demonstrate how they were adding value to the community through use of the grant monies. Some projects had deviated from their original bid plan without informing CPT. The requirement for post project information should be more explicit and chasing for this information should be more structured and focused. Where MA is spent by internal services such as Highways, the response rate for post project information is often poor. A number of projects had not publicised the funding on their website or displayed a SCC plaque to acknowledge the funding.	Some Improvement Needed	Information received from specific CIF projects visited should be reviewed to consider if any grant money should be reclaimed. (M) At grant approval stage decide which information CIF projects will subsequently be required to provide to meet monitoring requirements. (L) Adopt a more structured and time focussed approach to chasing post project information, targeting available resources to higher risk projects. (M) Members to be copied in on emails to projects requesting information. (L) CPT undertakes project visits where the lack of post project information provided and/or other risk factor may indicate misuse of the grant. (M) For SCC run projects the information to be provided post project is agreed before the grant is paid, and options for working more effectively with internal stakeholders be considered. (L)

Completed Audit Reports (February 2017)

Annex A

Audit	Background to review	Key findings	Audit opinion (1)	Recommendations for improvement (Priority) (2)
Safeguarding in Education	The council has a duty to safeguard and promote the welfare of children including those attending Surrey's 282 maintained schools and colleges, 386 academies, and 120 independent schools. Statutory guidance from the Department for Education (DfE) details the responsibilities of schools and colleges to safeguard children.	The Education Safeguarding Team conducts an annual audit that enables schools to assess their safeguarding arrangements and identify areas for improvement. While it is for schools' governing bodies to ensure issues are addressed, the council could take a more formal approach to ensuring actions are taken to prevent issues going unresolved. There is a range of template policies, guidance and training available and it is encouraging to note that 10 of the 14 academies' policies are based on the council's template. Sample testing of 50 schools and academy websites highlighted action is required by several schools and academies to meet the DfE requirements to make policies publicly available.	Some Improvement Needed	Address the Child Protection and Safeguarding Policy issues with six maintained schools and inform three academies of the issues identified. (H) Consider requesting termly updates from schools that have identified substantial areas for improvement. (L)

Completed Audit Reports (February 2017)

Annex A

[1] **Audit Opinions**

Effective	Controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Some Improvement Needed	A few specific control weaknesses were noted; generally however, controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Significant Improvement Needed	Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and objectives should be met.
Unsatisfactory	Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met.

[2] **Audit Recommendations**

Priority High (H) - major control weakness requiring immediate implementation of recommendation
Priority Medium (M) - existing procedures have a negative impact on internal control or the efficient use of resources
Priority Low (L) - recommendation represents good practice but its implementation is not fundamental to internal control

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