



# South Kesteven District Council

## Internal Audit Progress Report

13 March 2024

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# 1 Key messages

The Internal Audit Plan for 2023/24 was presented to the Governance and Audit Committee at the 29 November 2023 meeting. We will work closely with management to deliver an internal audit programme which remains flexible and 'agile' to ensure it meets your needs in the current circumstances.

This report provides an update on progress against that plan and summarises the results of our work to date.



Audit dates for the 2023/24 Internal Audit Plan have been agreed with management and scopes have all been issued and agreed. All audits have been sufficiently resourced and are booked into our internal audit scheduling software. We are on track to deliver all audits during the current financial year to be able to provide our Head of Internal Audit Opinion.



Five reports have been issued as final since the last committee meeting in line with our planned timings outlined in Appendix A. These are Food Safety Management (3.23/24), Governance (4.23/24), Recruitment and Retention (5.23/24), Cyber Treatment Plan (6.23/24), and Risk Management (8.23/24), details can be found in section two below.



The draft report for Responsive Repairs has been issued and is awaiting final management responses and approval. The remaining audits have been completed or are in the process of being conducted.

## 2 Reports

### 2.1 Summary of final reports being presented to this committee

This section summarises the reports that have been finalised since the last meeting.

Assignment	Opinion issued	Actions agreed		
		H	M	L
<p><b>Food Safety Management (3.23/24)</b></p> <p><u>Objective of review:</u></p> <p>We will review and assess compliance with the Food Safety Management requirements for food hygiene inspections and consistency of ratings under the Food Hygiene Scheme.</p> <p><u>Overall assurance rating and management actions:</u></p> <p>Overall our review confirmed that there was an appropriate control framework in place which was being complied with in practice. Staff have received training for completing the required inspections, and inspections are carried and recorded within the Flare system. However, our review identified areas for improvement including ensuring inspections are conducted in line with the required frequencies set out by their risk levels.</p> <p>This resulted in the agreement of three low priority management actions.</p>		0	0	3
<p><b>Governance (4.23/24)</b></p> <p><u>Objective of review:</u></p> <p>This review will confirm that governance meetings are being conducted in line with defined schedules and that each meeting has an up to date Terms of Reference, each meeting is quorate, and timelines for agendas and minutes are being adhered to.</p> <p><u>Overall assurance rating and management actions:</u></p>		0	0	1



Assignment	Opinion issued	Actions agreed		
		H	M	L

Overall our review confirmed that there was an appropriate control framework in place for the governance functions within the Council, and these had been clearly laid out within the Constitution. Meetings are conducted in line with the required frequencies and actions are followed up at the next meeting. However, our review identified one area for improvement relating to conducting annual self-assessments at each committee.

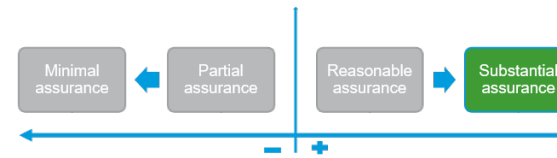
This resulted in the agreement of one low priority management action.

**Recruitment and Retention (5.23/24)**

0 0 3

Objective of review:

This review will assess the processes in place for how the Council recruit and retain key staff to ensure that these processes are effective and being complied with in practice.



Overall assurance rating and management actions:

Overall our review confirmed that there was an appropriate control framework in place within the Council. The various activities outlined within the recruitment policy are being undertaken. However, our review identified areas where enhancements are required or controls are not being consistently adhered to in relation documenting training attendance, fully completing staff requisition forms, and retaining interview decision documents.

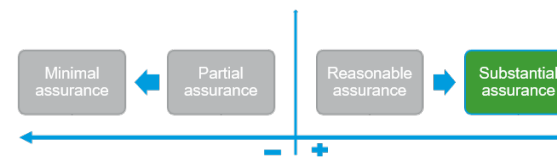
This resulted in the agreement of three low priority management actions.

**Cyber Treatment Plan (6.23/24)**

0 0 1

Objective of review:

We will assess the progress made towards the completion of the actions within the Cyber Treatment Plan.



Overall assurance rating and management actions:



Assignment	Opinion issued	Actions agreed		
		H	M	L

Our testing found that 31 of the 32 actions had been correctly implemented or superseded in line with the initial action set by DLUHC and this is accurate to what was being reported to the Finance and Economic Overview and Scrutiny Committee. We noted that one action was partially implemented, and for two further actions, although completed as per the DLUHC action, additional improvements could still be made to enhance the control environment.

We have agreed one low priority management action to complete the remaining action and to consider the other two areas for further improvements.

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**Risk Management (8.23/24)**

Advisory

9 Recommendations

Objective of review:

This review will assess the progress the Council has made with risk management to the date of the audit, and provide advisory input with regards to future improvements and good practice which can be incorporated.

Conclusion

Our review identified that although there is a Risk Management Framework in place, through the implementation of the recommendations identified within this report, this could be further improved to ensure that there is a fully embedded effective risk management process in place.

As a result of this advisory review we have noted nine recommendations.

We have provided examples of best practice to management with regards to creating an assurance framework and the three lines of assurance.

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## Appendix A – Progress against the internal audit plan 2023/24

Assignment	Status / Opinion issued	Actions agreed			Target Audit and Governance Committee	Actual Audit and Governance Committee
		L	M	H		
<b>Debtors and Debt Recovery</b>	Final Report Issued – Reasonable Assurance	5	0	0	January 2024	January 2024
<b>Follow Up 1</b>	Final Report Issued – Reasonable Progress	1	4	0	January 2024	January 2024
<b>Food Safety Management</b>	Final Report Issued – Substantial Assurance	3	0	0	March 2024	March 2024
<b>Recruitment and Retention</b>	Final Report Issued – Substantial Assurance	3	0	0	March 2024	March 2024
<b>Governance</b>	Final Report Issued – Substantial Assurance	1	0	0	March 2024	March 2024
<b>Responsive Repairs</b>	Draft Report Issued				March 2024	-
<b>Cyber Treatment Plan</b>	Final Report Issued – Substantial Assurance	1	0	0	March 2024	March 2024
<b>Risk Management</b>	Final Report Issued – Advisory	9 Recommendations			June 2024	March 2024
<b>Payroll</b>	Fieldwork Completed				June 2024	-
<b>Section 106 Agreements</b>	Fieldwork Underway				June 2024	-



Assignment	Status / Opinion issued	Actions agreed			Target Audit and Governance Committee	Actual Audit and Governance Committee
		L	M	H		
Purchasing and Creditors	Fieldwork Completed				June 2024	-
Follow Up 2	Fieldwork Underway				June 2024	-



## Appendix B – Other matters

### Changes to the audit plan

Our approach to working with you is to respond to your changing assurance needs. By employing an 'agile' or a 'flexible' approach to our service delivery, we are able to change the focus of audits / audit delivery.

There have been no changes to the internal audit plan.

### Quality assurance and continual improvement

To ensure that RSM remains compliant with the IIA standards and the financial services recommendations for Internal Audit we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews being used to inform the training needs of our audit teams.

The Quality Assurance Team is made up of; the Head of the Quality Assurance Department (FCA qualified) and an Associate Director (FCCA qualified), with support from other team members across the department.

This is in addition to any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments.

### Post assignment surveys

We are committed to delivering an excellent client experience every time we work with you. Your feedback helps us to improve the quality of the service we deliver to you.

Currently, following the completion of each product we deliver we attached a brief survey for the client lead to complete.

We would like to give you the opportunity to consider how frequently you receive these feedback requests; and whether the current format works. Options available are:

- After each review (current option).
- Monthly / quarterly / annual feedback request.
- Executive lead only, or executive lead and key team members.

## Appendix C - Key performance indicators (KPIs)

	Delivery			Quality		
	Target	Actual	Notes (ref)	Target	Actual	Notes (ref)
Audits commenced in line with original timescales	Yes	Yes	*	Conformance with PSIAS and IIA Standards	Yes	Yes
Draft reports issued within 10 days of debrief meeting	10 days	6 working days (average)		Liaison with external audit to allow, where appropriate and required, the external auditor to place reliance on the work of internal audit	Yes	Yes
Management responses received within 10 days of draft report	10 days	3 working days (average)		Response time for all general enquiries for assistance	2 working days	2 working days
Final report issued within 3 days of management response	3 days	1 working day (average)		Response for emergencies and potential fraud	1 working day	N/A

### Notes

\* This takes into account changes agreed by management and the Governance and Audit Committee during the year. Through employing an 'agile' or a 'flexible' approach to our service delivery we are able to respond to your assurance needs.



## For more information contact

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### **rsmuk.com**

The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Actions for improvements should be assessed by you for their full impact. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

Our report is prepared solely for the confidential use of South Kesteven District Council, and solely for the purposes set out herein. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM UK Risk Assurance Services LLP for any purpose or in any context. Any third party which obtains access to this report or a copy and chooses to rely on it (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM UK Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

RSM UK Risk Assurance Services LLP is a limited liability partnership registered in England and Wales no. OC389499 at 6th floor, 25 Farringdon Street, London EC4A 4AB.

# EXECUTIVE SUMMARY – FOOD SAFETY MANAGEMENT

With the use of secure portals for the transfer of information, and through electronic communication means, 100 per cent of our audit has been conducted remotely. Remote working has meant that we have been able to complete our audit and provide you with the assurances you require. Based on the information provided by you, we have been able to sample test to complete the work in line with the agreed scope.

## Why we completed this audit

A Food Safety Management audit was conducted to assess compliance with internal policies and procedures for the inspection of relevant businesses for their compliance with Food Law Code of Practice. This included ensuring that inspections had been conducted in line with the frequencies stipulated by their risk level, ensuring that any follow up inspections or actions had been completed and that staff conducting the inspections had the required training.

The Council require assurance in this area as there is a health and safety risk to individuals who order food or eat at the food outlets, and therefore the public needs assurance that the Council are ensuring these outlets are fit to serve food. The Council have authority to enforce improvements including Hygiene Improvement Notices (HIN) and therefore sufficient documentation is required to be maintained by the Council to support any enforcement action. During the year, a total of seven HINs had been issued to businesses.

Food Safety Management is the responsibility of the Environmental Health Department, led by the Environmental Health – Commercial Team Leader, with the Flare system acting as a central repository for all documentation relating to inspections and actions.

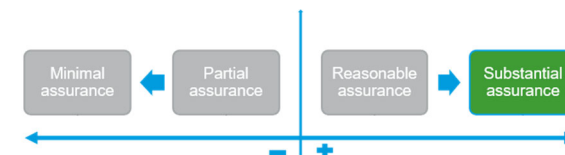
## Conclusion

Overall our review confirmed that there is an appropriate control framework in place which is being complied with in practice. Staff have received training for completing the required inspections, and inspections are carried and recorded within the Flare system. However, our review has identified areas for improvement including ensuring inspections are conducted in line with the required frequencies set out by their risk levels.

This has resulted in the agreement of three low priority management actions. Detail of these can be found in section two of the report.

### Internal audit opinion:

Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the Council relies to manage this area are suitably designed, consistently applied and effective.



## Key findings

We identified the following areas of good control design which, based on our testing, were being complied with in practice:



Authorised Officers hold qualifications to ensure that they are trained to complete inspections in line with the Food Law Code of Practice. Testing of five officers confirmed that in four instances they held appropriate qualifications and had conducted a minimum of 20 hours CPD in the current year. The remaining staff member was a Technical Support Officer and therefore did not require qualifications.



Inspections are allocated by the Environmental Health – Commercial Team Leader on a quarterly basis and this was confirmed through review of the Allocation Sheet which documented the Authorised Officers assigned to the inspection, last inspection date and the business risk rating score.



Testing of five risk rating changes confirmed that the inspection report had been completed in full, the change was approved by the Environmental Health – Commercial Team Leader and supporting notes were documented on the Flare system.



Where the Authorised Officer has deemed there to be poor safety management at the premises, they recommend improvement action such as revisits or action plans. Testing of three premises with risk ratings of two (improvement is necessary) confirmed in one instance revisits had taken place, and the remaining two had been scheduled for January 2024.



Hygiene Improvement Notices (HIN) can be issued in instances of poor compliance with the Food Hygiene Regulation. We conducted a walkthrough of one premise in receipt of a HIN and confirmed that the Enforcement Compliance Form was completed by the Authorised Officer and reviewed by the Team Leader as approval. A reinspection was subsequently conducted and confirmed the condition had improved.



Food complaints to be investigated can be submitted by a member of the public direct to the Council. Testing a sample of 10 complaints confirmed that in nine instances the complaint was investigated and closed with notes and evidence maintained on the system. The remaining complaint came from an anonymous complainant so could not be responded to, and the complaint was regarding a process which was not mandatory to be followed by the premises.



The Commercial Team meet on a monthly basis to discuss the food safety inspections and provide work updates across the Council which was confirmed for three months of this year through review of meeting minutes.

Details of the three low priority management actions are included below.



## Area: Policies and Procedures

- Through review of procedure for identifying inspections and allocating to officers, we noted that it was last reviewed in June 2017; and
- Through review of the internal procedure for for dealing with food products and food premises complaints, we noted that it does not set out the procedures for reporting a food complaint by online Complaint Form and contacting the Authorised Officer.

Through review of the staff shared drive, we confirmed that the procedures were made available to all staff to access. We also confirmed that these processes documented were reflective of the processes carried out by the Food Safety Management Team.

Due to the pandemic there has been a delay in the reviewing and updating of some of the procedures to reflect the current practices in the Council and remain up to date with the Food Law Code of Practice. Currently, the Environmental Health – Commercial Team Leader is reviewing the internal procedures and adding in details where appropriate, and there is a tracker to monitor the review progress. We obtained the file tracker and confirmed this.

However, without policies or procedures being updated. there is a risk that the Council are using outdated documents which may lead to a failure of complying with current laws and regulations, and the staff may follow incorrect procedures around food safety management.

<b>Management Action 1</b>	Management will continue to review all internal procedures related to food safety management and will also add in more relevant details where appropriate and maintain these documents up-to-date.	<b>Responsible Owner:</b> Environmental Health – Commercial Team Leader	<b>Date:</b> 31 March 2024	<b>Priority:</b> <b>Low</b>
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## Area: Addition and Closure

<b>Control</b>	The Technical Support Officer (TSO) is responsible for the registration and administration of new food businesses. The new business is required to complete a Food Registration Form, which is approved by the TSO and is added to the Council's food register system, Flare.  Businesses can contact the Authorised Officers and Customer Service Centre to report the closure of a business. Once it is confirmed, the property is inspected to confirm it has ceased trading and then both the Authorised Officers and the TSO can close the business in Flare system.	<b>Assessment:</b>	
		<b>Design</b>	✓
		<b>Compliance</b>	×

<b>Findings / Implications</b>	<b>Additions</b> Through discussion with the Environmental Health – Commercial Team Leader, we noted that the Technical Support Officer (TSO) is responsible for the registration and administration of new food business. Through review of the internal procedure for Food Registration and Closure of Business, we noted that it sets out the following procedures for new business registration: <ul style="list-style-type: none"> <li>• Food business operators must provide the Council with full details of the activities when registering their establishments by completing an online Food Registration form. Through review of Council website, we confirmed that the link of the form is displayed and accessible to all users.</li> </ul>
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## Area: Addition and Closure

- When a food business registers on the online system, an email notification is generated and sent to the Council's email inbox along with a summary of the registration. After the TSO reviewing the registration and confirming that the form has been filled in correctly, a copy of the form is added to the Flare system.

We obtained a report of new businesses registered since 1 April 2023 and selected five for review. We obtained the Food Registration Form and reviewed the record in the Flare system, to test and confirm that the addition was made appropriately by an authorised person, with all supporting documents in place. Through sample testing, we noted that, in all five cases, the Food Registration Form was in place and attached to the Flare system by the TSO. The address and date of registration on the Food Registration Form was in line with the record in Flare. In addition, we also confirmed that the registration was processed and added to the system within 28 days.

### Closure

Through discussion with the Environmental Health – Commercial Team Leader, we noted that a business is not removed from the Flare system, instead, it is marked as 'Closed'. When a business is closed down by the business owner, and the record needs closing down on the Flare system:

- Business owners can contact Authorised Officers to report a closure of a business. Once it is confirmed either through correspondence with the business or inspection that a business ceases trading, the Authorised Officer can close down the business in the Flare system, with supporting notes recorded in the system;
- Business owners can also contact the Customer Service Centre to report a closure of a business, which is then transferred to the TSO for further review. The TSO assigns one Authorised Officer to investigate and contact the business. Once it is confirmed that a business ceases trading, both the Authorised Officers and the TSO can close the business in the Flare system; and
- Authorised Officers can close down a business after an inspection has been conducted and they confirm it has ceased trading.

However, through review of the internal procedure for Food Registration and Closure of Business, we noted that it does not set out the procedures for a business owner contacting Authorised Officers to report a closure and the Authorised Officer closing down the business upon an inspection. Without an up-to-date procedure, there is a risk that staff may follow incorrect procedures when closing down a food business. This was covered by the action raised in the previous finding.

We obtained a report of businesses that have been closed in the Flare system since 1 April 2023 and selected five for review. We reviewed the record in the Flare system and supporting notes, to test and confirm that the closure had been made appropriately by an authorised person. Through sample testing, we noted the following:

- In one out of five instances, the business owner reported to the Customer Service Centre that the business was closed. The date of closure was recorded in the Flare system, however, there was no supporting notes in place.
- We noted that it was a high profile local business, and it is a known fact that the business ceased trading. Through review of the system, we confirmed that the TSO closed the business;

## Area: Addition and Closure

- In one out of five instances, the business owner reported to the Customer Service Centre that the business was closed. The date of closure was recorded in the Flare system, with supporting notes documented. The Authorised Officer tried to contact and inspect the business, but there was no response. Through review of the system, we confirmed that the TSO closed the business, which was agreed by the Team Leader;
- In one out of five instances, the Authorised Officer closed a business after the inspection was conducted. The date of closure was recorded in the Flare system, with supporting notes documented. The Authorised Officer sent a letter to the business and tried to visit, but there was no response. Through review of the system, we confirmed that the TSO closed the business, which was agreed by the Team Leader; and
- In two out of five instances, the business owner contacted the Authorised Officer to report a closure of a business. The date of closure was recorded in Flare system, with supporting notes documented. The Authorised Officer inspected the business and it had ceased trading. Through review of the system, we confirmed that the Authorised Officer closed the business, which was agreed by the Commercial Team Leader.

However, without a supporting note in place, the reason of closure remains unclear and therefore the business may have been closed in error and therefore future inspections will not be conducted.

<b>Management Action 2</b>	Management will ensure that for the business closed down in the Flare system, the supporting notes or reasons are clearly documented. Management will also remind staff of the importance to ensure all supporting notes are maintained in the system.	<b>Responsible Owner:</b> Environmental Health – Commercial Team Leader	<b>Date:</b> 31 March 2024	<b>Priority:</b> <b>Low</b>
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## Area: Inspection Frequencies

<b>Control</b>	The inspection of businesses is conducted in line with the risk rating, which is in accordance with the Food Law Code of Practice.	<b>Assessment:</b>
		<b>Design</b> ✓
		<b>Compliance</b> ×

**Findings / Implications** Through discussion with the Environmental Health – Commercial Team Leader, we noted that, in accordance with the Food Law Code of Practice, at each inspection, a risk score is given to each business to determine the frequency of inspection. The risk rating is based on assessment of several elements, including type of food and processing, number and type of consumers potentially at risk; current compliance, risk of contamination, and confidence in management.

The risk rating is categorised as follows:

- Category A: inspection should be conducted at least every six months;

## Area: Inspection Frequencies

- Category B: inspection should be conducted at least every 12 months;
- Category C: inspection should be conducted at least every 18 months;
- Category D: inspection should be conducted at least every 24 months; and
- Category E: inspection should be conducted at least every three years.

Review of the Food Law Code of Practice also confirmed inspections should receive an inspection no later than 28 days after the required frequency.

We selected 10 businesses from the Council's Inspection Report dated 1 April 2023 to 29 November 2023. We tested to confirm that the inspections were conducted in line with the agreed frequencies based on the risk rating, and all supporting documentation had been maintained appropriately. Our testing confirmed the following:

- In four of ten samples reviewed, inspections were not conducted in line with the agreed frequencies based on the risk rating. In addition, the inspections were conducted more than 28 days after the due intervention date. All inspection reports had been maintained.
- In two of ten samples reviewed, inspections were not conducted in line with the agreed frequencies based on the risk rating. However they were conducted within 28 days after the agreed frequencies based on the risk rating and this is in line with the code.
- In four of ten samples reviewed inspections were conducted in line with the agreed frequencies based on the risk rating.
- In all ten samples reviewed inspection report forms were completed in full, signed by the Inspection Officer and business owner.
- In one instance the risk band provided in the inspection report was incorrect. Discussions with the Council confirmed this was a clerical error and once identified, we confirmed the Commercial Team Leader had amended this and rectified the risk band.

For the four inspections conducted outside of the required window we confirmed that these were not deemed high risk as there most recent hygiene ratings were good and the team were at the time responding to more high priority matters such as a fatal workplace accident, a prosecution case and had one role vacant. Therefore the overall risk here has been deemed low.

Without conducting inspections in line with the agreed frequencies with no reasonable or documented explanation, there might be a failure of identifying any potential food safety issues due to delay of inspection.

Without correctly documenting the risk band, it causes error when allocating work and there might be a failure of conducting the next inspection in line with agreed frequencies.

<b>Management Action 3</b>	Management will ensure that for inspections completed more than 28 days after the due date, reasons for the delay will be documented on the system. Management will remind staff of the inspection frequencies to ensure they are in line with the risk band associated and that all dates match on the inspection report.	<b>Responsible Owner:</b> Environmental Health – Commercial Team Leader	<b>Date:</b> 31 March 2024	<b>Priority:</b> Low
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# EXECUTIVE SUMMARY - GOVERNANCE

With the use of secure portals for the transfer of information, and through electronic communication means, 100 per cent of our audit has been conducted remotely. Remote working has meant that we have been able to complete our audit and provide you with the assurances you require. Based on the information provided by you, we have been able to sample test, to complete the work in line with the agreed scope.

## Why we completed this audit

A governance audit was conducted to confirm that governance meetings are being conducted in line with defined schedules and that each meeting has an up to date Terms of Reference, each meeting is quorate, and timelines for agendas and minutes are being adhered to. These are all aspects of good governance, set out within the Council's Constitution and is a key element to the Head of Internal Audit Opinion which is provided each year. This review also considered whether each committee is appropriately discharging their duties and conducting their roles and responsibilities laid out with in the Terms of Reference. Testing focused on the following committees:

- Governance and Audit Committee;
- Licensing Committee;
- Planning Committee;
- Standards Committee; and
- Finance and Economic Overview and Scrutiny Committee.

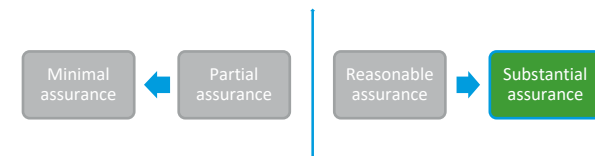
The Assistant Director (Governance and Public Protection) and Monitoring Officer is responsible for overseeing the governance functions within the Council.

## Conclusion

Overall our review confirmed that there is an appropriate control framework in place for the governance functions within the Council, and these have been clearly laid out within the Constitution. Meetings are conducted in line with the required frequencies and actions are followed up at the next meeting. However, our review has identified one area for improvement relating to conducting annual self-assessments at each committee. This has resulted in the agreement of one low priority management action. Detail of this can be found in section two of the report.

### Internal audit opinion:

Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the Council relies to manage this area are suitably designed, consistently applied and effective.



## Key findings

### We identified the following findings:



The Council's Constitution is maintained up to date and is available via the Council website. This includes details of each committee and was last updated in November 2023.



Part three of the Constitution outlines the delegated functions of each committee as required. This was confirmed through review of the document and we confirmed these were up to date and reflective of current practices.



The Terms of Reference for each committee we tested (where required) were confirmed to be up to date and outlined the key elements to be covered by the committee.



The Council utilises a timetable which details when reports are to be submitted, additionally the timetable is used to incorporate reporting deadlines with individual committee work programmes. Walkthrough of meeting minutes from the Governance and Audit Committee, Finance and Economic Scrutiny Committee and the Standards Committee confirmed that decisions were in line with the Terms of Reference or work programme.



Testing of the five committees confirmed that meetings were being conducted in line with the defined frequencies. These timeframes matched to the 2023/24 meeting schedule.



Testing of the Governance and Audit Committee, and the Finance and Economic Scrutiny Committee for three meetings confirmed that actions were documented and followed up at the next meeting. The Standards Committee is a new meeting and therefore could not be tested for this, and the remaining two committees did not have any required actions to follow up.



Sample testing of six key decisions across these committees confirmed that in all instances scrutiny of the decisions was provided and documented within the meeting minutes. Each of these key decisions also had scrutiny provided by Cabinet.



Testing a sample of 10 members confirmed that each member had completed their annual declaration of interests within the preceding 12 months. These declarations were also included on the Council's website.

**Details of the low priority management action is included below.**

## 2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Area: Annual Self-Evaluation				
<b>Control</b>	<i>Partially Missing Control</i> The Governance and Audit Committee and the Finance and Economic Scrutiny Committee undertake a self-assessment of performance each year and produces an annual report. The remaining committees do not conduct this process.	<b>Assessment:</b>		
		<b>Design</b>		×
		<b>Compliance</b>		-
<b>Findings / Implications</b>	<p>Through discussions with the Assistant Director (Governance and Public Protection) and the Monitoring Officer, it confirmed that among the tested committees, the Governance and Audit Committee and the Finance and Economic Scrutiny Committee, are both required to undergo annual self-assessments. The Standards Committee, being newly established, and the Planning and Licensing Committees, governed by legislation, do not partake in self-evaluations. The annual self-assessments are integral components of the committees' reporting procedures.</p> <p>Upon examination of the Governance and Audit Committee's annual report, it was established that the evaluation process involves a review of the committee's annual and indicative work plan and timetable. This analysis enables the committee to gauge its performance and accomplishments over the preceding 12 months, illustrating an accurate understanding of its operational effectiveness.</p> <p>The Finance and Economic Scrutiny Committee's receive a KPI report twice per year, however, this is in relation to the service areas under its responsibility as opposed to reflecting upon how it is operated over the year. The Finance and Economic Scrutiny Committee did not have an annual report produced for 2022/23, however, this will be conducted for the 2023/24 municipal year.</p> <p>Moving forwards, all five Overview and Scrutiny Committees will have an annual produced. The Council will incorporate these as part of its consideration process, contributing to an informed understanding of the operational effectiveness of the committees within the broader governance structure.</p> <p>While the Planning and Licensing committees are rooted in legislation, there is value in introducing annual self-evaluations to gauge the operational effectiveness of these committees. Failing to monitor the operational effectiveness poses the risk of the committee overlooking inefficiencies and missing opportunities to identify and implement best practices.</p>			
<b>Management Action 1</b>	Management will undertake annual self-evaluations for the Planning and Licence committees to be aware of operational effectiveness of these committees. An annual report will also be produced for all Overview and Scrutiny Committees.	<b>Responsible Owner:</b> Assistant Director (Governance and Public Protection) and the Monitoring Officer	<b>Date:</b> 30 September 2024	<b>Priority:</b> <b>Low</b>

# EXECUTIVE SUMMARY – RECRUITMENT AND RETENTION

With the use of secure portals for the transfer of information, and through electronic communication means, 100 per cent of our audit has been conducted remotely. Remote working has meant that we have been able to complete our audit and provide you with the assurances you require. Based on the information provided by you, we have been able to sample test to complete the work in line with the agreed scope.

## Why we completed this audit

A Recruitment and Retention Audit has been conducted to assess the processes in place for how the Council recruits and retains key staff to ensure that these processes are effective and being complied with in practice. This included reviewing the components of the recruitment process in line with the policy, ensuring that relevant activities are undertaken as required. Having a robust recruitment and retention process at the Council is important as it ensures that the Council has the right people with the right skills and abilities to meet its current and future needs.

Recruiting Managers are responsible for identifying the need for new staff, and for completing a staff requisition form to be approved by both HR and Finance. They are also responsible for shortlisting applicants and conducting interviews and informing HR of their decisions at each stage. HR is also responsible for issuing employment contracts to successful applicants and conducting pre-employment checks.

The Council are currently in the process of reviewing its existing policy to enhance current practices.

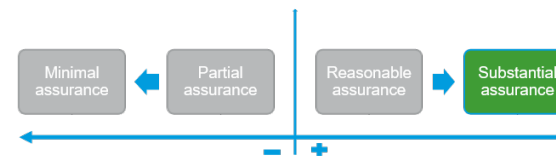
## Conclusion

Overall our review confirmed that there is an appropriate control framework in place within the Council. The various activities outlined within the recruitment are being undertaken. However, our review has identified areas where enhancements are required or controls are not being consistently adhered to in relation documenting training attendance, fully completing staff requisition forms, retaining interview decision documents and ensuring employment contracts are signed and returned by new starters prior to employment commencement. This has resulted in the agreement of three low priority management actions.

### Internal audit opinion:

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Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the Council relies to manage this area are suitably designed, consistently applied and effective.



## Key findings

We identified the following areas of good control design which, based on our testing, were being complied with in practice:



A Recruitment Selection Policy is in place which outlines the objectives and principles of recruitment. A new policy has been drafted for approval at the March 2023 Employment Committee which includes further details on the recruitment process from identification through to job offer and onboarding. No management action is required as a new policy has been drafted to include greater detail.



We confirmed that the Recruiting Manager is responsible for creating job descriptions for vacant roles identified and all job descriptions are reviewed and approved by HR before they are advertised. This process was confirmed for our sample of 20 new starters.



For our sample of 20 new starters, we confirmed that:

- In all instances right to work checks had been completed before the start date;
- In 16 instances the required two references were received. In three instances one referenced had been received but this was confirmed as sufficient, and in the remaining instance the member of staff had already worked for the Council through an agency.
- For the two instances that required a DBS check, we confirmed that a DBS had been obtained.



All relevant pre-employment checks are required to be completed before the new starters employment start date. Where this is not achieved, the start date is extended and the new starter does not commence work until all required checks have been completed.



We confirmed that exit interviews are conducted via survey monkey prior to staff leaving the Council. This information is analysed and presented to the CMT and Chairman and Vice Chairman of the Employment Committee. Of 56 leavers, 31 agreed to partake in the leaving interview.



On an annual basis, members of staff have an appraisal with their line manager, as part of the appraisal their is a section on the learning and development needs which captures the training requirements for career development. Once appraisals have been completed with all staff, HR create a development plan to ensure members of staff receive the necessary training as requested as part of the appraisal. Action plans are reviewed as part of staff appraisals. This process was confirmed for a sample of five staff.

Details of the three low priority management actions are included below.

## 2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Area: Recruitment training	
<b>Control</b>	<p>The Council have recruitment and selection training in place which line management are required to attend on a bi annual basis, this training is also provided to any new starters within a line management role as part of their induction. Human Resources (HR) are responsible for maintaining the material to ensure its relevancy and up to date.</p>
	<p><b>Assessment:</b></p> <p><b>Design</b>                      ✓</p> <p><b>Compliance</b>                ×</p>
<b>Findings / Implications</b>	<p>Discussions with Management identified that internal recruitment training is conducted for relevant staff by HR each quarter. Review of the training pack for line management confirmed that it detailed key recruitment information including the following:</p> <ul style="list-style-type: none"> <li>• Avoiding direct and indirect discrimination;</li> <li>• Writing the job description;</li> <li>• Writing and posting job adverts;</li> <li>• The shortlisting process including usage of iTrent to send out messages to applicants;</li> <li>• Nature of interviews/ assessments; and</li> <li>• Components of pre-employment checks.</li> </ul> <p>We also confirmed that the training pack clearly outlines the respective responsibilities of both HR and line managers throughout the recruitment process.</p> <p>In addition, the training pack highlighted that all relevant recruitment resources are available to staff via the recruitment framework page on the intranet. Review of the training pack confirmed that it covers the essential elements of the recruitment process.</p> <p>Review of the iTrent Guide for Recruiting Managers confirmed that it outlines the instructions that Recruitment Managers should follow when a requisition form has been approved to when an offer is made to the qualifying candidate.</p> <p>iTrent Instructions outlined within the guidance document include the following.</p> <ul style="list-style-type: none"> <li>• Moving applicants to shortlisting stage;</li> <li>• Moving unsuccessful applicants to reject after shortlisting;</li> <li>• Creating interview schedule;</li> <li>• Inviting candidates; and</li> <li>• Moving successful applicant to Offer stage.</li> </ul> <p>Discussions with the Head of Service – Human Resources and Organisational Development further identified that recruitment training is also conducted during new starter induction for Line Managers.</p>

## Area: Recruitment training

Review of the training document confirmed that it outlines key activities to be completed by Line Managers before a new starter joins their team and after they have started. These include the following.

- Obtaining references;
- Checking right to work documents;
- Completion of the IT new starter form; and
- Confirm completion of eLearning modules.

We also identified that recruitment training is conducted in person and also via Teams. The Head of Service – Human Resources and Organisational Development highlighted that where training is conducted in person, attendance is documented via sign in sheets. However, these are not retained centrally by Managers. In addition, where training had been conducted via Teams, the Council has not been able to document and retain attendance.

Where training attendance is not documented and retained, there could be that risk that training completion could not be effectively monitored and staff involved in recruitment have not received the required training.

<b>Management Action 1</b>	Management will document and retain training attendance for recruitment processes to enhance effective monitoring.	<b>Responsible Owner:</b> Head of Service – Human Resources and Organisational Development	<b>Date:</b> 29 February 2024	<b>Priority:</b> <b>Low</b>
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## Area: Identification of Post

<b>Control</b>	Recruiting Managers are required to complete a Staff Requisition Form which provides justification details on the rationale of recruiting a new member of staff within their department. The form is required to be approved by Finance and the Director for their business area.	<b>Assessment:</b>	
		<b>Design</b>	✓
		<b>Compliance</b>	×

<b>Findings / Implications</b>	Discussions with Head of Service – Human Resources and Organisational Development confirmed that for each staff employed, the Recruiting Manager completes a Staff Requisition Form which is then approved by Finance and the Director or relevant Business Partner. Review of the Staff Requisition Form template confirmed that it outlines the job title, business area, working hours, and contract type.  We noted that the form also details relevant considerations to be confirmed by the Recruiting Manager including whether the role could be filled by an apprentice, outsourced or distributed among existing staff. Furthermore, we confirmed through review that the form had sections for comments from both HR and Recruiting Manager and also required approval from Finance and the Director. The HR Manager highlighted that where a new role had been agreed as part of a restructure, no staff requisition forms are required.
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## Area: Identification of Post

Testing a sample of 20 staff confirmed the following.

- In 18 out of 20 instances, Staff Requisition Forms had been completed and retained. We also confirmed that three out of 18 requisition forms retained had not been signed or dated by the Recruiting Manager, although comments had been provided on the form. We noted that another form had also not been signed or dated by Finance.
- In two out of 20 instances a Staff Requisition Form had not been completed. The HR Manager explained that these were not required in these instance because the vacancies had been part of an internal restructure.

Where documents are not properly signed by the appropriate person, there is a risk of delay in the hiring process or that roles are recruited for where it could have been filled internally or was not required.

<b>Management Action 2</b>	Management will ensure that Staff Requisition Forms are completed in full and signed by all relevant parties.	<b>Responsible Owner:</b> Head of Service – Human Resources and Organisational Development	<b>Date:</b> 29 February 2024	<b>Priority:</b> <b>Low</b>
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## Area: Interview process

<b>Control</b>	There is a shortlist decision form in place in which Recruiting Managers are required to complete when shortlisting for the advertised role. The form includes a scoring matrix in which the Recruiting Manager will use to determine which applicants are selected for interview. The Recruiting Manager will then use the interview templates which also includes a scoring matrix to score the interview.  Interview questions are tailored to the role being hired for.	<b>Assessment:</b>	
		<b>Design</b>	✓
		<b>Compliance</b>	×
<b>Findings / Implications</b>	Discussions with Head of Service – Human Resources and Organisational Development identified that decision forms are completed by each Recruiting Manager which outlines the basis for choice of candidate.  Review of an example shortlisting decision form confirmed that it detailed the following key information: <ul style="list-style-type: none"> <li>• Applicant ID instead of name;</li> <li>• Vacancy job title;</li> <li>• Date; and</li> <li>• Interviewer.</li> </ul> <p>We also noted that the shortlisting decision form outlines the role specific criteria based on the personal specification listed within the job description. These serve as the scoring matrix by which managers select the most qualified can applicant to be interviewed.</p> <p>Testing a sample of 20 new starters confirmed the following.</p> <ul style="list-style-type: none"> <li>• In seven out of 20 instances, shortlisting decision forms had been completed by Recruiting Managers and retained.</li> </ul>		

## Area: Interview process

- In six out of 20 instances, we confirmed candidates were sole applicants who had proven competency with an agency.
- In five out of 20 instances, we confirmed that shortlisting decision notes had been documented but not retained by Recruiting Managers.
- In two out of 20 instances, we confirmed that shortlisting was not required. Correspondence with Head of Service – Human Resources and Organisational Development identified that these involved single applicants for roles.

We identified through discussions that managers also complete interview scoring forms for applicants who progress to the interview stage from the shortlisting stage. Review of the interview score sheet confirmed that it detailed the various scores and weights used by Recruiting Managers.

We also confirmed that the interview score sheet provides a list of questions tailored to the role being interviewed for as well as interviewer comments indicating applicant's suitability for the role.

Testing a sample of 20 new starters confirmed the following.

- In 10 out of 20 instances, we confirmed that interview scoring form had been completed as required.
- In six out of 20 instances, we confirmed that interview scoring forms were completed but had not been retained by Recruiting Managers. Correspondence with the Head of Service – Human Resources and Organisational Development identified that for one of these, it had been disposed of during the office move.
- In four out of 20 instances, we confirmed that completion of interview scoring forms was not required because candidates were sole applicants had been working for the Council via an agency.

Review of the interview scoring form had been completed and retained further confirmed that in all 10 instances interview questions had been tailored to suit the particular role.

Where shortlisting forms and interview scoring forms are not retained, there could be difficulty in ascertaining whether the requisite process has been duly followed and offer is made to most qualifying candidate.

<b>Management Action 3</b>	Management will ensure that all shortlisting forms and interview scoring forms are completed and retained to promote transparency of the recruitment process.	<b>Responsible Owner:</b> Head of Service – Human Resources and Organisational Development	<b>Date:</b> 31 March 2024	<b>Priority:</b> Low
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# EXECUTIVE SUMMARY – CYBER TREATMENT PLAN

With the use of secure portals for the transfer of information, and through electronic communication means, 100 per cent of our audit has been conducted remotely. Remote working has meant that we have been able to complete our audit and provide you with the assurances you require. Based on the information provided by you, we have been able to sample test, to complete the work in line with the agreed scope.

## Why we completed this audit

In early 2022, the District Council was contacted by the Department for Levelling Up, Housing and Communities (DLUHC) regarding the completion of a cyber risk assessment and subsequent treatment plan to address any risks identified. The Council met quarterly with the DLUHC representative to discuss the various risks, progress made towards addressing the risks, and to provide any guidance that the Council needed. DLUHC has signed off on the completion of the action plan in Autumn of 2023.

As the implementation status of the actions was documented by DLUHC, we focussed our testing on whether the actions which the Council has implemented have addressed the underlying risk identified in the initial risk assessment. We also reviewed the reporting processes by which the progress towards completing the action plan was shared across the Council's governance structure.

## Conclusion

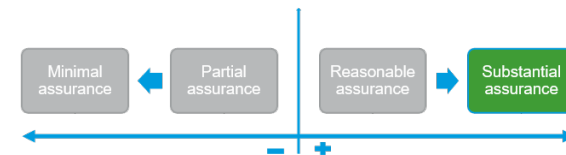
Our testing found that 31 of the 32 actions had been correctly implemented or superseded in line with the initial action set by DLUHC and this is accurate to what is being reported to the Finance and Economic Overview and Scrutiny Committee. We noted that one action was partially implemented, and for two further actions, although completed as per the DLUHC action, additional improvements could still be made to enhance the control environment.

We have agreed one low priority management action to complete the remaining action and to consider the other two areas for further improvements.

### Internal audit opinion:

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Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the Council relies to manage this area are suitably designed, consistently applied and effective.



## 2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Area: Action Plan Implementation				
<b>Control</b>	The Cyber Treatment Plan utilised by the Council is monitored by the IT Team and shows the completion status of each recommendation. The Plan has a column next to each recommendation for additional notes.	<b>Assessment:</b>		
		<b>Design</b>		✓
		<b>Compliance</b>		×
<b>Findings / Implications</b>	<p>As part of our testing we reviewed the current status of all of the 32 actions within the action plan. As the implementation statuses of the actions were agreed with consultants working on behalf of DLUHC, we have validated the evidence to support this and also assessed if the underlying risk has been addressed.</p> <p>We confirmed that as per the Council's current status, DLUHC had approved the completion of all actions (either completed or superseded) with one action remaining. We were provided with evidence or rationale for the other 31 actions marked as completed or superseded.</p> <p>For two of the actions marked as complete, although DLUHC had agreed as completed and as per the original action were closed off, we and the Council acknowledged that although the specific action is complete, there are still further improvements which could be made to enhance the processes for defining recovery time objectives and fully decommissioning old servers.</p> <p>Whilst our findings do not indicate any weakness in the monitoring of the action plan (as this is primarily controlled by the consultants representing DLUHC), we have agreed an overarching action to ensure that the remaining action is completed and further improvements are considered.</p>			
<b>Management Action 1</b>	The Council will complete the remaining outstanding action, and consider the further improvements on the further two areas identified.	<b>Responsible Owner:</b>	<b>Date:</b>	<b>Priority:</b>
		IT Services Manager	31 May 2024	Low

## APPENDIX A: EXCEPTION TABLE

Below is a summary of the instances where we have identified the ongoing action, and two further enhancements to the control framework.

Original Recommendation	Action Plan notes	Audit findings	Next step	SKDC Response
Implement a higher degree of separation between the domain controllers and the rest of the network. This could take the form of VLAN separation	We have strengthened our Windows Firewall implementation as we upgrade domain controllers to newer OSes (to meet 2012R2 EoL). We are installing a new network core in June/July '23 where we will segment further with ACLs and FW separation.	Whilst we have confirmed that the domain controllers upgrade is ongoing, the Council has not yet been able to install and configure new core switches which would enable them to isolate the core network and the domain controllers.	The Council will install its available switches to isolate its domain controllers.	Switches are almost ready to be installed so this recommendation can be completed.
Define RPO and RTO limits with business sign-off and ensure that the recovery approach is documented and tested	All backups processes are documented	Whilst the Council has documented its backup processes and this has been approved by DLUHC, a wider improvement could be made within the Council regarding RTO and RPO's for business continuity.	The RPO and RTO of various systems will be agreed as part of business continuity documentation.	The RTO is to be discussed with the BC Officer and documented accordingly.
Continue with plans to move away from unsupported server operating systems, where possible, including working with suppliers on upgrade paths for legacy systems	Plans in place to remove unsupported services and services going EOL in the near future	The Council has continued to move away from unsupported server operating systems as per the DLUHC action. Seven servers remain running 2012R2, which are expected to be decommissioned in April 2024. The Council have paid Microsoft for extended support on these.	The seven remaining servers running Windows Server 2012R2 will be decommissioned.	The action was to continue with our plans to remove unsupported O/S "where possible" we have done and continue to do that as part of the plan. We have also paid Microsoft for extended support on Server 2012r2 so they are supported until we replace them anyway.

# EXECUTIVE SUMMARY – RISK MANAGEMENT

With the use of secure portals for the transfer of information, and through electronic communication means, 100 per cent of our assignment has been conducted remotely. Remote working has meant that we have been able to complete our assignment and provide you with the advisory input you require. Based on the information provided by you, we have been able to sample test to complete the work in line with the agreed scope.

## Why we completed this audit

The Council has invested time and resources over the past few years into risk management. We have undertaken a risk management review to provide assurance that the Council has an effective risk management framework in place that allows for risks to be managed effectively, and how this has been embedded at both corporate and operational level.

An effective risk management framework is essential for ensuring that the Council is identifying risks in a timely manner, putting in place mitigating actions to ensure the likelihood and impact of the risks materialising are limited and that the risks are within their approved appetite. The Council has access to the 4Risk software, however it is not currently being utilised to maintain its risk registers. At the time of our review, the Council was in the process of reviewing their strategic risks with support provided by RSM. This entails them participating in strategic risk workshops provided by RSM to review the strategic risk register including risk scoring and risk appetites. As a result of the workshops the strategic risk register has recently been updated. The next stage is to review and update the Risk Management Framework to capture the changes introduced as a result of the strategic risk management workshops.

## Conclusion

Our review identified that although there is a Risk Management Framework in place, through the implementation of the recommendations identified within this report this could be further improved to ensure that there is a fully embedded effective risk management process in place. As a result of this advisory review we have noted nine recommendations which have been detailed in section two of this report.

We have provided examples of best practice to management with regards to creating an assurance framework and the three lines of assurance.

## Key findings

**We identified the following areas of good control design which are being complied with in practice:**



The Risk Management Framework 2021-2023 Appendix C details the roles and responsibilities for Officers and Members who collectively have a key responsibility to ensure that risk management is effective across the whole of the Council's operations.



Review of the updated strategic risk register dated March 2024 confirmed that each of the 15 risks had been linked to one of the Council's corporate priorities. These included:

- Connecting Communities
- Sustainable South Kesteven
- Enabling Economic Opportunity
- Housing
- Effective Council



Horizon scanning is undertaken as part of a cyclical exercise to identify new and emerging areas of risks that need to be considered by the Council. This exercise focusses on opportunities as well as potential threats and areas of difficulty that are emerging from the exercise, with the outcomes being recorded on the risk registers and appropriate action being agreed by the Corporate Management Team and Risk Management Group. We were informed by the Governance and Risk Officer that the strategic risk review was via strategic risk workshops facilitated by RSM with Corporate Management Team and Assistant Directors.

**The areas for improvement are included in Section 2 below.**

## 2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

### Area: Policies and Procedures

#### Findings summary

There is a Risk Management Framework 2021-2023 in place at the Council which provides an outline of the Council's arrangements for risk management. This framework is based on good enterprise risk management practices as defined in the ISO 31000: 2018 Risk Management guidelines and the ALARM (Association of Local Authority Risk Managers) Risk Management Guide and Toolkit. The purpose of this framework is to set out how the Council will manage risk, and to ensure that risks are identified at the right time, to facilitate effective decision making.

The framework consists of the following areas:

- Risk Management Policy Statement - Statement of intent on the Council's approach to risk;
- Risk Management Strategy - Defines the activities and responsibilities for managing risk and reporting arrangements;
- Risk Management Guidance - Guidance on how to fulfil strategy objectives;
- Strategic Risk Register - Register recording all strategic risks and who is responsible for managing them;
- Service Risk Register - Register recording all service area risks and who is responsible for managing them; and
- Project Risk Register - Register of project risks.

Appendix D of the Risk Management Framework details the risk management process summary which includes the process for risk design, identification and prioritisation and provides further details surrounding the four steps:

- Risk Identification;
- Risk Analysis;
- Risk Response; and
- Record, Monitor and Report.

Review of the staff intranet confirmed that the Risk Management Framework 2021-2023 was available to staff. Review of the meeting minutes and the paper presented to the Governance and Audit Committee meeting held on 9 June 2021 confirmed that the Interim Director of Finance presented the report on the Risk Management Framework 2021-2023, the minutes noted that there had been a move to incorporate risk appetite which the committee had previously worked on. It was noted that the committee approved the draft risk Management Framework for 2021-2023.

The Council has participated in strategic risk workshops facilitated by RSM to review its strategic risk register including risk scoring. As a result of the workshops the strategic risk register has recently been updated. The next stage is to review and update the Risk Management Framework to capture the changes introduced as a result of the strategic risk workshops as they

## Area: Policies and Procedures

are not currently reflected which could lead to inconsistencies in working practices. It was noted that the Risk Management Framework for 2021-2023 was now out of date.

### Recommendation 1 for management

The Risk Management Framework will be updated to capture the information gathered from the strategic risk workshops.

## Area: Risk Appetite

### Findings summary

Review of the Risk Management Framework 2021-2023 confirmed that it includes a section on risk appetite. This section defines risk appetite as the amount of risk that an organisation is willing to take on in pursuit of its strategic objectives. Appendix A of the Framework details the Council's Risk Appetite Statement from the following risk appetite levels:

- Averse;
- Minimal;
- Cautious;
- Open; and
- Hungry.

These appetites need to be assigned to the new strategic risks outlined within the new Risk Management Framework.

### Recommendation 2 for management

Risk appetite will be assigned to the new strategic risks based on the risk appetites outlined within the new Risk Management Framework.

## Area: New and emerging risks

### Findings summary

Review of the Risk Management Group Terms of Reference dated June 2022 confirmed that it outlined that the group supports risk management activity across the Council and key activities include:

- To promote and embed risk management activity throughout all service areas;
- To review exceptional service risks in order to consider their overall impact on the Council;
- To review and implement the Risk Management Framework; and
- To identify risk management training needs across the Authority.

The group is attended by the Heads of Service, Assistant Directors and the Governance and Risk Officer, and takes place on a quarterly basis. Review of the meeting PowerPoint presentations from January, April and September 2023 confirmed that strategic risks had been included in the April and September 2023 presentations and service level risks had been included in the presentation for January 2023. We were however unable to confirm the level of discussions taking place surrounding the risks as the meetings are not minuted.

It was noted that the identification of new and emerging risks is not noted within the remit of this group. The Council should consider including this as part of the group's agenda/terms of reference as this would help promote a more transparent and consistent approach to risk management.

### Recommendation 3 for management

Consideration will be given to reviewing and updating the remit of the Risk Management Group to include the identification of risks and consider emerging risks at meeting as well as feed back any issues re control / compliance failing.

## Area: Operational Risk Register

### Findings summary

We reviewed the Service Risk Register dated June 2023, which detailed 96 risks that had been identified for all service areas:

The risks are captured from service plans which are completed on an annual basis. Review of the Service Risk Register confirmed that it detailed the risk description, cause and effect of the risk, risk control, residual risk score and mitigating actions, however it did not detail any implementation dates against any of the actions. Where implementation dates are not identified then risks, controls and actions may not be effectively managed to mitigate the risks and reduce the residual risk score. See actions raised below.

There was also no evidence to confirm that the service risks had been reviewed since June 2023. Where risks and controls are not being reviewed on a regular basis this could lead to ineffective risk management within the Council.

We were informed that following completion of the service plans the service risks will be captured within 4Risk to enable regular review.

### Recommendation 4 for management

Service risks and controls will be reviewed on a regular basis to confirm that the risks are up to date and that the controls are operating effectively to mitigate the risk.

## Area: Risk Scoring

<b>Findings summary</b>	<p>The Risk Management Framework 2021-2023 details that the risk scoring methodology is based upon a 4x4 risk scoring matrix for the impact and likelihood of the risk.</p> <p>Review of the new strategic risk register confirmed that each of the 15 risks had been provided a residual risk score based upon the 4x4 scoring matrix, which had each been RAG rated based upon the outcome of the score. Best practice suggests assessing both the inherent risk and residual risk allows the Council to determine how effective the mitigating controls and sources of assurance are.</p> <p>The Council have access to a risk management software, 4Risk, which allows the recording and monitoring of strategic risks – we were informed that the old strategic risks are held on 4Risk and the new risks will be uploaded once they have been approved. 4Risk will help further embed risk management within the Council and provide a more effective mechanism in place for risk recording, risk monitoring, reporting and escalation from operational level risk where required.</p>
<b>Recommendation 5 for management</b>	<p>The Council should consider re-implementing the use of the risk management software, 4Risk, and rolling this out to the risk owners, this will help further embed risk management within the Council and provide more effective mechanism in place for risk recording, risk monitoring, reporting and escalation from operational level risk where required.</p>
<b>Recommendation 6 for management</b>	<p>The Council should consider assessing inherent risk, alongside the residual risk to help identify how effective the mitigating controls and sources of assurance are in reducing the overall risk score.</p>

## Area: Mitigating Controls

<b>Findings summary</b>	<p>Review of each of the 15 risks recorded on the new strategic risk register confirmed that key controls and mitigations had been identified in each case. Furthermore actions have been identified for eight out of the 15 risks to further bridge the gap in any controls weaknesses and reduce the risk score.</p> <p>We acknowledge that the strategic risk register is still evolving and will detail implementation dates and risk owners for all the risks and actions. Where implementation dates and risk owners are not identified then risks, controls and actions may not be effectively managed to mitigate the risks and reduce the residual risk score. We were informed that CMT own the risks collectively and therefore it is the actions that will be assigned owners as opposed to the risk.</p>
<b>Recommendation 7 for management</b>	<p>The risk register will be updated to include the risk owners for each risk as well as the implementation dates against each of the actions.</p>

## Area: Assurance framework

### Findings summary

The Risk Management Framework 2021-2023 Appendix B Risk Management Governance Framework details the following assurance levels for the five stages below:

- Strategic - Review by internal and external audit, and Annual Governance Statement;
- Service - Annual Assurance Statement and Internal audit review;
- Project - Strategic Management Team and Performance Review;
- Health and Safety - External reviews; and
- Business Continuity - Desktop exercises to determine robustness and External reviews.

However from review of the risk register it was identified that the sources of assurance for each risk has not been identified. The risk register could be further enhanced through identifying whether the assurance is internal or external or using the 'three lines of assurance' model provided in the Appendix to this report. This can help to ensure that gaps are reduced or eliminated, and unnecessary duplication avoided (See example Board Assurance Framework below in Appendix B).

The effectiveness of the Council's risk management arrangements is assessed annually as part of the Annual Governance Statement (AGS), which includes the Annual Audit Opinion, and is signed off by the Chief Executive and Leader of the Council. In compiling the AGS, assurances are obtained from a wide range of sources including assurance statements. We were informed by the Governance and Risk Officer that the assurance statements are currently being completed with a deadline of 1 March 2024 therefore we have been unable to review the assurance statements as well as the AGS.

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### Recommendation 8 for management

Sources of assurance will be considered for each of the risks and included onto the risk register which will help identify any assurance gaps and action to be taken to reduce these gaps.

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## Area: Reporting

### Findings summary

We reviewed the Risk Management Annual Report 2022/23 which was presented to the Governance and Audit Committee at the meeting held on 29 November 2023 for approval. Review of the report confirmed it included the following:

- Update on the Risk Management Framework 2021-2023;
- Update on the Risk Management Group reporting; and
- Strategic Risk Register - update provided on the review and approval of the register and the use of the risk management software, A Risk Management Annual Report is a summary of the key risk management activities, outcomes, performance highlights and challenges which have occurred over the year. We did identify areas that the Council should consider including within their annual risk management report, these are noted below, but not limited to these areas:
- Risk management training, including induction, refresher and any webinars/toolbox talks/workshops available;
- Risk communications and awareness - the activity undertaken by the Council to raise awareness of risk management; and embed this across the Council;
- Risk management aim and objectives for the next year; and
- Changes in the risk environment included any new and emerging risks included on the risk registers.

Review of the papers presented at the Governance and Audit Committee meeting held on 15 March and 29 November 2023 confirmed that an update on the strategic risk register was provided detailing the progress being made towards implementing the actions for each of the risks, which was seven risks at the time. At the meeting held on 29 November 2023, members were presented with changes being made to the risk scoring matrix as well as the updated made to the risk register as a result of the RSM risk management workshops.

The Council may want to consider producing a summary of the top risks which helps focus the Governance and Audit Committee member's attention on significant risks, with explicit consideration being given to implications on the strategic risks. Where adequate information is not reported on a regular basis, the Council may be unaware of the key risks affecting the Council leading to insufficient scrutiny of the risks and controls in place as well as an assessment of risk, with explicit consideration being given to implications on the strategic risks.

The Council may also want to consider allocating the strategic risks to sub-committees so that they undertake deep dives into areas of risk that they are close to. The outcomes can then provide a wider range of assurance for the Governance and Audit Committee.

### Recommendation 9 for management

Consideration will be given to updating the content of the annual risk management report to include the following areas:

- Risk management training, including induction, refresher and any webinars/toolbox talks/workshops available;
- Risk communications and awareness - the activity undertaken by the Council to raise awareness of risk management;
- Risk management aim and objectives for the next year; and
- Changes in the risk environment included any new and emerging risks included on the risk registers.