Herefordshire Council

AGENDA

Audit and Governance Committee

Date: **Monday 13 May 2013**

Time: **10.00 am**

Place: **The Council Chamber, Brockington, 35 Hafod Road, Hereford, HR1 1SH**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

Ben Baugh, Governance Services
Tel: 01432 261882
Email: bbaugh@herefordshire.gov.uk

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Agenda for the Meeting of the Audit and Governance Committee

Membership

Chairman	**Councillor J Stone**
Vice-Chairman	**Councillor JW Millar**
	Councillor CNH Attwood
	Councillor EMK Chave
	Councillor PGH Cutter
	Councillor AJ Hempton-Smith
	Councillor TM James
	Councillor Brig P Jones CBE
	Councillor PJ McCaull

[Note: At the time of publication, there is one vacancy on the Committee]

AGENDA

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	Public information	5 - 6
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details of any Members nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by Members in respect of items on the agenda.	
4.	**MINUTES** To approve and sign the minutes of the meeting held on 15 March 2013.	7 - 12
5.	**INTERNAL AUDIT 2012/13, FOOD HYGIENE - FORMAL WRITTEN RESPONSE** The purpose of this report is to update Members formally on the actions and improvements undertaken by the Environmental Health and Trading Standards Service in response to the KPMG audit report.	13 - 20
6.	**ANNUAL FEE 2013/14 FOR HEREFORDSHIRE COUNCIL** To seek Audit and Governance Committee's agreement for the Annual Fee amount.	21 - 28
7.	**INTERNAL AUDIT PROGRESS 2012/13** The purpose of this Internal Audit Report is to update Members on the progress of internal audit work and to bring to their attention any key internal control issues arising from work recently completed.	29 - 40
8.	**PUBLIC SECTOR INTERNAL AUDIT STANDARDS AND INTERNAL AUDIT CHARTER** The purpose of this report is to update the Audit and Governance Committee on the new Public Sector Internal Audit Standards (PSIAS) and to present a new Internal Audit Charter for approval.	41 - 58
9.	**INTERNAL AUDIT PLAN 2013/14** The purpose of this report is to seek the Audit and Governance Committee's approval of the Annual Internal Audit Plan for 2013/14.	59 - 86

/p.t.o.

10.	**CONSULTATION ON THE REVIEW OF THE COMPLAINTS AND FEEDBACK POLICY AND PROCEDURE** To invite the Audit and Governance Committee to comment on the operation of the Council's policy and procedures for handling complaints, comments and compliments.	87 - 130
11.	**COMMERCIAL CONFIDENTIALITY** To provide the Audit and Governance Committee with a briefing on commercial confidentiality.	131 - 136
12.	**DATE OF NEXT MEETING** Friday 5 July 2013 at 10.00am.	

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Audit and Governance Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford, HR1 1SH on Friday 15 March 2013 at 10.00 am

Present: **Councillor J Stone (Chairman)**
Councillor JW Millar (Vice-Chairman)

Councillors: CNH Attwood, EMK Chave, PGH Cutter, TM James, Brig P Jones CBE, PJ McCaull and NP Nenadich

In attendance: **Councillor A Seldon, as Chairman of the General Overview and Scrutiny Committee**

53. APOLOGIES FOR ABSENCE

There were no apologies for absence received.

54. NAMED SUBSTITUTES (IF ANY)

In accordance with paragraph 4.1.23 of the Council's Constitution, Councillor NP Nenadich attended the meeting as a substitute member for the vacant position on the Audit and Governance Committee.

55. DECLARATIONS OF INTEREST

No declarations of interest were made.

56. MINUTES

The Democratic Services Officer circulated a list of minor typographical errors that had been identified in the draft minutes and recommended consequential amendments. In addition to these, a further amendment was made to Minute 48 (Communication with the Audit and Governance Committee) as follows:

> Page 3, paragraph 5: …Referring to the Hereford Futures Governance Update received by the General Overview and Scrutiny Committee (minute 27 of 14 January 2013 refers), a Committee Member commented that the Audit and Governance Committee should receive reports about *the governance of* related parties.

In respect of Minute 47 (Annual Audit Fee Letter), the Committee noted that it was a standard and generally accepted local authority practice to pay the external auditors, Grant Thornton, for their work in advance, rather than in arrears.

Further to Minute 49 (Internal Audit Progress 2012/13), the Chairman invited the Head of Consumer and Business Protection to provide a brief overview of measures undertaken and work planned in response to the audit report on Food Licensing. The principal points of the presentation and the discussion included:

1. The Head of Consumer and Business Protection explained the recent changes to the system relating to inspections of registered food premises, which were the responsibility of the Council's Environmental Health Commercial Team. The previous system, which allocated food hygiene star ratings to premises either selling, preparing or manufacturing food products, had been replaced by a more stringent scoring

system whereby premises were given a rating of between 0 and 5, with 3 being the minimum acceptable standard. The new system was known as the Food Hygiene Rating System.

2. A key area of concern emerging from the audit had been the number of food hygiene assessments undertaken as part of the inspection programme, which had fallen below that advised by the Food Standards Agency (FSA) code of practice. The main reason for this had been identified as an insufficient resource with which to carry out the inspections. Standing at approximately 2,600 premises, Herefordshire had a comparatively high number of licensed food premises. These factors had resulted in a programme of less frequent food inspections, which would necessitate endorsement by the Regulatory Committee. The Regulatory Committee would receive a report on the matter at its meeting on 21 May 2013, when it would be asked to approve the reduced inspection programme.

3. The Committee noted that, although the Council had been an early adopter of the excellent previous food hygiene rating system, nationally it had been rejected in favour of the Food Hygiene Rating System. This meant that the Council was having to cover additional ground in order to be once more in-step, nationally.

4. In response to a question from a Committee member, the Head of Consumer and Business Protection confirmed that the Commercial Team had been involved in inspections relating to the recent national discoveries of horse meat in food products.

5. The Head of Consumer and Business Protection was asked to confirm the number of notifications that had been received in relation to food poisoning outbreaks. He said that they were minimal, although adding that in reality, one single outbreak had the potential for devastating or substantial effects. He said that he would provide the precise figures to members after the meeting.

6. The Head of Consumer and Business Protection would present a full report to the Audit and Governance Committee at its next meeting on 16 April 2013, which would address any outstanding concerns, and outline the work undertaken to increase the assurance rating for the service to “substantial”. The Committee thanked him for his presentation.

RESOLVED: That, subject to the above amendments, the minutes of the meeting held on 19 February 2013 be approved as a correct record and be signed by the Chairman.

57. BUDGET MONITORING REPORT 2012/13

The Chief Officer: Finance & Commercial updated the Audit and Governance Committee on the financial position to 31 January 2013. The report was identical to the one that had been considered by Cabinet the previous day. The report was also part of the Committee’s agreed work programme, forming the first of two updates planned for the financial year, which would be linked to the budget to provide the optimum amount of information. The report presented the Council’s financial position to the end of January 2013, and gave projected financial information to the end of the financial year.

The Chief Officer: Finance & Commercial explained the layout and format of information contained in the report. The appendices set out the Council’s positions in terms of revenue, capital, and treasury management respectively. The Treasury Management Report, although not strictly required as frequently as the revenue and capital information, would be included regularly as a measure of good practice, to ensure that members were kept fully informed of the Council’s up-to-date financial position.

The Committee noted the key points summary on pages 11 and 12 of the agenda, and in particular the projected overspend of £3.9 million, which would need to be met largely from the general funds reserve of £6.1 million. Referring to the table on pages 12 and 13, outlining the main financial movements from the December 2012 projected spend, members noted in particular the continued increases in expenditure for adult social care, and the significant number of claims under the Bellwin grant scheme in respect of flood damage.

Members acknowledged that a significant proportion of the movement in adult social care expenditure arose from an increase in backdated packages for residential and nursing placements. Herefordshire also faced additional challenges caused by a significantly higher than average ageing population, and the rural nature of the county, which sometimes made service provision exceptionally difficult. In response to a question about the modelling used to calculate future demand for adult social care services, members noted that the Council had worked with an external organisation to make projections, due to the complex nature of the system. The £354k included emergency/short-term intervention care, which was usually larger than anticipated and difficult to include in the projections.

The Chief Officer: Finance & Commercial reported that the Council had received the highest number of Bellwin claims of any local authority in England due to the exceptional flooding experienced by the county in recent months. The allocation of £356k represented a one-off excess charge irrespective of the number of claims made. However, this was the first year that the Council had been required to pay an excess, and the Committee was advised that the Council had complained to central government about this. Assurance was given that the increased incidences of flooding had been budgeted for as far as possible in future projections. In response to a question about the winter gritting budget, he confirmed that the increase of £120k related specifically to gritting runs, and followed a budget-setting model which assumed a certain number of "winter days" based on information available at the time. It was therefore possible that this figure might change in future projections.

A Committee Member observed that the number of appeals against decisions made by the Planning Committee was also increasing, and this was incurring additional costs to the Council. The Chief Officer: Finance & Commercial confirmed that in general, additional costs where appropriate are checked to see if covered by the Council's insurance policy, although further costs were sometimes incurred through seeking specialist legal advice, and this represented an additional financial pressure. Due to the unpredictable frequency of appeals, it was sometimes difficult to budget for every eventuality. The Committee noted that both the practices of the Planning Committee and the scheme of delegation to officers, were clear on the point of including specific policy reasons for all planning decisions, and in particular those that went against officer recommendation.

The Committee commended the financial team for securing excellent interest rates on its short-term borrowing.

The Chief Officer: Finance & Commercial reported that he would shortly be chairing financial control meetings for each directorate on the instruction of the new Chief Executive, Mr A Neill, as a measure to increase financial control. The Committee welcomed the additional measure.

RESOLVED: That the report and the forecast position be noted.

58. AUDIT PLAN 2012/13

Mr P Jones and Mr T Tobin of Grant Thornton informed the Committee of the work to be undertaken by them over the coming months for the year ended 31 March 2013. The Audit Plan for Herefordshire Council had been presented in an improved format, and it gave details of the key issues and risks affecting the Council, along with the main phases of the external audit which would need to be completed prior to issuing the annual audit opinion and value for money conclusion.

Six substantial challenges/opportunities had been identified as:

1. reduction in central government funding;
2. Herefordshire regeneration;
3. adult social care;
4. waste disposal;
5. the 'Rising to the Challenge' agenda; and
6. Business Rate retention.

Work would be carried out in every risk area listed, focussed most intensively in the six substantial areas, and with a lesser emphasis on other areas of lower risk. The broad approach to the audit was to ensure that the Council had adequate processes in place to deliver, measured against its own benchmarks.

In response to a question from a Committee Member, it was noted that the business retention rate of 50% - set by central government - applied to new businesses from 1 April 2013 onwards. One consideration might be to apply a "smoothing reserve" in the future to counter any potential unforeseen changes as a result of the new system. In addition, certain assumptions would need to be made around the figures for Council tax collection rates and write-offs.

Following a request from members, and in the light of the report to Cabinet on 14 March 2013 on the Council's commissioning and commercial strategy, Mr Jones agreed to consider as part of the audit, the risks attached to commissioning and ensuring the correct level of expertise was applied to managing contracts. The Committee requested that a report on the commissioning and commercial strategy be considered at one of its future meetings.

With reference to page 51 of the agenda, it was reported that the review of information technology (IT) controls had been completed, and no significant risks had been identified.

With reference to page 54 of the agenda, the Committee noted that the audit fees represented a 40% decrease on the previous year. The Committee thanked Grant Thornton for a thorough, informative, and well-set-out report. It was also reported that Martin Bell, who had worked on previous Council audits, had taken retirement, and the Committee asked for its thanks to be conveyed to him for his excellent work.

RESOLVED: That

(a) the content of the Audit Plan 2012/13 be noted; and

(b) a report on the commissioning and commercial strategy be considered at a future meeting of the Audit and Governance Committee.

59. CHANGES TO THE CONSTITUTION

The Head of Governance presented his report about proposed changes to the Council's Constitution. The changes were necessary to comply with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, which prescribed a number of procedural changes to ensure that the public had access to meetings and documents where a local authority executive, committee or individual, took an executive decision. Included in the provisions, was a measure to ensure that local authorities gave 28 days' notice of any key decisions in general, and key decisions to be taken in private along with any representations made about why they should be made in public. However, shorter notice was permissible in some circumstances under new rules of general exception or special urgency.

Under the new regulations, the requirement of the Leader to report on executive decisions had been relaxed from quarterly to annually. Members agreed that the Leader would include information on executive decisions as part of the Leader's report to every Council meeting with the exception of the annual Council meeting.

Further changes to the Constitution were necessary under the Localism Act 2011, which required local authorities to determine the term of office to be served by the Leader of the Council. Prior to the Act, Leaders had served a mandatory four-year term, and now it was for each local authority to determine the Leader's term of office. During the ensuing debate, the Committee noted that there was no direct process within the Constitution to remove a Leader from post before the end of his or her term, excepting a motion of "no confidence" - which would not enforce the removal of a Leader from post, and could ultimately be ignored. Members felt it was important to balance the need to provide consistency and adequate length of Leadership, and to demonstrate confidence in a Leader, with the need for having a mechanism in place to remove a Leader if necessary. It was felt that this balance was best served by appointing Leaders every year at annual Council, and allowing the same Leader to be re-appointed up to a maximum of four years. The general presumption would therefore be that a Leader would be re-appointed the maximum amount of times, but that there would be the provision to remove a Leader at annual Council any time before the end of the four-year period.

RESOLVED: That it be recommended to Council that

(a) the Leader should include details of each executive decision taken during the period since the last report was submitted to the Authority where the decision was regarded as urgent in his regular report to each Council meeting (except the annual meeting); and

(b) the term of office of Leaders of the Council should be one year, with an option for Leaders to serve consecutive one-year terms up to, and not exceeding, a maximum of four years.

60. DATE OF NEXT MEETING

Tuesday 16 April 2013 at 10.00am.*

[* *Note: The meeting due to be held on 16 April 2013 was cancelled subsequently. Therefore, the next scheduled meeting was to be held on Monday 13 May 2013.*]

It was agreed that the meeting scheduled for Friday 6 September 2013 be moved to Friday 13 September 2013 to assist with the presentation of the accounts.

The meeting ended at 11.42 am **CHAIRMAN**

Herefordshire Council

MEETING:	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**16 APRIL 2013**
TITLE OF REPORT:	**INTERNAL AUDIT 2012/13 FOOD HYGIENE - FORMAL WRITTEN RESPONSE**
REPORT BY:	**HEAD OF CONSUMER & BUSINESS PROTECTION**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

None.

4. Purpose

The purpose of this report is to update Members formally on the actions and improvements undertaken by the Environmental Health and Trading Standards Service in response to the KPMG audit report dated 2012 (ref 104/2012-13), regarding implementation of the Food Standards Agency (FSA) Food Law Code of Practice (England) (April 2012), in relation to undertaking Food Hygiene Inspections.

5. Recommendations

THAT:

(a) Subject to any comments the Audit and Governance Committee wish to make, the report be noted; and

(b) The Committee supports and endorses the actions proposed in order to raise the Corporate Assurance Grading with respect to adherence to the FSA's Food Law Code of Practice (England) (April 2012).

6. Key Points Summary

6.1 In exercising their functions and in particular, undertaking the Council's annual programme of planned food hygiene inspections, local food authorities must have regard to the requirements of the statutory Food Law Code of Practice (England) (April 2012) which requires that:-

- the registering of food premises is carried out in accordance with relevant legislation,

statutory Codes of Practice and centrally issued guidance;

- food hygiene inspections are being carried out in accordance with relevant legislation, statutory Codes of Practice and centrally issued guidance (e.g. there is a robust programme of inspections, there is clear methodology behind its compilation etc.);

- the food hygiene inspections are being undertaken appropriately and are being properly recorded and reported;

- complaints made by members of the general public and which relate to the standard of hygiene at food premises are properly recorded and investigated, and that this is done in a timely manner;

- internal policies and procedures are up-to-date and reflective of the relevant legislation, statutory Codes of Practice and centrally issued guidance; and

- performance management and data quality arrangements are adequate.

7. Alternative Options

7.1 a) Full implementation of the FSA's Code of Practice could be undertaken if additional resource was corporately provided to the Environmental Health and Trading Standards Service. This may however, have an adverse effect on other service areas within Herefordshire Council.

b) Prioritising work within EH & TS solely for the implementation of the FSA's Code of Practice. This would have a severe detrimental effect on the implementation of other key areas of statutory work such as consumer safety, consumer protection, health and safety, and infectious disease control etc.

8. Reasons for Recommendations

8.1 The Audit and Governance Committee should be aware of the improvements made already and to maintain an overview of actions required to raise the corporate assurance level in relation to implementation of Food Law Code of Practice (England) (April 2012) within the food authority (Herefordshire Council), and thus protecting the organisation from possible reputational damage and statutory intervention by the FSA.

9. Introduction and Background

9.1 This report addresses the request from the Audit and Governance Committee for a written response to the initial presentation by KPMG of their audit report findings, following an internal audit on food law enforcement within Herefordshire Council that specifically relates to food hygiene undertaken as part Herefordshire Council's internal audit plan for 2012/13. It also gives context to the internal audit report findings and highlights the remedial action already undertaken, as well as, identifying any further remedial action that is planned.

10. Key Considerations

Summary of progress against the recommendations of the internal audit report Food Hygiene (Ref 104/2012-13).

10.1 **The Annual Programme of Inspections (1)**

10.2 The Food Law Code of Practice (England) (April 2012) states that Food Authorities that are responsible for enforcing food hygiene law are required to determine the food hygiene intervention rating and intervention frequency of establishments in their area using the risk assessment criteria as laid out in Annex 5 of the Code; this will then determine their planned food hygiene intervention programmes.

10.3 **Recommendation (1) -** Where a decision is taken by (senior) management to deviate from the requirements of the above named Code, specifically in terms of how the annual programme of food hygiene inspections is carried out, this should be formally documented in writing with acknowledgement of the risk that the Authority is willing to accept. Such decisions should be communicated to the relevant Cabinet member and / or to the Regulatory Committee.

10.4 **Action (1) -** The work plan is risk based and current resourcing issues have led to the decision to accept that the Code of Practice cannot be met and therefore to target resource accordingly i.e. higher risk premises. Regulatory Committee have been informed of this decision and a report outlining the revised food hygiene inspection programme for 2013/14 and the risks associated with not complying with the FSA's Code of Practice is to be presented to the Committee at their next meeting on the 28 May 2013 for approval.

10.5 **Annual Reporting to the Regulatory Committee (2)**

10.6 The Regulatory Committee is responsible for overseeing the Council's functions and duties in relation to Environmental Health, Food Acts and related legislation, Trading Standards and Consumer Protection, Animal Health and Welfare, Licensing etc. In order to gain assurance that the Council is meeting its statutory obligations in these areas, the Committee receives annual reports that outline the activities of Environmental Health and Trading Standards, Health and Wellbeing for the previous financial year. The purpose of such reports is to enable the Committee to gain assurance that the Council is meeting its statutory obligations in these key areas. Reporting to this Committee is relatively new.

10.7 **Recommendation (2) -** The section of the annual report that is presented to the Regulatory Committee and which relates to the performance and activity of the Environmental Health (Commercial) Team needs to be reviewed for its adequacy and effectiveness in communicating the Authority's position in relation to meeting its statutory obligations in food law enforcement. Part of the review process should entail discussions with the Regulatory Committee as to their requirements, a look at similar reports of other local authorities, data quality etc.

10.8 **Action (2) -** Revised and improved reporting mechanisms have been introduced and incorporated into the corporate performance management reporting system P+. These will form the basis of a quarterly report to Regulatory Committee informing them of progress against meeting the agreed inspection programme and any deviations from it, including an explanatory note as to why any further deviations have had to be made. Discussions on format and presentation regarding data and commentary have been held with Regulatory Committee and any necessary requirements have been addressed.

10.9 **Management Monitoring of the Performance and Activity of the Environmental Health (Commercial) Team (3)**

10.10 The Framework Agreement on Official Food and Feed Controls by Local Authorities (Amendment 5, April 2010) (Chapter 2: The Standard) requires each Authority to verify its

conformity with the Standard and with relevant legislation, statutory Codes of Practice and centrally issued guidance.

10.11 **Recommendation (3) -** Management should develop and maintain documented procedures for monitoring the Environmental Health Commercial Team's conformity with Food Acts and related legislation, Codes of Practice etc. Such procedures should clearly state the names of the officers / posts responsible for performance monitoring, the quantitative and qualitative aspects of the service that will be monitored together with reasons for this, how management checks and how any corrective action taken in respect of non-conformity will be evidenced, the frequency with which management will review the adequacy and effectiveness of performance measures etc.

10.12 **Action (3) -** The food inspection procedure that formed part of the former EH & TS quality management system has been reviewed and revised to take the audit recommendations into account. This new procedure will establish specific work instructions relating to improved controls and monitoring by management. This will be implemented by 31 May 2013. A copy will be kept in a dedicated Food Hygiene Programme Audit Folder specifically set up for recording audit actions.

10.13 **Training and Training Records (4)**

10.14 The Food Law Code of Practice (England) (April 2012) states that Food Authorities should ensure that authorised officers receive relevant structured on-going training and that such training should explain new legislation and procedures and technological developments relevant to food businesses subject to their control. The minimum on-going training should be 10 hours per year based on the principles of continuing professional development. The Code requires Food Authorities to record on-going and revision training undertaken by their authorised officers.

10.15 **Recommendation (4) -** The Team Manager for Environmental Health Commercial should ensure that the Food Law Code of Practice (England) (April 2012)* is complied with in terms of continuing professional development and training records. All staff should receive a minimum of 10 hours on-going training per year based on the principles of continuing professional development; all on-going training should be recorded. ** Section 1: Administration; Chapter 1.2: Qualifications and Experience; Paragraph 1.2.4 & 5*

10.16 **Action (4) -** A new electronic folder to keep scanned food training records has been created on the shared drive and staff have been informed of this and have been reminded of the requirement to maintain their training record. The record of food training has been confirmed and will be reviewed more specifically at individual performance appraisal.

10.17 **Follow-Up Visits (5)**

10.18 It is the responsibility of the inspecting officer to decide whether it is necessary to schedule a follow-up visit as a result of the findings of the initial inspection of a food business establishment. The decision should be based on the level of risk that the food business establishment poses to the health and well-being of the general public.

10.19 **Recommendation (5) -** Where the findings from the initial inspection result in the Environmental Health Officer scheduling a follow-up visit, this should be undertaken by the agreed date. If circumstances prevent this from happening, the Environmental Health Officer should ensure that reasons for the delay in carrying out the follow-up inspection are recorded on APP Civica and / or on the manual file for the food establishment.

10.20 **Action (5) -** The team have now been re-trained in this aspect of reporting. Management checks will undertaken through the production of a 'Work in Progress' report produced quarterly and addressed through 1-2-1s with staff.

10.21 **Qualifications of Authorised Officers (6)**

10.22 The Food Law Code of Practice (England) (April 2012) requires that officers authorised to undertake food hygiene and food safety controls, with the exception of sampling, should hold one of the qualifications, or equivalent qualifications, as specified by the Code and that they should be competent to carry out these functions. In addition, it also requires Food Authorities to keep copies of certificates of registration and qualifications.

10.23 **Recommendation (6)** - In order to comply with the Food Law Code of Practice (England) (April 2012)*, the Team Manager for Environmental Health Commercial should ensure that certificates of registration and evidence of qualifications are retained on file for all authorised officers within the Team. This information should be easily accessible, particularly given that it can be subject to audit by external bodies such as the Food Standards Agency (FSA). ** Section 1: Administration; Chapter 1.2: Qualifications and Experience; Paragraph 1.2.5*

10.24 **Action (6) -** A new qualifications folder has been created to store certified copies of all officers' relevant certificates of registration.

10.25 **Duplication Checks - Food Establishments (7)**

10.26 APP Civica is used by a number of Council departments (e.g. Waste Management and Trade Services, Planning, Licensing, Community Protection, Pest Control etc) including Environmental Health and Trading Standards. Premises / trader records are shared across all of the users. There should only ever be one record per premises / trader; specific usage types are allocated to denote which Council departments have an interest in the premises (e.g. type 'F' denotes that Environmental Health has a particular interest in the premises; type 'G' denotes that Trading Standards has a particular interest in the premises and so on).

10.27 **Recommendation: 7** - In order to address the above control weaknesses, the following is recommended:-

- The Business Support Officer should evidence on the 'Application for Registration of a Food Business Establishment' form that a check of the system for existing premises / trader records has been undertaken.

- The Environmental Health (Commercial) Team needs to liaise with the Trading Standards Team in order to confirm whether the six potential duplicate food premises records are in fact duplicates. Where this is found to be the case, the APP Support Team need to be contacted so that the records can be merged and that the data is moved across correctly.

- The Team Manager for Environmental Health Commercial, in conjunction with Trading Standards, should run reports to identify any duplicate food premises records on APP Civica; this should be done at least annually.

10.28 **Action (7) -** Completed. An annual check forms part of the preparation of the annual food return to the FSA and a copy will be kept in the Food Hygiene Programme Audit Folder. A nominated officer will also be responsible for liaising between Environmental Health Commercial and Trading Standards to ensure that any duplicate premises records identified

are resolved and that the Business Support Officer has duly annotated the 'Application for Registration of a Food Business Establishment' form that a check of the system for existing premises / trader records has been undertaken.

10.29 **Sign-off of Changes in the Intervention Rating / Risk Rating of a Food Business (8)**

10.30 The Food Law Code of Practice (England) (April 2012) places specific conditions on a Food Authority in relation to the point at which the intervention rating of a business can be revised, how justification for the revision should be reached and how reasons for revising the rating should be recorded / evidenced. It also requires that the operation of the food hygiene intervention rating scheme within the Food Authority be subject to periodic management review to ensure that staff are using the scheme correctly and consistently.

10.31 **Recommendation (8) -** In order to ensure that officers are complying with the requirements of the Food Law Code of Practice (England) (April 2012)* when revising the intervention rating of a food establishment, management should sign-off revisions as they see fit (e.g. sign-off all significant changes in rating and / or sign-off all changes in the rating of high risk food businesses etc); evidence of sign-off should be retained on the establishment file. ** Section 4: Interventions; Chapter 4.1: Interventions; Paragraph 4.1.5.2.5 and Annex 5: A5.2: Food Hygiene Intervention Rating Scheme. Further assurance on the correct and consistent use of the intervention rating scheme by officers could be obtained from periodic management review of establishment files - see Recommendation No. 3.*

10.32 **Action (8) -** The 'sign-off' checks have been incorporated into the APP action diary programme requiring a senior officer sign-off where there has been a change in risk from the highest risk category 'A' to 'B'. A quarterly check of sample ratings has been instituted and will be recorded in the Food Hygiene Programme Audit Folder.

10.33 **Action on Receipt of a Food Registration Form (9)**

10.34 Based on discussions with key staff within the Environmental Health (Commercial) Team and following testing on a sample of completed 'Application for Registration of a Food Business Establishment' forms, weaknesses were identified in relation to action taken by the Authority immediately following their receipt.

10.35 **Recommendation (9) -** In order to address the weaknesses as outlined above, the following is recommended:

- All completed food registration forms should be date stamped on receipt at the Authority as is a requirement of the Food Law Code of Practice* (England) (April 2012). ** Section 1: Administration; Chapter 1.5: Registration of Food Business Establishments; Paragraph 1.55: Action on Receipt of a Completed Registration Form*
- All completed food registration forms should be signed by the applicant in order to demonstrate that they are aware of the Provisions of Regulation (EC) No. 852/2004 on the hygiene of foodstuffs, Article 6(2). Where the form is completed on-line, the applicant / business operator should complete the declaration section. Where the form has not been signed / declaration section has not been completed, it should be returned to the applicant for action forthwith.
- The applicant should provide all of the information that is required of the Authority's registration form. If any of the information is omitted, the Authority should either make contact with the applicant to obtain the missing information or return the form to the applicant for full completion per the Food Law Code of Practice (England) (April 2012)*. ** Section 1: Administration; Chapter 1.5: Registration of Food Business Establishments; Paragraph 1.55: Action on Receipt of a Completed Registration Form*

- All of the information provided by the applicant on the registration form should be recorded on APP Civica.

10.36 **Action (9) -** Date stamping of incoming forms was instituted during the audit. The on-line form has been improved and now requires the declaration before it can be submitted. A work instruction is to be implemented by 31 May 2013 which requires the officer receiving the registration form to check it and to get the business operator to correct any omissions. Registrations forms will be scanned and stored in APP Civica.

11. Community Impact

11.1 Failure to comply with the code of practice on food law may have an adverse impact upon food hygiene standards within the county.

12. Equality and Human Rights

12.1 This report does not impact upon on this area.

13. Financial Implications

13.1 This report does not impact upon this area.

14. Legal Implications

14.1 Failure to deliver the planned programme of food hygiene inspections in accordance with legislation, regulation and statutory Codes of Practice could compromise the health and wellbeing of individuals, groups, the community as a whole etc. This could cause significant reputational damage and lead to the Food Standards Agency (FSA) taking over the responsibilities of food law enforcement from the Council.

15. Risk Management

15.1 In view of the Limited Assurance grading that has been issued in that the Council's annual programme of planned food hygiene inspections does not fully accord with the requirements of the Food Law Code of Practice (England) (April 2012), the risk of failing to fulfil relevant legislative requirements is to be noted in the Places and Communities Risk Register with reference RSK.EEC.35(EHTS) until such time as the Council's revised programme has been formally noted and agreed by the appropriate body or person.

16. Consultees

16.1 None.

17. Appendices

17.1 None.

18. Background Papers

18.1 None identified.

Herefordshire Council

MEETING :	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**ANNUAL FEE 2013/14 FOR HEREFORDSHIRE COUNCIL**
REPORT BY:	**CHIEF OFFICER: FINANCE & COMMERCIAL**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

To seek the Audit and Governance Committee's agreement for the Annual Fee amount.

5. Recommendation

THAT the Audit and Governance Committee agrees the Audit Fee letter.

6. Key Points Summary

- The proposed audit fee for 2013/14 is £164,803 which remains at the same level as 2012/13. The Council's composite indicative fee grant certification for the Council in 2013/14 is £8,400. This was £10,600 in 2012/13.

- Committee approved the 2012/13 Audit Plan at the meeting of 15 March 2013.

7. Alternative Options

7.1 There are no alternative options.

8. Reasons for Recommendations

8.1 Grant Thornton is the Council's appointed external auditor. The annual fee letter is an opportunity for the Audit and Governance Committee to be informed of the planned outputs and proposed fee.

9. Introduction and Background

9.1 The report is a key part of the overall governance framework and ensures the Council meets the requirement to sign off the annual Audit Plan which was agreed by Committee at the meeting on 15 March 2013.

10. Key Considerations

10.1 The Annual Audit Fee letter details the amount to be paid to Grant Thornton (£164,803) which remains at the same level as the previous year. The Council's composite indicative fee grant certification for the Council in 2013/14 is £8,400; this was £10,600 in 2012/13. Any fee amendments will be discussed with the Council's Chief Officer: Finance & Commercial and a report would then go to the Audit and Governance Committee.

10.2 The Audit fee covers work on the audit of financial statements, value for money conclusion and Whole of Government accounts aspects.

10.3 The Audit Commission indicates that given the timescale of the financial challenge faced by local government it will review the robustness of Herefordshire's medium term financial plan. The value for money of any variations to the waste disposal contract along with a review of progress on benefits realisation from the transformation programme will also be reviewed.

10.4 The letter lists the planned outputs and their indicative dates.

11. Community Impact

11.1 This report does not impact on this area.

12. Equality and Human Rights

12.1 This report does not impact on this area.

13. Financial Implications

13.1 The Council Audit will cost £164,803 and Grant Certification totals £10,600. The overall total of £175,403 and Committee should note the amount is within budget.

14. Legal Implications

14.1 There are no legal implications.

15. Risk Management

15.1 The requirement to supply accounts for audit that have appropriate working papers requires the Council's contractor (Hoople Ltd) to meet all deadlines and requirements outlined in the accounts timetable closure process.

15.2 The external auditor will require Council management and accounting staff to be available to help locate information and provide explanations so that the accounts are audited to the required standard. This also applies to Hoople Ltd.

16. Consultees

16.1 The Leadership Team including the Chief Officer: Finance & Commercial.

17. Appendices

17.1 The Annual Fee letter for 2013/14.

18. Background Papers

18.1 None.

Herefordshire Council,
Brockington
35 Hafod Road,
Hereford,
HR11SH

Grant Thornton UK LLP
Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

T +44 (0)121 2124000

www.grant-thornton.co.uk

18 April 2013

Dear David

Planned audit fee for 2013/14

The Audit Commission has set its proposed work programme and scales of fees for 2013/14. In this letter we set out details of the audit fee for the Council along with the scope and timing of our work and details of our team.

Scale fee

The Audit Commission defines the scale audit fee as "the fee required by auditors to carry out the work necessary to meet their statutory responsibilities in accordance with the Code of Audit Practice. It represents the best estimate of the fee required to complete an audit where the audited body has no significant audit risks and it has in place a sound control environment that ensures the auditor is provided with complete and materially accurate financial statements with supporting working papers within agreed timeframes."

For 2013/14, the Commission has independently set the scale fee for all bodies. The Council's scale fee for 2013/14 is £164,803 which is the same as the audit fee for 2012/13.

Further details of the work programme and individual scale fees for all audited bodies are set out on the Audit Commission's website at: www.audit-commission.gov.uk/audit-regime/audit-fees/201314-fees-work-programme.

The audit planning process for 2013/14, including the risk assessment, will continue as the year progresses and fees will be reviewed and updated as necessary as our work progresses.

Scope of the audit fee

Our fee is based on the risk based approach to audit planning as set out in the Code of Audit Practice and work mandated by the Audit Commission for 2013/14. It covers:

- our audit of your financial statements
- our work to reach a conclusion on the economy, efficiency and effectiveness in your use of resources (the value for money conclusion)
- our work on your whole of government accounts return.

Value for money conclusion

Under the Audit Commission Act, we must be satisfied that the Council has adequate arrangements in place to secure economy, efficiency and effectiveness in its use of resources, focusing on the arrangements for:

- securing financial resilience; and
- prioritising resources within tighter budgets.

We undertake a risk assessment to identify any significant risks which we will need to address before reaching our value for money conclusion. We will assess the Council's financial resilience as part of our work on the VFM conclusion and a separate report of our findings will be provided.

We will continue to assess the Council's arrangements and discuss any additional work required during the year. We have previously discussed the need to review the arrangements the Council has put in place to ensure value for money in relation to any variation to the current waste disposal contract. We are in discussion with the Council as to the appropriate timing of this review and therefore at this stage have not allowed any time in the fee to carry out this work.

Certification of grant claims and returns

The Council's composite indicative fee grant certification for the Council in 2013/14 is £8,400. This was £10,600 in 2012/13.

Billing schedule

Our fees will be billed as follows:

Main Audit fee	**£**
September 2013	41201
December 2013	41201
March 2014	41201
June 2014	41200
Grant Certification	
June 2013	8,400
Total	**173,203**

Outline audit timetable

We will undertake our audit planning and interim audit procedures in March. Upon completion of this phase of our work we will issue our detailed audit plan setting out our findings and details of our audit approach. Our final accounts audit and work on the VFM conclusion will be completed in September 2014 and work on the whole of government accounts return in September 2014.

Phase of work	Timing	Outputs	Comments
Audit planning and interim audit	March 2014	Audit plan	The plan summarises the findings of our audit planning and our approach to the audit of the Council's accounts and VFM.
Final accounts audit	July-September 2014	Report to those charged with governance	This report will set out the findings of our accounts audit and VFM work for the consideration of those charged with governance.
VFM conclusion	Jan to September 2014	Report to those charged with governance	As above
Financial resilience	Jan to Sept 2014	Financial resilience report	Report summarising the outcome of our work.
Whole of government accounts	September 2014	Opinion on the WGA return	To be carried out at the same time as final accounts audit.
Annual audit letter	October 2014	Annual audit letter to the Council	The letter will summarise the findings of all aspects of our work.
Grant certification	June to December 2014	Grant certification report	A report summarising the findings of our grant certification work

Our team

The key members of the audit team for 2013/14 are:

	Name	Phone Number	E-mail
Engagement Lead	Phil Jones	0121 2325232	phil.w.jones@uk.gt.com
Engagement Manager	Terry Tobin	0121 2325276	terry.p.tobin@uk.gt.com
VFM/Advisory Lead	Ian Barber	0121 2325357	ian.m.barber@uk.gt.com
Audit Executive	Allison Thomas	0121 2325278	allison.a.thomas@uk.gt.com

Additional work

The scale fee excludes any work requested by the Council that we may agree to undertake outside of our Code audit. Each additional piece of work will be separately agreed and a detailed project specification and fee agreed with the Council.

Quality assurance

We are committed to providing you with a high quality service. If you are in any way dissatisfied, or would like to discuss how we can improve our service, please contact me in the first instance. Alternatively you may wish to contact Jon Roberts, our Public Sector Assurance regional lead partner (jon.roberts@uk.gt.com)

Yours sincerely

Phil Jones
For Grant Thornton UK LLP

Herefordshire Council

MEETING :	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**INTERNAL AUDIT PROGRESS 2012/13**
REPORT BY:	**HEAD OF INTERNAL AUDIT**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

The purpose of this Internal Audit Report is to update Members on the progress of internal audit work and to bring to their attention any key internal control issues arising from work recently completed.

5. Recommendation

THAT subject to any comments the Committee wish to make the report be noted.

6. Key Points Summary

- Audit Services has finalised a number of audits, these are: Legal Services, Benefits (Council Tax and Housing), Public Health - Food Licensing, reviews of Income Collection Procedures (over three separate Council functions), Treasury Management and Data Protection.
- There are a number of audits being completed. Draft reports have been issued in connection with Payroll, Debtors and Hoople (Governance and Performance Management). Additionally, Audit Services is on site and completing audits of Procurement, General Ledger, Creditors and IT Controls.
- Audit Services is continuing to provide support, guidance and information in a number of areas to Council Officers in respect of specific reviews. We have provided further information on these areas at points 13 to 16.

7. Alternative Options

7.1 This report is for information and therefore alternative options are not applicable.

8. Reasons for Recommendations

8.1 To ensure compliance with good practice as set out in the CIPFA Code of Practice for Internal Audit in Local Government in the United Kingdom.

9. Introduction and Background

9.1 The purpose of this report is to ensure that the Committee is informed of the status of internal audit work and any key internal control issues identified from work completed in the last quarter.

10. Key Considerations

Summary of progress against the audit plan

10.1 The Internal Audit plan was approved by the Audit and Governance Committee on 6 July 2012. We have set out the number and type of audit reviews to be completed in Appendix 1.

10.2 Internal Audit Services is progressing with the Internal Audit Plan. To date, ten audit reviews have been finalised. There are currently seven reviews being completed by Audit Services, with draft reports issued in three areas. The remainder of the reviews in the audit plan are being scoped and agreed with members of the Council's Leadership Team, the Council's Chief Officer: Finance & Commercial and Directors as appropriate.

10.3 Audit Services is confident that sufficient audit work will be completed so that the Head of Internal Audit can form an opinion on the Council's system of internal control. However, it is also closely monitoring its progress against completing all of the audits set out within the Internal Audit Plan and any consequent impact on the delivery against the plan. This process involves assessing the impact of additional reviews which have been requested, changes to staffing within the section (involving a team member becoming part time), and other members of staff being unavailable due to sickness. These issues have been discussed as part of our regular meetings with the Chief Officer: Finance & Commercial.

Audit Reviews completed

10.4 Our review of the Council's Legal Services function was given a "Limited Assurance" opinion. We noted that officers who request advice and assistance from Legal Services are happy with the quality of service they receive from the function and are kept fully updated on the progress of cases and also feel the legal service meets their service needs. However, we identified a number of areas where processes and controls could be improved. For example, the function needing to develop specific and measureable service priorities and objectives, in addition to completing a benchmarking exercise to assess if the function is delivering a value for money service. We also noted that the function needed to develop a Practice Manual for staff and as part of this process agree performance objectives for officers. The Council is aware of these areas for development and the new Head of Service has developed an action plan that seeks to address the issues which have been identified.

10.5 Our review of the Council's Data Protection function was given a "Limited Assurance" opinion. Our review did identify some controls in place to assist with Data Protection Act compliance. For example, the Council has established an Information Governance Delivery Plan and a Risk Treatment Plan which it will use as an action plan to help fulfil its Data Protection responsibilities. Additionally, responsibility for data protection compliance within

the Council and its directorates has been formally assigned to the Knowledge and Information Service Manager. However, we noted that the Council needed to develop processes in some key areas.

10.6 For example, the Council has yet to carry out a personal data audit to ensure the current data protection notification held by the Information Commissioners Office is fully representative of the data currently held. We also noted that there is a risk that Council data can be downloaded onto unencrypted USB devices and Council staff can access confidential and sensitive data on home computers. Additionally, we noted that Council staff should complete annual training on data protection and the safe processing of personally identifiable information.

10.7 As part of our Internal Audit Plan for 2013/14 we will assess the progress the Council has made in progressing the recommendations which we have raised in our Legal Services and Data Protection reports and present our findings to a future meeting of the Audit and Governance Committee.

10.8 Our review of the Benefits (Council Tax and Housing) function was given a "Substantial Assurance" opinion. We found a number of good controls operating within the function and made no recommendations following our review.

Audit and other reviews in progress

10.9 There are currently a number of reviews being completed by Audit Services. Work on these is progressing well with draft reports issued in areas such as Payroll and Debtors. There are also a number of audits where on-site work is currently being completed, these include:

- Creditors;
- General Ledger;
- Procurement;
- IT Access Controls; and
- Anti-Fraud and Corruption - Hot Topics and Risk Areas.

10.10 We will report any significant issues arising from these reviews to future meetings of the Audit and Governance Committee.

Other audit input

10.11 Audit Services has reviewed the system by which the Council capitalises highways expenditure. This audit was requested by the Chief Officer: Finance & Commercial. This review assessed how the Council accounts for this type of expenditure and ensures compliance with the CIPFA Code of Practice on Local Authority Accounting. Related to this review, we have also reviewed the Council's capital planning process which identifies and agrees capital expenditure schemes. We have issued draft reports to the Chief Officer: Finance & Commercial in these areas.

10.12 Audit Services was also requested by the Chief Officer: Finance & Commercial to review and assess internal controls within the Integrated Community Equipment Store (ICES). This function is funded through Section 75 of the National Health Service Act 2006 and provides medical equipment to aid independent living. We have issued a draft report to the Chief Officer: Finance & Commercial in this area.

10.13 The Council has worked together with KPMG in reviewing key aspects of its Adult and Social Care function. This work has involved reviewing aspects of the function's IT systems, such as the link between Framework I and the Council's Agresso financial system, in addition to how it procures Care Services. We have issued a draft report to the Chief Officer: Finance & Commercial in this area.

10.14 Audit Services has also completed work in other areas as requested by the Chief Officer: Finance & Commercial and other officers within the Council. For example, we have reviewed the process by which the Council is seeking to make payments to its partners as part of the Borders Broadband project.

11. Community Impact

11.1 This report does not impact on this area.

12. Equality and Human Rights

12.1 This report does not impact on this area.

13. Financial Implications

13.1 There are no financial implications.

14. Legal Implications

14.1 There are no legal implications.

15. Risk Management

15.1 There is a risk that the level of work required to give an opinion on the Council's systems of Internal Control is not achieved.

16. Consultees

16.1 The HPSLT and the Chief Officer: Finance & Commercial were consulted in the drafting of this report.

17. Appendices

17.1 Appendix 1 - Status of Audit Plan 2012/13

17.2 Appendix 2 - Audit Opinions - Definition of Assurance Grading

17.3 Appendix 3 - Rating of Recommendations

18. Background Papers

18.1 None.

Appendix 1 – Status of Audit Plan 2012/13 – May 2013

Note – The scope and timing of audits is subject to confirmation and the agreement of the Project Sponsor.

Audit Review	Status	Audit Opinion	Recommendations		
			P1	P2	P3
Core Support Systems					
Payroll	Draft report issued	-	-		
Creditors	In progress	-	-		
Treasury Management	Completed	Substantial	-	-	-
Income Collection – Car Parking	Completed	Adequate	-	1	1
Income Collection – Bereavement Services	Completed	Adequate	-	2	1
Income Collection – Industrial Lets	Completed	Limited	1	2	-
Debtors	Draft Report issued	-	-		
Budgetary Control	Planned for May 2013	-	-		
NNDR and Council Tax	Completed	Substantial	-	-	2
General Ledger	In progress	-	-		
Benefits (Council Tax and Housing)	Completed	Substantial	No recommendations made		
Asset Register	In progress	-	-		
Procurement	In progress	-	-		
Rising to the Challenge – Project Review	As this project has now been completed we have agreed with management to input into the Council's Rising to the Challenge Closure Report.	-	-		
Health and Safety – Follow Up	Planned for May 2013	-	-		

Audit Review	Status	Audit Opinion	Recommendations		
			P1	P2	P3
Sustainability – Follow Up	Planned for May 2013	-			
Business Continuity – Follow Up	Planned for May 2013	-			
Legal Services	Complete	Limited	2	7	-
IT Systems					
ISO 27001 Modern Records Unit	Complete	Adequate	-	4	2
Access Controls review - Agresso, Academy, ISIS and Abacus	In progress – Draft report to be issued shortly	-		-	
Data Protection	Complete	Limited	3	2	-
IT Strategy	In discussions with management we have agreed to defer this audit to 2013/14 as the Council is currently reviewing its overall IT requirements.	-		-	
Anti-Fraud Systems					
Anti-Fraud and Corruption Arrangements	This work will involve joint KPMG and Council workshops which are currently being arranged. The aim of the workshops will be to enhance staff understanding of this area and the part staff can play in detecting and reporting fraudulent incidents.	-		-	
Anti-Fraud and Corruption – Procedures Audit	Planned for May 2013	-		-	
Anti-Fraud and Corruption – Hot Topics and Risk Areas	In progress	-		-	
Audit Commission - Anti-Fraud Survey	In progress	-		-	

Audit Review	Status	Audit Opinion	Recommendations		
			P1	P2	P3
Governance Systems					
Performance Management – Follow Up	Planned for May 2013	-	-		
Operational Systems - Directorates					
Hoople – Client Side Management	We have reviewed (where appropriate) the Council's contract management arrangements with Hoople as part of the audits we have completed. We have identified and reported any significant issues where they have arisen.	-	-		
Hoople – Governance/ Performance Management	Draft Report issued	-	-		
Adult and Social Care – Financial Management and Follow Up	The reviews of these areas have been incorporated within a KPMG consultancy review which is currently being completed.	-	-		
Adult and Social Care – Procurement (Follow Up)		-	-		
Places and Communities - Public Health – Food Licensing	Completed	Limited	1	4	4
Places and Communities – Procurement	In discussions with management the need for this audit has been superseded by the Council needing additional consultancy support in this area which is currently being provided.		-		

Schools			
Financial Management	In discussions with management we have agreed to defer the audit of this area and complete the work as part of the Internal Audit Plan for 2013/14. This will allow us to review and test how Schools are complying with the new Financial Value Standard which fully came into effect in 2013/14.	-	-

Appendix 2 – Audit Opinions – Definition of Assurance Grading

Conclusion	Definition
No assurance	One or more priority one recommendations and fundamental design or operational weaknesses in more than one part of the area under review (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
Limited assurance	One or more priority one recommendations, **or** a high number of medium priority recommendations that taken cumulatively suggest a weak control environment (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in a significant exposure to reputation or other strategic risks).
Adequate assurance	One or more priority two recommendations (i.e. that there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Substantial assurance	No or priority three only recommendations (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).

Appendix 3 – Rating of Recommendations

At the last Audit and Governance Committee Members requested further clarification on how audit recommendations are graded. We detail below how we assess the importance of recommendations which we make. Within the table we also set out how we can apply these priorities to recommendations we could make in a particular audit. This example is a review of Health and Safety.

Priority	Definition	Health and Safety Example Audit
Red *(Priority 1*	A **significant** weakness in the system or process which is putting the Council at **serious risk** of not achieving its **strategic** aims and objectives. In particular: significant adverse impact on **reputation**; non-compliance with key statutory requirements; or substantially raising the likelihood that any of the Council's strategic risks will occur. Any recommendations in this category would require **immediate attention**.	Issues that result in non-compliance with Health and Safety Legislation, i.e. No Health and Safety Policy in place.
Amber *(Priority 2)*	A **potentially significant** or **medium level** weakness in the system or process which **could** put the Council at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on the Council's reputation or for raising the likelihood of the Council's strategic risks occurring, **if not addressed.**	Issues that may result in non-compliance with Health and Safety legislation if not corrected or improved, ie Health and Safety Policy in place, however, incomplete in one or two sections.
Green *(Priority 3)*	Recommendations which could **improve** the efficiency and/or effectiveness of the system or process but which are **not vital** to achieving the Council's strategic aims and objectives. These are generally issues of **good practice** that we consider would achieve better outcomes.	Issues that are best practice, ie Health and Safety Policy in place, however, could be subject to minor improvement, such as listing new job titles for staff.

Herefordshire Council

MEETING:	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**PUBLIC SECTOR INTERNAL AUDIT STANDARDS AND INTERNAL AUDIT CHARTER**
REPORT BY:	**HEAD OF INTERNAL AUDIT**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

The purpose of this report is to update the Audit and Governance Committee on the new Public Sector Internal Audit Standards (PSIAS) and to present a new Internal Audit Charter for approval.

5. Recommendation

THAT subject to any comments the Committee wish to make, the contents of this report are noted and the Internal Audit Charter is approved.

6. Key Points Summary

- New professional standards governing internal audit work in the UK public sector have been introduced, which the Council's internal audit service must adhere to.
- One of the new requirements is the development of an Internal Audit Charter, which is appended for the Committee to consider and approve.

7. Alternative Options

7.1 The Council must adhere to the new PSIAS and therefore alternative options are not applicable.

8. Reasons for Recommendations

8.1 To ensure the Council complies with recommended practice as set out in the PSIAS.

9. Introduction and Background

9.1 The purpose of this report is to inform the Committee about recent changes to the professional standards governing internal audit services in the public sector. The report also introduces a new Internal Audit Charter, which is required by the PSIAS, for consideration and approval by the Committee.

10. Key Considerations

Public Sector Internal Audit Standards

10.1 Since 2006 internal audit work at local authorities has been governed by the Code of Practice for Internal Audit in local government in the United Kingdom, issued by Chartered Institute of Public Finance and Accountancy (CIPFA). This Code has now been replaced by the new PSIAS, which are effective from 1 April 2013.

10.2 The PSIAS are based on the mandatory elements of the Institute of Internal Auditors International Professional Practices Framework and are intended to promote the professionalism, quality, consistency and effectiveness of internal audit across the public sector. They have been adopted as a single set of standards to replace the previous sector specific requirements, including the 2006 CIPFA Code for local government. They also:

- define the nature of internal auditing within the UK public sector;
- set basic principles for carrying out internal audit work;
- establish a framework for providing internal audit services which add value and lead to improved organisational processes and operations; and
- establish the basis for evaluation of internal audit performance and drive improvement planning.

10.3 The PSIAS contain a Code of Ethics, the purpose of which is to promote an ethical culture in the internal auditing profession. This is structured into the following 'principles' and 'rules of conduct' which describe the behaviour norms expected of internal auditors.

10.4 KPMG, which provides the management and professional leadership of the Council's internal audit team, already has established ethical policies and procedures which its staff must adhere to which meet the requirements of the Code of Ethics. The Council's in-house internal audit team have been briefed on these ethical requirements.

10.5 The standards themselves are structured as follows:

- Attribute standards: these relate to the characteristics of organisations and parties performing internal audit activities, covering:
  - purpose, authority and responsibility;
  - independence and objectivity;
  - proficiency and due professional care;

- quality assurance and improvement; and

- Performance standards: these describe the nature of internal audit activities and provide quality criteria against which performance can be evaluated, covering:
  - managing the internal audit activity;
  - nature of work;
  - engagement planning;
  - performing the engagement;
  - communicating results;
  - monitoring results; and
  - communicating the acceptance of risks.

10.6 There are also specific 'implementation standards' which provide further detailed requirements that apply to work which is either of an assurance or consulting nature.

10.7 CIPFA has published a Local Government Application Note to provide sector-specific interpretations and additional guidance on the PSIAS. The detailed requirements of both the PSIAS and the CIPFA Application Note are broadly similar to those of the previous 2006 CIPFA Code. To that effect, their introduction does not require any fundamental review of, or changes to, the policies and procedures governing the Council's internal audit work. A full and detailed review has however been undertaken by KPMG to ensure that any new or amended requirements are identified and complied with, and training is being provided to the Council's in-house team.

10.8 There are, however, a number of differences between the 2006 CIPFA Code and the new standards including:

- the requirement for an Internal Audit Charter (see further below);
- some differences in terminology (see further below); and
- the requirement for a quality assurance and improvement programme.

Internal Audit Charter

10.9 One specific requirement of the new PSIAS is the development of an Internal Audit Charter. This sets out the purpose, authority and responsibilities of internal audit, along with other detailed points required by the PSIAS. In effect, it acts as the terms of reference of the Council's internal audit function.

10.10 An Internal Audit Charter has been drafted for the Council and this is appended to this report.

10.11 The PSIAS refers to 'senior management' and 'the board' and requires that these are defined within the Charter, but does not provide definitions. The CIPFA Application Note does address this in a local government context but does not provide a definitive view, recognising that in a local authority aspects of the role of a board may be fulfilled by an audit committee, cabinet or even full council. The Application Note therefore leaves it open to each authority to decide. The Internal Audit Charter therefore proposes that:

- the term 'senior management' is interpreted to mean one or more of the Council's Leadership Team, Chief Executive and Chief Officer: Finance & Commercial; and

- the role of 'the board' will be fulfilled by the Audit and Governance Committee.

11. Community Impact

11.1 This report does not impact on this area.

12. Equality and Human Rights

12.1 This report does not impact on this area.

13. Financial Implications

13.1 The PSIAS influence the way in which the internal audit service is delivered, but do not fundamentally impact on the cost to the Council of doing so. The internal audit service will continue to be delivered within the current budgeted level of resource and using the existing operating model of KPMG managing the 'in-house' team (who are employed by Hoople Ltd).

14. Legal Implications

14.1 The Accounts and Audit Regulations 2011 require that local authorities in England "undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control". The PSIAS and CIPFA's Local Government Application note, taken together, represent *proper practices* in this context. Compliance with the PSIAS and the CIPFA Application Note, including the adoption of an Internal Audit Charter, therefore ensures compliance with the requirements of the 2011 Regulations.

15. Risk Management

15.1 There is a risk that the Council does not comply with proper practices, as required by the 2011 Regulations.

15.2 The review of policies and procedures against the new PSIAS, and the adoption of the Internal Audit Charter, mitigate this risk.

16. Consultees

16.1 The Leadership Team including the Chief Officer: Finance & Commercial were consulted in the drafting of this report.

17. Appendices

17.1 Internal Audit Charter.

18. Background Papers

18.1 None.

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Internal Audit Charter

Herefordshire Council

April 2013

PUBLIC SECTOR AUDIT

Contents

The contacts in Internal Audit in connection with this report are:

Darren Gilbert
Head of Internal Audit
KPMG LLP (UK)

Tel: 07768 462015
darren.gilbert@kpmg.co.uk

Mukhtar Khangura
Senior Manager
KPMG LLP (UK)

Tel: 07876 217128
mukhtar.khangura@kpmg.co.uk

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Distribution

David Powell (Chief Officer – Finance and Commercial Services)

Audit & Governance Committee

1. Introduction

1. Introduction

Internal audit within the public sector is governed by the *Public Sector Internal Audit Standards* (PSIAS), on which CIPFA has published a *Local Government Application Note* which provides guidance on the application of the PSIAS to local authorities. The objectives of the PSIAS are to:

- define the nature of internal auditing within the UK public sector;
- set basic principles for carrying out internal audit in the UK public sector;
- establish a framework for providing internal audit services which adds value to the organisation, leading to improved organisational processes and operations, and
- establish the basis for the evaluation of internal audit performance and drive improvement planning.

Under the PSIAS internal audit activity should be driven by an Audit Charter, which is a formal document that defines the following:

- the purpose, authority and responsibility of internal audit activity, along with internal audit's position within the organisation and its access to records, personnel and physical properties relevant to the performance of engagements *(section 2.1.1 and 2.1.2);*
- the scope of internal audit activities *(section 2.1.2).*
- the terms 'board' and 'senior management' for the purposes of internal audit activity (*section 1*);
- the arrangements for appropriate resourcing *(section 1.3);*
- the nature of assurance services provided to the organisation (*section 2.1.2*);
- the nature of consulting services *(section 3.9);*
- the role of internal audit in any fraud-related work *(section 3.7);* and
- arrangements for avoiding conflicts of interest if internal audit undertakes non-audit activities (*section 3.8*).

This document outlines how each of those documents is met. It also sets the methodology used to complete internal audit work *(section 3)* and our quality assurance process (s*ection 4).*

As required by the PSIAS, this Audit Charter also sets out the "*Definition of Internal Auditing, the Code of Ethics and the Standards".*

1.1.1 The definition of Internal Audit

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

The senior management within the Council are responsible for establishing and maintaining appropriate risk management processes, control systems, accounting records and governance arrangements. Internal audit plays a vital part in advising the organisation that these arrangements are in place and operating properly.

1.1.2 Code of Ethics

Internal auditors in UK public sector organisations must conform to the Code of Ethics as defined by the Institute of Internal Auditors (IAA). The Code of Ethics promotes an ethical culture in the profession of internal auditing. A code of ethics is necessary and appropriate for the internal audit profession, founded as it is on the trust placed in its objective assurance about risk management, control and governance. The Code of Ethics covers four main areas:

- *Integrity* - The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement;
- *Objectivity* - Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined. Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements;
- *Confidentiality* - Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so; and
- *Competency* - Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services.

1. Introduction (*cont.*)

1.1.3 The Standards

The PSIAS encompass the mandatory elements of the Institute of Internal Auditors (IIA) International Standards for the Professional Practice of Internal Auditing (the Standards). These Standards are principle-focused and provide a framework for performing and promoting internal auditing. The standards are adhered to in the delivery of the Council's internal audit plan.

1.2 Organisational Independence

The PSIAS state that the Chief Audit Executive must confirm to the board, at least annually, the organisational independence of internal audit. Organisational independence is achieved when the Chief Audit Executive reports functionally to the board. Examples of functional reporting to the board involves the board approving the internal Audit Charter and the risk based internal audit plan.

1.3 Senior management and the Board

The Chief Audit Executive (referred to as the 'Head of Internal Audit' within Herefordshire Council (the Council)) should discuss the Definition of Internal Auditing, the Code of Ethics and the Standards with senior management and the board. 'Senior management' within the Council has been defined as the Leadership Team, the Chief Executive and the Chief Officer (Finance & Commercial Services), and the 'Board' as the Audit & Governance Committee.

This process occurs through the Audit Charter being submitted and approved by the Leadership Team and the Audit & Governance Committee periodically.

On a day to day basis, the Head of Internal Audit will report to the Chief Officer (Finance & Commercial Services). The Head of Internal Audit also has direct lines of reporting to the Council's Head of Paid Service (Chief Executive), Monitoring Officer and the Audit & Governance Committee. These officers and the Committee in turn have the ability to liaise directly with the Head of Internal Audit.

1.4 The need for Internal Audit

The need to maintain an internal audit function is implied by Section 151 of the Local Government Act 1972 under which local authorities are required to make proper arrangements for the administration of their financial affairs and to delegate responsibility for those arrangements to one of their officers. The Accounts & Audit Regulations 2011 are explicit about the requirement to maintain an adequate and effective internal audit of accounting records and of the system of internal control in accordance with the proper practices in relation to internal control.

1.5 Leadership and resourcing of the Internal Audit function

KPMG has been engaged by the Council to lead the Internal Audit function. KPMG appoints a senior and experienced auditor to act as the Council's Head of Internal Audit, who reports directly to the Chief Officer (Finance & Commercial Services). The Chief Officer (Finance & Commercial Services) is the Council's Responsible Financial Officer under the terms of Section 151 of Local Government Act 1972.

The Head of Internal Audit is responsible for the day to day management of the Internal Audit Team. The Head of Internal Audit also has the freedom to report to any level of management (officers and Members as appropriate) on audit findings without censure.

The Council is required to provide KPMG with sufficient resources in order to deliver the Internal Audit Plan. This could either be Council staff, staff from its subsidiary entity (Hoople Limited), procuring audit resources directly from KPMG, or any mixture of these options.

1.6 Approval of the Audit Charter

The final approval of this charter rests with the Audit & Governance Committee.

2. The Role of Internal Audit

2.1 The Role of Internal Audit

This section sets out:

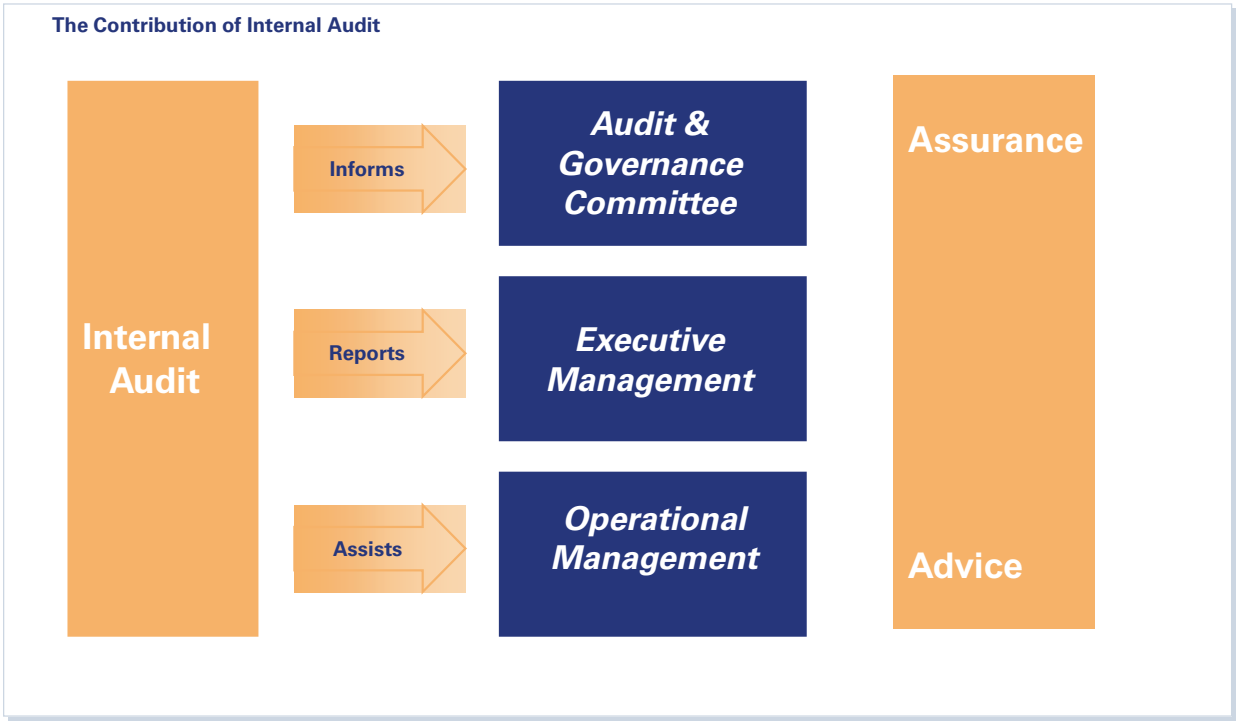
- the core role of Internal Audit; and
- the key functions of the Council's Internal Audit section.

2.1.1 Core role of Internal Audit

The role of Internal Audit is to provide assurance to Members and senior management that there are adequate and effective internal control arrangements in place to mitigate key risks and achieve objectives. This covers the Council's entire control environment and not just financial controls.

However, in these ever changing times, Internal Audit should not only provide its core role but provide an added value service. In performing its role, Internal Audit aims to, where appropriate:

- contribute to the improvement of the internal control environment;
- identify opportunities for performance improvement;
- evaluate where systems are over controlled or inefficient; and
- identify cost saving opportunities.



2. The role of Internal Audit *(cont.)*

2.1.2 The key functions of Internal Audit

The Team's key functions are to:

- Assist the Council in the accomplishment of its objectives by bringing a systematic and disciplined approach to the evaluation and improvement of risk management, corporate governance and internal control processes.
- Assist the Council in the effective discharge of its functions by providing independent analysis, appraisal, advice and recommendations on the activities subject to internal audit review.
- Review, appraise and report on the adequacy and effectiveness of the systems of financial and internal control.
- Review, appraise and report on the relevance, integrity and reliability of financial and other management information.
- Review, appraise and report on the level of compliance with the policies, plans, procedures, statutory requirements and regulations that could have a significant impact on the Council's activities.
- Review, appraise and report on the arrangements for protecting assets from loss resulting from theft, fraud, fire or misuse and, as appropriate, verifying their existence.
- Review and appraise the economy, efficiency and effectiveness with which resources are deployed and recommend improvements in procedures and systems that will reduce wastage, extravagance and fraud.
- Review service delivery arrangements and projects to ascertain whether the activities are being carried out as planned and the results are consistent with the Council's established policies.
- Maintain a programme of review and assessment of the Council's risk management processes in order to provide assurance on their integrity.
- Carry out any ad hoc appraisals, inspections, investigations, examinations or reviews requested by senior management, the Audit & Governance Committee or the political executive.
- Act as the liaison with the Council's external auditors and co-ordinate audit effort with them in order to avoid duplication of effort and increase audit coverage.
- Maintain technical competence through continuing education and active participation in professional activities.
- Adhere to the Code of Ethics, standards and guidelines of the relevant professional institutes.
- Utilise the resources designated for use by the Internal Audit team to maximise the efficiency and effectiveness of the internal audit function.
- Serve on internal working groups as appointed by senior management.

This Charter and the Council's Standing Orders and Financial Regulations confirm the authority conferred on the Internal Audit team by the Council. The Head of Internal Audit and the Internal Audit team have the authority to:

- decide on the nature, scope and timing of audits;
- have access at reasonable times to premises or land used by the Council;
- have access at reasonable times to any employee;
- have access to all assets, records, documents, correspondence and control systems relating to any matter or business of the Council; and
- have any information and explanation considered necessary concerning any matter under examination.

The Council's officers are required to assist the Internal Audit team in the performance of their audit duties and to respond promptly to any requests for information, explanation, discussion, entry to premises or access to documents.

2. The role of Internal Audit *(cont.)*

Internal Audit can vary its approach between assurance and advice according to the objective of each review. In many cases, it combines approaches to offer a service of value to all who are involved. Examples are shown below.

Fraud and investigations

Internal Audit can monitor fraud risk management and may conduct preliminary and / or detailed investigations into suspected or actual frauds to identify any control failures.

We could consider:

- where the Council is susceptible to fraud;
- how the Council protects itself (policies, training, insurance);
- how the Council monitors, detects and responds to incidences of fraud; and
- where has fraud occurred, why, and what has been done about it.

Risk and controls evaluation

Internal Audit can review systems, controls and procedures established by management and provide independent feedback as to whether they are fit for purpose and operating as intended.

For the activity under review this considers whether:

- there is a robust internal risk management framework; and
- controls are designed and operating effectively?

Pre/intra implementation support

Internal Audit can provide support and advice as new systems and processes are being scoped and developed.

This ensures Internal Audit's input is timely – to minimise criticism after the event and:

- helps ensure that investment risks are identified and managed;
- recommends controls which need to be built into new systems / processes;
- confirms that developing systems are 'on track' to deliver; and
- gives early warning of issues (e.g. overspend, delays etc.).

Process improvement

Internal Audit can provide assistance to management in analysing the processes that exist within a defined system and can provide advice on improving such processes.

This can consider issues such as whether :

- systems and processes are 'fit for purpose';
- processes can be refined or simplified;
- efficiencies can be made; and
- learning from examples of good practice can be identified.

3. Internal Audit Methodology

3.1 Internal Audit Methodology

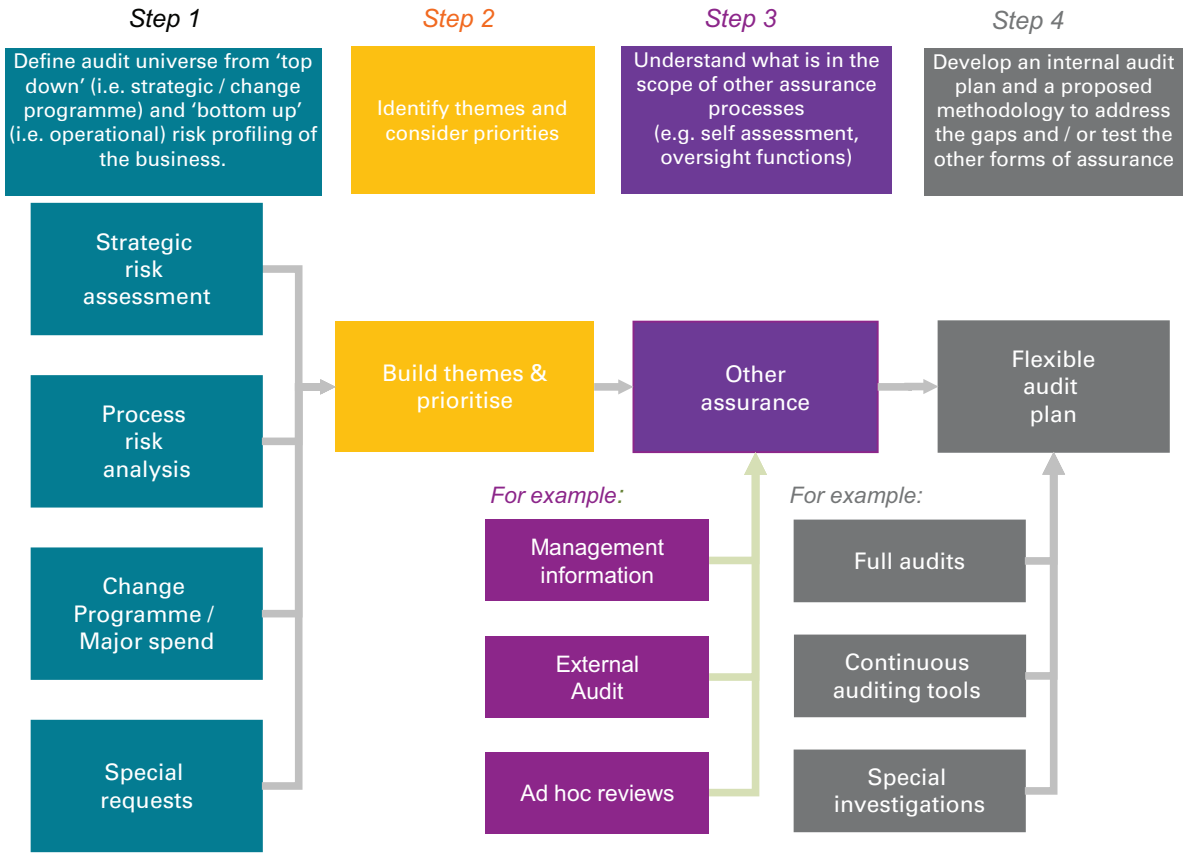
In order to deliver an effective service and met the needs of the Council, KPMG applies a comprehensive internal audit methodology. The key processes of this are as follows:

- preparation of a comprehensive internal audit plan;
- a tailored audit approach using a defined methodology and assignment control documentation;
- regular reporting to management and the Audit & Governance Committee on findings and a review of progress against the plan to ensure the function is delivering the work;
- the use of performance indicators to measure and report on the quality and delivery of the work which the function completes;
- clearly defined processes by which Internal Audit liaises with staff, management and the members of the Audit & Governance Committee; and
- the role of internal audit with regard to anti-fraud and corruption.

3.2 Internal Audit Plan

KPMG will perform an annual risk assessment to inform the development of internal audit plan for approval by the Chief Officer (Finance & Commercial Services) and Audit & Governance Committee. KPMG then oversees and manages the delivery of that plan, remaining alert for any new, emerging or changing risks, and reports the results within the Council's reporting structure. The plan will be based on an assessment of the risk pertaining to the achievement of the Council's objectives.

The plan will form the basis of the annual operational plan for the Internal Audit team. The key steps which are followed in developing the plan are summarised below.



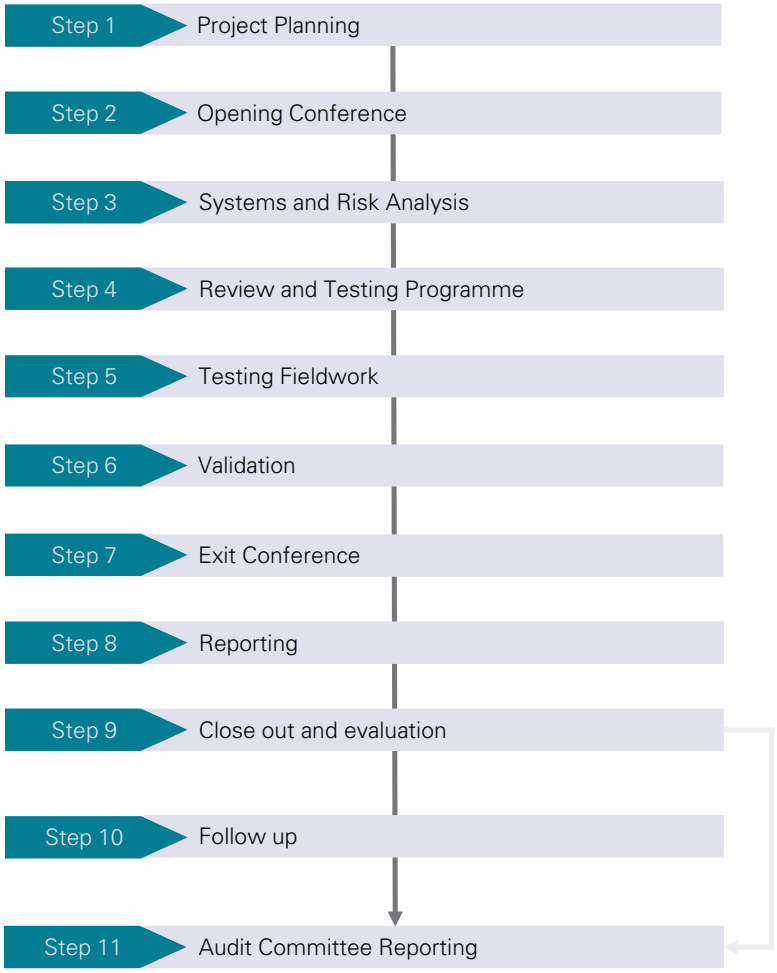
3. Internal Audit Methodology *(cont.)*

3.3 Audit Approach

Internal Audit will utilise a risk-based approach to the individual reviews. This involves:

- identifying the risks that may impact on the areas under review achieving their objectives and identifying and evaluating the systems of internal control designed by management;
- compliance testing of the operation of controls; and
- making appropriate recommendations and advising management on how systems of internal control may be streamlined or strengthened.

The different delivery stages of the audit process are shown below. The approach to individual reviews recognises that different approaches will be required in different circumstances, for example in some cases as systems are being developed or revised it may be beneficial for us to defer detailed testing until a later date, but instead focus on understanding and contributing to the development of the design of the control framework.



3. Internal Audit Methodology *(cont.)*

3.4 Reporting

3.4.1 Individual reviews

On completion of individual reviews, Internal Audit will produce a report for management that will outline the objectives and scope of the work, risks considered during the review, an assessment of the effectiveness of internal controls, an overall opinion and observations on performance improvements. Each report will include an action plan. Management will consider the report and provide management responses to the recommendations made in the report. Internal Audit will then review the appropriateness of these and finalise the report. The overall opinion will be based on the findings flowing from the review. Internal Audit will use the following conclusions (although it should be noted that these represent an indicative approach as the overall assurance provided is a matter of professional judgement).

Conclusion	Definition
No assurance	One or more priority one recommendations and fundamental design or operational weaknesses in more than one part of the area under review (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
Limited assurance	One or more priority one recommendations, **or** a high number of medium priority recommendations that taken cumulatively suggest a weak control environment (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in a significant exposure to reputation or other strategic risks).
Adequate assurance	One or more priority two recommendations (i.e. there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Substantial assurance	No or priority three only recommendations. (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).

3.4.2 Progress reporting

Internal Audit will present regular progress reports to the Audit & Governance Committee. These reports will set out the progress the function has made in completing the internal audit plan, key issues and findings from the audits completed and an update on any other audit and assurance issues.

3.5 Overall opinion

Following our internal audit work for the year Internal Audit will produce an Annual Internal Audit Report. This will summarise the work completed and will provide an overall opinion in respect of the Council's risk, control and governance arrangements. This audit opinion will be based on a review of the following:

- core systems, both financial and other;
- anti-fraud systems;
- corporate systems;
- governance systems;
- IT Systems;
- the level of recommendations agreed for action by management; and
- the results of the recommendations follow-up review.

3. Internal Audit Methodology *(cont.)*

3.6 Audit Protocols

Internal Audit's work will observe the following protocols:

3.6.1 Individual assignments

- Provide advance notice to the manager of each service area to be audited.
- Conduct a preparatory meeting with the nominated manager of the service being audited to discuss the nature of the audit, the length of engagement and the co-ordination of the review around operational constraints. The detail of the audit programme will be reviewed at that meeting with the nominated manager.
- Conduct interim meetings with the nominated service manager as appropriate to discuss progress with the review and findings as they arise.
- Preparation of a written draft internal audit report following the conclusion of the audit.
- Conduct a final meeting with the nominated service manager to discuss the draft report and confirm the accuracy of the audit findings and the appropriateness of the audit recommendations.
- Agreed amendments to the draft report will be reflected in the final report along with the nominated service manager's response to the recommendations. Final copies of the report will be distributed as appropriate.
- The Head of Service is responsible for making sure that the action plan included in the audit report is implemented.

3.6.2 Audit & Governance Committee

The Head of Internal Audit is required to report to the Audit & Governance Committee. To facilitate the work of the Audit & Governance Committee the Head of Internal Audit will:

- attend its meetings and contribute to setting the agenda (for those meetings where there are 'audit' agenda items);
- participate in the Committee's review of its own remit and effectiveness;
- ensure that it receives, and understands, documents that describe how internal audit will fulfil its objectives (e.g. the audit plan, annual work programmes, progress reports);
- report the outcomes of internal audit work in sufficient detail to allow the Committee to understand what assurance it can take from that work and/or what unresolved risks to issues it needs to address;
- establish if anything arising from the work of the Committee requires consideration of changes to Internal Audit's programme; and
- present an Annual Internal Audit Report including an overall opinion on the control environment, the extent to which the audit plan has been achieved, and a summary of any unresolved issues.

3.7 Deterring and Detecting Fraud

Managing the risk of fraud and corruption and the deterrence of fraud is a responsibility of management. The Internal Audit team is responsible for examining and evaluating the adequacy and effectiveness of actions taken by management to fulfil this obligation.

The Chief Officer (Finance & Commercial Services) will decide, in consultation with the Head of Internal Audit, the scope of any internal enquiries or investigations, subject to consultation with the relevant member of the Council's senior management team as appropriate.

The Council's anti-fraud and corruption policy requires officers to notify Audit Services of all suspected or detected fraud, corruption or impropriety.

The results of all fraud and corruption work, and knowledge regarding levels of detected or suspected fraud, corruption and impropriety, are used to inform the Head of Internal Audit's annual risk-based audit plan and annual internal audit opinion.

3. Internal Audit Methodology *(cont.)*

3.8 Conflicts of interest

Internal Audit shall not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may be in conflict with the interests of the organisation.

If a conflict of interest appears to arise from Internal Audit's input into non-audit activities, this should be discussed and resolved with input from the Head of Internal Audit, the Chief Officer (Finance & Commercial Services) and the Chair of the Audit & Governance Committee.

3.9 Consulting services

The Chief Officer (Finance & Commercial Services) along with other Council officers may request Internal Audit's input into non-audit work. These reviews could include advising officers in the design of processes and controls within a new system, reviewing documentation which is to be followed by officers to assess its suitability or undertaking ad-hoc reviews to assist in resolving a control issue that has arisen.

These type of reviews may impact on the delivery of audit work, could raise conflict of interest issues or require specialist input. All these requests should be reviewed, discussed and approved by the Head of Internal Audit so that any such issues are resolved and prior to the commencement of the work.

4. Quality Assurance

4.1 Quality Assurance

We have a quality assurance and improvement programme that covers all aspects of the internal audit activity. This programme is designed to enable an evaluation of internal audit conformance with the PSIAS and the Code of Ethics. The programme also assesses the efficiency and effectiveness of internal audit and identifies opportunities for improvements within the function's internal procedures to ensure that the service it delivers is of an appropriate quality and in compliance with professional standards.

As part of this process we will also be working to a number of performance measures, these are detailed below:

Performance Measure	Target
Terms of Reference agreed and issued 5 working days prior to start of audit	95%
Draft Report issued 10 working days after the de-brief meeting	95%
Management responses received within 10 working days of issue of draft report	95%
Final report issued within 5 working days of management responses being received	95%
Proportion of recommendations agreed by management	95%
Client Satisfaction Rate	90%

We will report against the indicators, together with results of the quality and assurance programme and progress against any improvement plans as part of the Annual Internal Audit Report.

Herefordshire Council

MEETING :	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**INTERNAL AUDIT PLAN 2013/14**
REPORT BY:	**HEAD OF INTERNAL AUDIT**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

The purpose of this report is to seek the Audit and Governance Committee's approval of the Annual Internal Audit Plan for 2013/14.

5. Recommendation

THAT, subject to any comments, the Annual Internal Audit Plan 2013/14 is approved.

6. Key Points Summary

- The draft Annual Internal Audit Plan for 2013/14 is set out in Appendix 1.
- The Plan sets out the work required for Internal Audit to give an opinion on the adequacy and effectiveness of the Council's risk management, governance and internal control arrangements.
- Discussions are on-going over possible changes to the Internal Audit arrangements to reflect the distinct organisational status of Hoople. This may lead to the removal of certain audits from the Council's audit plan, with the work instead being performed as part of Hoople's internal audit arrangements and the Council receiving assurance from Hoople over the operation of controls. Any change to the internal audit arrangements will require an amendment to the 2013/14 Plan.

7. Alternative Options

7.1 There are no alternative options as this Plan is a requirement of the Public Sector Internal Audit Standards (PSIAS).

8. Reasons for Recommendations

8.1 To ensure the Council complies with recommended practice as set out in the PSIAS.

9. Introduction and Background

9.1 Preparation and adoption of the Annual Internal Audit Plan represents best practice as required by the PSIAS and the document is an integral part of the Council's internal control assurance process. Under its terms of reference the Audit and Governance Committee is required to review and approve the Annual Internal Audit Plan.

10. Key Considerations

Internal Audit Plan 2013/14

10.1 The Annual Internal Audit Plan (attached at Appendix 1) is a risk based plan that takes account of the Council's risks, key issues and objectives. This plan has been compiled through discussions with the Chief Officer: Finance & Commercial, input from senior management across the Council, Internal Audit's knowledge of the Local Government sector, a desk top review of key documents such as the Council's risk registers and a review of findings from previous internal audits.

10.2 In the light of the financial challenge being faced by the Council it is appropriate that Committee note that the plan may be amended as the year progresses to accommodate any emerging pressures in Adult Social Care.

Hoople

10.3 Hoople provides financial, IT and other back office services on behalf of the Council covering many of the systems traditionally audited through the Council's Internal Audit Plan. The systems audited have continued to be covered through the Council's Internal Audit Plan since the establishment of Hoople as a stand-alone entity, allowing time for Hoople to embed. However, this has meant that certain audits have been conducted for, and reported to, the Council when in fact they relate to systems, operations and controls that are actually managed on a day-to-day basis by Hoople.

10.4 Discussions have therefore been held with the Chief Officer: Finance & Commercial and Hoople's management over possible changes to the Internal Audit arrangements to reflect the distinct organisational status of Hoople. This may lead to the removal of certain audits from the Council's audit plan, with the work instead being performed as part of Hoople's own internal audit arrangements. If effected, this would mean that these audits would be reported to Hoople's management and audit committee, rather than directly to the Council. However, the Council would continue to receive assurance from Hoople over the operation of controls for these areas. In practice, the operational model of KPMG managing an Internal Audit team managed by Hoople would allow combined audits to be undertaken, allowing full consideration of systems and controls on both the client side (Council) and contractor side (Hoople).

10.5 These discussions are still on-going and as a result the Internal Audit Plan presented at Appendix 1 does not reflect any change. Should the changes be pursued, they will need to be approved by both the Audit and Governance Committee and Hoople's audit committee and amendment to the 2013/14 Plan.

11. Community Impact

11.1 This report does not impact on this area.

12. Equality and Human Rights

12.1 This report does not impact on this area.

13. Financial Implications

13.1 The internal audit service will continue to be delivered within the current budgeted level of resource and using the existing operating model of KPMG managing the 'in-house' team (who are employed by Hoople Ltd).

14. Legal Implications

14.1 The Accounts and Audit Regulations 2011 require that local authorities in England "undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control". An adequate and effective Internal Audit function which is led by a robust Internal Audit Plan is fundamental to the fulfilment of these requirements.

15. Risk Management

15.1 There is the risk that the Annual Internal Audit Plan does not take into account the key issues and risks facing the Council and does not provide adequate coverage of the Council's key systems for the Head of Internal Audit to form an opinion on the Council's control environment. The process by which the plan has been compiled mitigates this risk.

15.2 There is also a risk that there may be insufficient resources available to deliver the planned programme of audit work. To mitigate this, the plan has been based on an assessment of the resources available from both Hoople and KPMG. Regular meetings are held between the Head of Internal Audit and the Chief Officer: Finance & Commercial which allows regular monitoring of resource availability.

16. Consultees

16.1 The HPSLT and the Chief Officer: Finance & Commercial were consulted in the drafting of this report.

17. Appendices

17.1 Internal Audit Plan 2013/14.

18. Background Papers

18.1 None.

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Herefordshire Council

Annual Internal Audit Plan 2013/14

PUBLIC SECTOR AUDIT

Contents

The contacts
in connection with this
report are:

Darren Gilbert
Head of Internal Audit
KPMG LLP (UK)

Tel: 029 2046 8205
darren.gilbert@kpmg.co.uk

Mukhtar Khangura
Internal Audit Manager
KPMG LLP (UK)

Tel: 0121 232 3216
mukhtar.khangura@kpmg.co.uk

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Section One

Executive Summary

This audit plan outlines the proposed internal audit input for 2013/14. It has been prepared with reference to previous audit issues, prior year internal audit activity, risks and developments within Herefordshire Council (the Council) and topical issues in the sector.

The plan also sets out how we will comply with the relevant standards for provision of your internal audit function. It provides a risk based analysis of the Council's operations as a basis for our work and summarises the performance metrics we will use.

1.1 Purpose of this plan

This plan meets the requirements under the Public Sector Internal Audit Standards (PSIAS) and CIPFA's Local Government Application Note for the 'Chief Audit Executive' (the Head of Internal Audit) to produce a risk based annual Internal Audit Plan. The Internal Audit Plan sets out the number and types of review which will be undertaken to underpin the Head of Internal Audit opinion's on the Council's internal control environment. Under the PSIAS there are a number of areas that the risk based Internal Audit Plan must include:

- it must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be developed and delivered (*Section three, four and five*);
- it must detail how it links into the organisational objectives and priorities (*Appendix three*);
- the approach to using other sources of assurance and any work required to place reliance upon those other sources (*Section three*); and
- the resources and skills required to deliver the plan *(Section five)*.

We have set out detail to support each of these requirements within the main body of our report.

1.2 Internal Audit's objectives

The role of Internal Audit is to provide assurance to Members and senior management that there are adequate and effective internal control arrangements in place to mitigate key risks and achieve objectives. This covers the Council's entire control environment and not just financial controls. However, in these ever changing times, Internal Audit should not only provide its core role but provide an added value service. In performing its role, Internal Audit aims to, where appropriate:

- contribute to the improvement of the internal control environment;
- identify opportunities for performance improvement;
- evaluate where systems are over controlled or inefficient; and
- identify cost saving opportunities.

The detailed terms of reference for Internal Audit are set out within our Audit Charter.

1.3 Key issues and Risks

The Council faces a number of significant risks and challenges over the next financial year and beyond, both financially and operationally. These include:

- Ensuring that it delivers its Medium Term Financial Plan, given the challenges it faces in terms of increased demand on its services and significant reductions in funding;
- Delivering key projects such as its "Root and Branch review". This programme seeks to deliver, amongst other objectives, improved performance at a reduced cost through different ways of working. The framework over this programme has recently been developed further and the Council needs to ensure that these revised processes deliver the aims of the project successfully;
- Ensuring that the key services can successfully implement new ways of working so that the Council can effectively meet the financial challenges it is facing;
- Continuing to embed working arrangements with Hoople. It is the organisation's second year of operation and it has defined its role and set out its relationship with the Council. The next key step for the Council and for Hoople is to start to develop the services it could provide to other organisations. As part of this development process, the Council needs to effectively monitor the service Hoople is providing to ensure that it meets its aims and objectives and that a clear and effective control environment is in place within the organisation given the financial constraints it is operating under; and
- Ensuring the continued effectiveness of its routine control and governance processes such as its risk management, performance and financial management functions within the current period of change.

1.4 Developing the plan

We have compiled a risk based plan that takes account of the Council's key issues and objectives. This plan has been compiled through:

- discussions with the Leadership Team, the Chief Officer (Finance & Commercial Services) and other senior managers;
- our knowledge of the sector;
- a desk top review of key documents, such as the Council's risk registers; and
- a review of findings from previous internal audits.

The Internal Audit Plan includes reviews of key financial, operational and corporate systems. We believe that a total of 970 days of internal audit input is required to deliver the plan. This input will ensure that a fully comprehensive internal audit service is provided to the Council. We have set out our Internal Audit Plan at Appendix 1 and have provided further information in Section four.

We have set out within our plan audits of key financial systems, for example reviews of the Creditors and Payroll systems. These systems are currently being run by Hoople on behalf of the Council. We are in discussions with management both within the Council and Hoople on how the audits of these systems will be completed in 2013/14. We will report the results of these discussions and the impact they may have on the Internal Audit Plan to the Audit & Governance Committee for review and approval.

1.5 Resources

The Audit Service is being led by KPMG, with Darren Gilbert as the Council's Head of Internal Audit and Mukhtar Khangura as the Internal Audit Manager. The service is to be provided using a combination of resources predominantly from Hoople with additional input from KPMG. All staff have considerable experience of providing an effective and efficient internal audit service.

It should be noted that the estimated number of audit days stated above is the minimum required to deliver the proposed programme of audit work. The range of days provides some flexibility in the delivery of individual audit engagements, but it does not represent a general contingency to allow for additional work that may be required for emerging risks and issues, or any requests for the Internal Audit team or KPMG to undertake 'advice and assistance' reviews. The deliverability of the Internal Audit Plan will be kept under constant review by KPMG and any need or request for additional work, along with how this will be resourced, will be discussed and agreed with the Chief Officer (Finance & Commercial Services).

1.6 Audit Approach

We have a comprehensive audit approach and quality assurance process that meets the PSIAS. This process is set out in our Audit Charter and is summarised in Section six of this Plan. This ensures that our work is of a high standard and delivers a quality internal audit service to the Council.

Section Two

Internal Audit Objectives

Internal Audit is an assurance function that provides an independent and objective opinion to the Council on risk management, control and governance by evaluating its effectiveness in achieving the organisation's objectives. It objectively examines, evaluates and reports on the adequacy of the control environment as a proper economic, efficient and effective use of resources.

2.1 The requirement for Internal Audit

The need to maintain an internal audit function is implied by Section 151 of the Local Government Act 1972 under which local authorities are required to make proper arrangements for the administration of their financial affairs and to delegate responsibility for those arrangements to one of their officers. The Accounts & Audit Regulations 2011 are explicit about the requirement for a local authority to maintain an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control.

The PSIAS and CIPFA's Local Government Application note, taken together, represent 'proper practices' in this context. Our Audit Charter sets out how this is met for the Council.

2.2 Core Role of Internal Audit

The core role of Internal Audit is to provide assurance to Members and senior management that there are adequate and effective internal control arrangements in place to mitigate key risks and achieve objectives. This covers the Council's entire control environment and not just financial controls.

However, in these ever changing times, Internal Audit should not only provide its core role but provide an added value service. In performing its role, Internal Audit aims to, where appropriate:

- contribute to the improvement of the internal control environment;
- identify opportunities for performance improvement;
- evaluate where systems are over controlled or inefficient; and
- identify cost saving opportunities.

Internal Audit is not responsible for ensuring that adequate and effective internal controls are established to manage the key risks. That responsibility lies with senior management.

2.3 Independence of Audit Services

As required by the PSIAS and set out in the Audit Charter, the Head of Internal Audit must confirm the organisational independence of Internal Audit to the Audit & Governance Committee at least annually. Organisational independence is achieved when the Head of Internal Audit reports functionally to the Committee. Examples of functional reporting to the Committee include the Committee approving the Internal Audit Charter and the risk based Internal Audit Plan.

On a day to day basis the Head of Internal Audit reports to the Chief Officer (Finance & Commercial Services). The Head of Internal Audit also has direct lines of reporting to the Council's Head of Paid Service (Chief Executive), Monitoring Officer and the Audit & Governance Committee. These officers and the Committee in turn have the ability to liaise directly with the Head of Internal Audit.

The Council has engaged KPMG to lead its Internal Audit function and this arrangement supports the independence of the Head of Internal Audit role. The Head of Internal Audit is responsible for the day to day management of the Audit Services Team. No independence issues have been identified regarding the Internal Audit team, and we confirm that Internal Audit is not involved in any operational processes or have any managerial responsibilities that could create a threat to independence.

Section Three

Developing the Plan

We have undertaken a number of actions to ensure that our programme of work meets the needs of the Council and provides an effective and efficient assurance service.

3.1 Developing the plan

All local authorities face a very challenging environment with pressures to both increase performance and decrease costs. We believe that a responsive and effective internal audit function can help the Council in meeting these challenges while assisting the Council achieve its objectives. This can only be achieved by developing a comprehensive Internal Audit Plan in which the resources available to the internal audit function are allocated to areas of greatest need. We have developed the plan taking into consideration the issues below:

3.2 Desktop review

In developing the Internal Audit Plan, we have taken account of the following:

- the Council's corporate risk register;
- discussions with officers, including the views of the Chief Officer (Finance & Commercial Services) and other senior managers;
- emerging issues and risks facing the sector;
- the Council's objectives detailed within its Corporate Plan 2013-15;
- existing projects, strategies and initiatives that the Council is undertaking;
- input from the Internal Audit team;
- the performance of the Council from a review of its Key Performance Indicators; and
- the Council's 'Root and Branch' project.

3.3 Views of Leadership Team and other officers

We have met with members of the Leadership Team and have factored in their views to the existing plan. In some instances, Corporate Directors and Assistant Directors have asked that further meetings are held to determine the exact nature and scope of individual reviews. For example, we have allocated time in the plan to focus on issues in relation to a review of the Highways contract. The precise coverage of this reviews will be addressed through further discussions with relevant officers.

3.3 Liaison with the External Auditors

We understand the importance of the good working relationships with the External Auditors in order to minimise duplication of effort. We are due to meet with the external auditors shortly in order to build their requirements into the audit plan, where appropriate.

3.4 Liaison with the other assurance providers/links to wider projects

We recognise that there are other review functions and assurance providers (both internal and external) who provide some assurance over aspects of the Council's operations e.g. OFSTED and the Care Quality Commission. Where possible we will seek to place reliance on such work and reduce internal audit coverage appropriately.

We are also liaising with the Internal Audit team within NHS Herefordshire to ensure that an effective working relationship is established and to identify any opportunities for joint review.

Section Four

Key Issues and Coverage

Our detailed programme of work sets out how we propose to provide assurance over the key risks you face. It might be necessary to update this Internal Audit Plan during the year, should the Council's risk profile change and different risks emerge that would benefit from internal audit input. We will ensure that management and the Audit & Governance Committee are kept up to date with all work we perform.

4.1 Overview

The Council faces a number of significant challenges and risks over the next financial year as it continues to implement a number of key programmes and initiatives. The Council has identified these risks within its Corporate Risk Registers. These include:

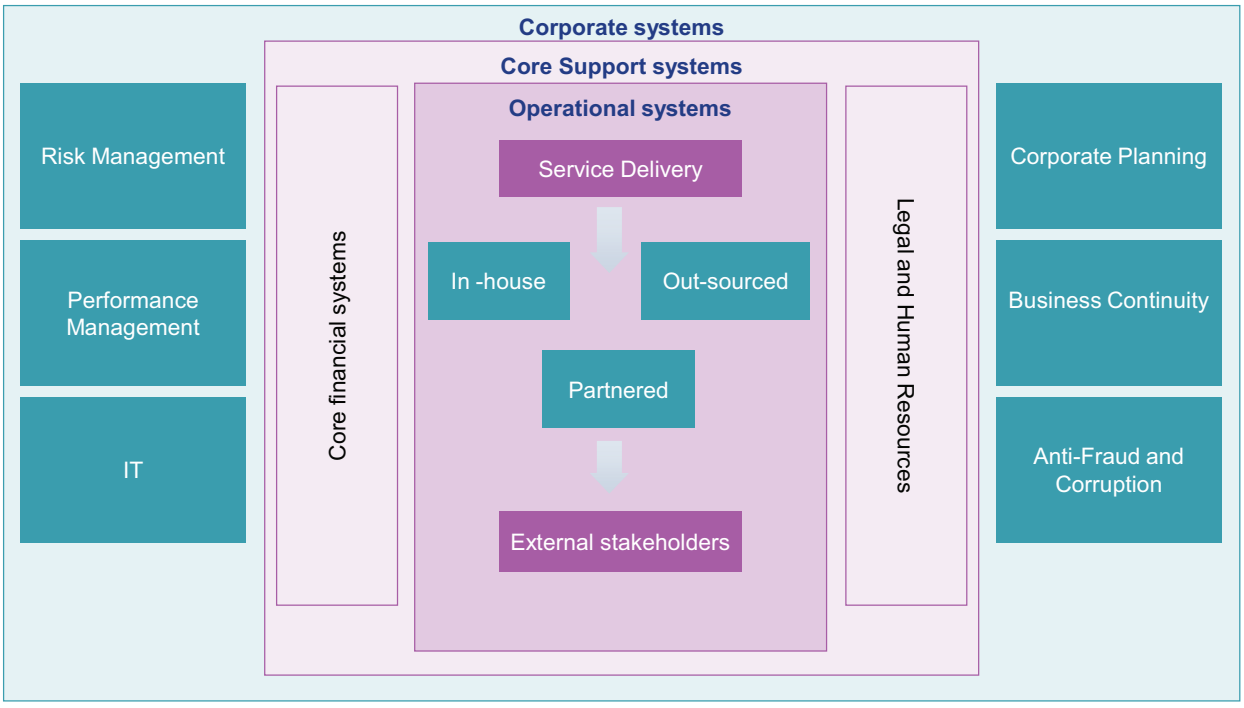
- failure to deliver the 'Root and Branch' programme resulting in services that do not meet the needs of the Council;
- failure to deliver the significant cost savings outlined for 2013/14;
- inadequate commissioning of services which are not delivered to the appropriate cost and quality; and
- failure to progress with the Integrated Waste Management PFI Scheme.

The Council will need assurance that the controls it has in place to mitigate these risks are being effectively applied and that its control environment is robust.

4.2 Councils control environment

The Council operates an overall control environment, which is the collection of systems and processes that helps it to manage risks and achieve its objectives. The main groupings within this framework influence the key strands to our internal audit work:

- Core support: these include systems that support the Council's service delivery, such as its financial systems;
- Corporate systems: these are the core business processes that give the Council direction and provide oversight over its activities. For example, the risk management, performance management and corporate planning processes; and
- Operational systems: these include the main systems associated with the Council's core activities and functions.



4.3 Audit Reviews

We have summarised the key areas of our Internal Audit Plan below, grouped by Corporate and Directorate systems. The indicative resource allocations for each area is shown in Appendix 1.

Area	Internal audit work in 2012/13
Core Support systems	These systems cover Financial Systems and Other systems that support the Council's service delivery and provide the Council direction and oversight over its activities. We have provided further detail on these audits below. **Financial Systems** These reviews will be carried out either as detailed reviews or audits that focus on key high level controls. The approach for each of these audits will be agreed with management prior to the commencement of the review. By adopting this approach we believe that we can prioritise audit resource to areas where it can best be utilised. The work undertaken on these systems will jointly be focused on the Council's systems and processes undertaken on their behalf by Hoople (where applicable). These audits may be subject to change based on the discussions between the Council, Hoople and KPMG. General Ledger This audit will focus on the controls the Council has in place over transactions posted to its General Ledger. This will include assessing controls over journal processing, suspense accounts and bank accounts. Creditors The Council pays a number of suppliers through its Creditors function. This audit will focus on the controls the Council has in place over how it raises orders and pays invoices relating to these suppliers. Payroll This audit will focus on the controls the Council has in place over payments made to its employees. As part of this audit we will review the Council's controls over employees who are added and removed from the payroll system. Treasury Management This audit will involve a review of the controls which ensure that the Council's Treasury Management policy is adhered to and that investment and borrowing transactions are undertaken in accordance with Council policy. Our audit will also involve a review of the Council's controls which ensure compliance with the Prudential code. Council Tax and NNDR This audit will focus on the controls which the Council has in place over collecting tax from personal and business premises. Benefits (Council Tax and Housing) The aim of this audit will be to assess the controls which the Council has in place over Benefit payments. We will assess controls over how entitlement to Housing and Council Tax Benefit is assessed, reviewed and monitored. We will also review controls over how benefit is reclaimed if it has been overpaid. Income Collection As part of this review we will follow up the recommendations which we made as part of our 2012/13 audit review to assess the progress the Council has made in implementing them.

4.3 Audit Reviews

Area	Internal audit work in 2012/13
Core Support systems *(cont.)*	**Other** Health and Safety The aim of this review will be to assess the Council's controls which ensure that it complies with its responsibilities under the Health and Safety at Work Act and other statutory processes. Business Continuity The aim of this audit will be to review the Council's controls which ensure that it can continue its operations in the event of an IT or other issue effecting its key systems. Root and Branch – Governance Our work in this area will focus on the controls which the Council has in place to ensure that the overall project is being properly governed and that it is achieving its aims and objectives. As part of this process we will also review a sample of projects to assess how they comply with the governance arrangements within this area. Transport This review will focus on the controls which the Council has in place which ensure that its Transport function is issuing permits to private companies in accordance with agreed policies and procedures. Legal Services As part of this review we will follow up the recommendations which we made as part of our 2012/13 audit review to assess the progress the Council has made in implementing them.
Corporate Systems	**IT Systems** Effective and efficient IT systems are key to ensuring that the Council fulfils its Corporate Objectives. Our work within this area will include reviews of: *ISO 27001* Our work in this area will focus on the Council's compliance with ISO27001. This Standard ensures that the Council has key processes and controls in place, for example over how it backs up and maintains its data. *IT Access Controls - Agresso and Other IT systems* This review will focus on the controls which ensure that the Council's systems are protected from unauthorised access and that its data is safeguarded. We will also review access controls over the Council's other IT systems including Academy, ISIS and Abacus. IT – Data Protection (Follow Up) As part of this review we will follow up the recommendations which we made as part of our 2012/13 audit review to assess the progress the Council has made in implementing them. IT Strategy As part of this audit will review the controls in place that ensures that the Council's IT Strategy has been compiled with reference to its aims and objectives, is deliverable and monitored on a regular basis.

Key issues and coverage *(continued)*

Area	Internal audit work in 2012/13
Corporate Systems *(cont.)*	**Anti-Fraud and Corruption** The Council has a duty to ensure that its resources are safeguarded against theft, misuse or loss. One of the ways in which it can do this is through the promotion of an effective anti-fraud and corruption environment. Our work in this area will be split into the following areas. *Hot Topics and review of high risk areas* We will assess how the Council is affected by current issues relating to Anti-Fraud and Corruption. For example, we will review key areas that could be subject to fraud and assess the effectiveness of the Council's arrangements to counter it. In 2013/14 we will focus on Grants. *Anti-Fraud Survey* We will also complete the Audit Commission's Anti-Fraud and Corruption Survey. **Governance systems** The Council needs to ensure that it has appropriate and robust corporate governance systems in place which ensure that its key risks are being managed and its performance is being accurately reported. *Risk Management* Our work in this area will involve reviewing the Council risk management controls and processes. We will assess the risk management framework, including the policy and procedures, risk maps and the controls which ensure that the management of risk is embedded within its corporate processes. *Performance Management* As part of our audit in this area we will review the Council controls which ensure that reports which are submitted to management and Members accurately reflect the performance of its services. *Savings and Benefits Realisation* The Council is seeking to make significant cost savings 2013/14. As part of this audit we will review the Council's controls which ensure that this challenging cost saving programme is managed appropriately.
Operational Systems - Directorates	**Places and Communities Directorate** *Public Health – Food Licensing* As part of this review we will follow up the recommendations which we made as part of our 2012/13 audit review to assess the progress the Council has made in implementing them. *Highways Contract* We will identify in conjunction with management areas of focus in relation to contract management and value for money. *Places and Communities – Delivery of Projects funded by the Skills Funding Agency* As part of this audit we will review the controls which ensure that monies received from the Skills Funding Agency are used in accordance with the grant conditions and that projects funded deliver their aims and objectives. *Places and Communities – Broadband rollout: project and financial management* Our review of this area will focus on the controls within the project that ensure the Council delivers on its aims and objectives and monies spent are properly accounted for. *Places and Communities – HALO* The Council works with HALO, which is a community based 'not for profit' organisation in the running of its leisure services. As part of this audit we will review the Council's controls which ensure that this partnership delivers on its objectives and has appropriate financial and governance arrangements in place.

Key issues and coverage – *(continued)*

Area	Internal audit work in 2013/14
Operational Systems - Directorates	**Places and Communities Directorate** *Homelessness & Housing Advice - Prevention Payments* This audit will review the processes and controls which ensure that Prevention payments are made appropriately and in accordance with the Council's procedures. **Corporate Services** *Digital channels project* The Council is seeking to implement digital channels to support cheaper and easier resident self-service. As part of this audit we will review the controls which the Council has in place that ensure that that project delivers on its aims and objectives.
Schools	We will assess and review how schools are complying with the new Financial Value Standard which fully came into effect in 2013/14. This will involve reviewing documentation which schools have submitted to the Council setting out how they comply with the standard. This will inform our approach on a sample basis.
Follow Up	This work in the area will entail following up high risk recommendations made within previous year's report and assessing the progress the Council has made in implementing them.
Completion of Audit Work – 2012/13	We have carried forward time to complete the remaining 2012/13 reviews which had not been completed by the year end (March 2013).

5.1 Audit team

The core members of your audit team are set out below. The team will be led by Darren Gilbert as the Head of Internal Audit. Darren will be supported by Mukhtar Khangura who will act as the Internal Audit Manager.

Your internal audit team

Darren Gilbert
Head of Internal Audit

Mukhtar Khangura
Internal Audit Manager

Hoople Audit Team

Julie Jones
Senior Auditor

Gary Williams
IT Auditor

Vicky Roissetter
Principal Auditor

All of the core Audit team members have significant experience of providing internal audit services. Darren and Mukhtar will be supported by three Hoople staff who have been providing internal services to the Council for a number of years and have considerable experience and knowledge of the organisation.

In addition to these core members of your team we will draw on other resources from KPMG to complete our reviews. These staff will report to Darren to ensure that their work is co-ordinated and to ensure that there is seamless delivery of the internal audit service.

Section Six

Our Audit Approach and Performance Indicators

6.1 Our Audit Approach

We aim to provide a service that not only meets your needs but also maintains consistently high standards and meets the requirements of the PSIAS. Our detailed audit approach is set out in our Internal Audit Manual, however, we summarised some aspects of the process below:

- preparation of a detailed audit plan;
- preparation of terms of reference which are provided to management two weeks prior to the audit commencing;
- the use of qualified, highly trained and experienced staff;
- regular review of progress against the plan to ensure we are delivering the work we have promised;
- a tailored audit approach using a defined methodology and assignment control documentation; and
- the review of all audit files and reports by the Manager and Head of Internal Audit as part of the Quality Assurance process.

6.2 Operating principles – the assignment process

We will utilise a risk-based approach to the individual reviews in line with the PSIAS. This involves:

- identifying the risks that may impact on the systems achieving their objectives and identifying and evaluating the systems of internal control designed by management;
- compliance testing of the operation of controls; and
- making appropriate recommendations and advising management on how systems of internal control may be streamlined or strengthened.

The different delivery stages of the audit process are shown below. Our approach to individual reviews recognises that different approaches will be required in different circumstances, for example in some cases as systems are being developed or revised it may be beneficial for us to defer detailed testing until a later date, but instead focus on understanding and contributing to the development of the design of the control framework.

6.3 Reporting

On completion of our individual reviews, we will produce a report for management that will outline the objectives and scope of our work, risks considered during our review, an assessment of the effectiveness of internal controls and considerations for performance improvements. Each report will include an action plan.

Following our internal audit work for the year we will produce an Annual Internal Audit Report. This will summarise the work completed and will provide an overall opinion in respect of risk, control and governance arrangements.

6.4 Performance Indicators

Our internal procedures ensure that the service we deliver is of an appropriate quality and in compliance with the PSIAS. Over the year, we will also be working to a number of performance measures, these include ones detailed below:

Performance Measure	Target
Terms of Reference agreed and issued 5 working days prior to start of audit	95%
Draft Report issued 10 working days after the de-brief meeting	95%
Management responses received within 10 working days of issue of draft report	95%
Final report issued within 5 working days of management responses being received	95%
Number of recommendations agreed by management	95%
Client Satisfaction Rate	90%

We will report performance against these indicators as part of our Annual Internal Audit Report.

Appendix 1 - Resource allocation for 2011/12 – 2014/15

Our Strategic Internal Audit Plan covering the years 2011/12 to 2014/15 is detailed on the following pages. We have explained below how this has been structured and the how the elements of the plan relate to our planning processes:

System		Internal audit risk assessment				Year
		Inherent	Control	Materiality	Aggregate	13-14
		H/M/L	H/M/L	H/M/L	H/M/L	✓

The first part of our analysis shows which area is being reviewed (i.e. operational, corporate or support system) and the specific system proposed for review.

The second part of our analysis considers our internal audit risk assessment and uses the following risk assessment process to analyse the system under review:

The third part of our analysis shows the audit coverage.

Inherent risk	Control risk	Materiality and risk	Aggregate
Our assessment of the overall level of risk associated with the audit area – this is effectively a gross relative risk of the potential impact on you in this area.	Our assessment of the risk that exists within a particular area based upon the controls that we are aware you have put in place – effectively the likelihood of the risk being realised. This is informed by previous internal audit reports and discussions with officers, but will be refined over time.	Our assessment of the potential financial or organisational consequence to you. This might be judged by the potential for a monetary loss or the extent to which it impacts on core business objectives.	This is our overall assessment of risk associated with each of the audit areas. It is reached with regard to each of the previous assessment of risks.

We have set out below audits for the years 2011/12 to 2014/15 based on our risk assessment process above. This analysis shows how we will cover each system on a cyclical basis based on the results of the risk assessment process. We have also set out (where applicable) reviews which link into the Council's risk register's and Corporate Plan in Appendix 2.

Strategic Internal Audit Plan 2011/12 – 2014/15						
			Years			
		Aggregate risk	2011/12	2012/13	2013/14	2014/15
Core support systems – Financial	Payroll	H	✓	✓	✓	✓
	Creditors	M	✓	✓	✓	✓
	Treasury Management	M	✓	✓	✓	✓
	Income Collection	M	-	✓	✓ Follow Up	✓
	Debtors	M	✓	✓	-	-
	Budgetary Control	M	-	✓	-	✓
	NNDR	M	✓	✓	✓	✓
	General Ledger	M	✓	✓	✓	✓
	Council Tax	M	✓	✓	✓	✓
	Benefits (Council Tax and Housing)	M	✓	✓	✓	✓
	Asset Register	M	-	✓	-	✓
	Procurement	M	-	✓	-	✓

Appendix 1 - Resource allocation for 2011/12 – 2014/15

			Years			
		Aggregate	2011/12	2012/13	2013/14	2014/15
Core support systems - Other	Transport Team	M	✓	-	✓	-
	Root and Branch – Governance	M	✓	-	✓	
	Rising to the Challenge	M	✓	✓	-	-
	Health and Safety	H	✓	✓ Follow Up	✓	-
	Sustainability	M	✓	✓ Follow Up	-	✓
	Member Allowances	M	✓	-	-	✓
	Business Continuity	M	✓	✓ Follow Up	✓	-
	Agency Payments	M	✓	-	-	-
	Legal Services	M	✓	✓	✓ Follow Up	✓
	Total days for Core Support Systems	245				
IT systems	ISO 27001 Information Security	M	✓	✓	✓	✓
	Access Controls review - Agresso, Academy, ISIS and Abacus	H	✓	✓	✓	✓
	Data Protection	H	-	✓	✓ Follow Up	✓
	IT Strategy	M	-	-	✓	✓
	Total days for IT systems	85				
Anti-Fraud systems	Anti-Fraud and Corruption and Anti-Money Laundering Arrangements	M	-	✓	-	✓
	Anti-Fraud and Corruption – Hot Topics and Risk Areas	M	✓	✓	✓	✓
	Gifts and Hospitality	M	✓	-	-	-
	Audit Commission - Anti-Fraud Survey	M	✓	✓	✓	✓
	Total days for Anti-Fraud systems	40				
Governance systems	Director Annual Assurance Statements	M	✓	-	-	✓
	Risk Management	M	✓	-	✓	-
	Performance Management	M	✓	-	✓	-
	Performance Management – Follow Up	M	-	✓	-	✓
	Performance Plus	M	✓	-	-	-
	Savings and Benefits Realisation	M	✓	-	✓	-
	Total days for Governance systems	70				

Appendix 1 - Resource allocation for 2011/12 – 2014/15

	System	Years				
		Aggregate	2011/12	2012/13	2013/14	2014/15
Operational systems – Directorate	Hoople – Client Side Management	M	-	✓	-	✓
	Hoople – Governance	M	✓	-	-	-
	Hoople – Governance (Follow Up)	M	-	✓	-	-
	People Services - Adult and Social Care – Financial Management	M	-	✓	-	✓
	People Services - Adult and Social Care – Procurement (Follow Up)	M	-	✓	-	-
	Places and Communities - Public Health – Food Licensing	M	-	✓	✓ Follow Up	✓
	Places and Communities - ABG Grant Review	M	✓	-	-	-
	Places and Communities - Planning	M	✓	-	-	-
	Places and Communities – Highways Contract Management	M	✓	-	✓	✓
	Places and Communities - Taxi Licensing	M	✓	-	-	-
	Places and Communities – Delivery of Projects funded by the Skills Funding Agency	M	-	-	✓	-
	Places and Communities – Broadband rollout – project and financial management	M	-	-	✓	-
	Places and Communities - HALO	M	-	-	✓	-
	Places and Communities - Homelessness & Housing	M	-	-	✓	-
	Corporate Services - Digital channels project	M	-	-	✓	-
	Total days for Operational systems	160				

Appendix 1 - Resource allocation for 2011/12 – 2014/15

	System	Years				
		Aggregate	2011/12	2012/13	2013/14	2014/15
	Schools	M	✓	-	✓	✓
	Total Days for Schools	30				
	Completion of 2012/13 Audit Work	145				
MGT	**Follow up (days)**	20				
MGT	**Contract management and Audit and Governance Committee attendance (days)**	175				
	Total	970				

We have given a range of days to be used for each functional area for every Internal Audit year. This allows Internal Audit to flexibly prioritise the audit resource allocated to each audit review based on its risk profile and in accordance with the scope agreed with management.

Appendix 2 – Links to Risk Register and Corporate Plan

We have set out below audits for the years 2013/14 and how they link into the Council's risk register's and Corporate Plan - 2013/15.

Internal Audit Plan 2013/14		
Audits	**Links to Risk Register (Risk Ref)**	**Corporate Plan**
Financial System Audits Payroll, Creditors, Treasury Management, General Ledger, NNDR, Council Tax and Benefits and Income Collection.	RSK.COR.007 – Medium Term Financial Plan	Linked to the Corporate aim of "To Support the delivery - Herefordshire Council will operate efficiently and effectively –(making the best use of resources available including money, buildings, IT and information)".
IT System Audits ISO 27001 Information Security, Access Controls review - Agresso, Academy, ISIS and Abacus and Data Protection (Follow Up), IT Strategy.	RSK.COR.007 – Medium Term Financial Plan	
Anti-Fraud Systems Anti-Fraud and Corruption – Hot Topics and Risk Areas and Audit Commission - Anti-Fraud Survey	RSK.COR.007 – Medium Term Financial Plan	
Governance Systems Risk Management and Performance Management and Savings and Benefits Realisation, Legal Services.	RSK.COR.007 – Medium Term Financial Plan	Linked to the Corporate aim of "To Support the delivery - Herefordshire Council will operate efficiently and effectively – (Developing a strong, integrated performance management culture and process that is effective in managing risk, maximising opportunity and promoting continuous improvement (includes linking performance outcomes to cost, risk management, corporate governance systems, lean systems thinking)".
Corporate System Business Continuity	RSK.EEC.20 - IT	Linked to the Corporate aim of "Enable residents to be independent and lead fulfilling lives so that - People stay safe".
Corporate System Health and Safety	RSK.COR.016 – Public Health	
Corporate Services - Digital channels project	RSK.EEC.16 – Digital rollout	Linked to the Corporate aim of "Enable residents to be independent and lead fulfilling lives".
Corporate System Root and Branch	RSK.COR.011 – Redefining role of the Council	Linked to the Corporate aim of "To Support the delivery of Herefordshire Council will operate efficiently and effectively – (Developing a robust commissioning framework and capability).
Places and Communities – Highways Contract	RSK.PBC.006 – Procurement of Contractor	Linked to the Corporate aim of "To Support the delivery - Herefordshire Council will operate efficiently and effectively – (Being focused on delivery and impact ensuring that benefits are realised and resources are linked to outcomes)
Education Transport	RSK.PBC.006 – Procurement of Contractor	
Places and Communities – Delivery of Projects funded by the Skills Funding Agency	RSK.HAC.004 – Skills Funding Agency	
Places and Communities – Broadband rollout – project and financial management	RSK.EEC.16 – Digital rollout	
Places and Communities - HALO	RSK.EEC.05 - Commissioning	
Places and Communities - Homelessness & Housing Advice	RSK.HAC.007 - The Homelessness Prevention Support Contract	

Appendix 3 - Opinion and Description of Levels of Assurance

Audit Opinion

The audit opinion on the Council's systems of internal control will be based on a review of the following:

- core systems, both financial and other;
- anti-fraud systems;
- corporate systems;
- governance systems;
- IT Systems;
- level of recommendations agreed for action by management; and
- results of the recommendations follow-up review.

An audit conclusion will be given to each audit review, which will inform the Head of Internal Audit's overall opinion on the Council's system of internal control.

Regular progress reports will be presented to the Audit & Governance Committee, with the Annual Internal Audit Report presented in the June following the financial year to which it relates.

We will use the following conclusions as the basis of the levels of assurance that we provide you with after each review (although it should be noted that these represent an indicative approach as the overall assurance provided are a matter of professional judgement).

Conclusion	Definition
No assurance	One or more priority one recommendations and fundamental design or operational weaknesses in more than one part of the area under review (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
Limited assurance	One or more priority one recommendations, **or** a high number of medium priority recommendations that taken cumulatively suggest a weak control environment (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in a significant exposure to reputation or other strategic risks).
Adequate assurance	One or more priority two recommendations (i.e. that there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Substantial assurance	No or priority three only recommendations. (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).

Appendix 3 - Opinion and Description of Levels of Assurance

We have also agreed the following definitions for the priority of the recommendations that we may raise within our reports:

Priority	Definition
Red *(Priority 1)*	A **significant** weakness in the system or process which is putting the Council at **serious risk** of not achieving its **strategic** aims and objectives. In particular: significant adverse impact on **reputation**; non-compliance with key statutory requirements; or substantially raising the likelihood that any of the Council's strategic risks will occur. Any recommendations in this category would require **immediate attention**.
Amber *(Priority 2)*	A **potentially significant** or **medium level** weakness in the system or process which **could** put the Council at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on the Council's reputation or for raising the likelihood of the Council's strategic risks occurring, **if not addressed.**
Green *(Priority 3)*	Recommendations which could **improve** the efficiency and/or effectiveness of the system or process but which are **not vital** to achieving the Council's strategic aims and objectives. These are generally issues of **good practice** that we consider would achieve better outcomes.

Herefordshire Council

MEETING	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**CONSULTATION ON THE REVIEW OF THE COMPLAINTS AND FEEDBACK POLICY AND PROCEDURE**
REPORT BY:	**HEAD OF COMMUNICATIONS AND ENGAGEMENT**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

To invite the Audit and Governance Committee to comment on the operation of the Council's policy and procedures for handling complaints, comments and compliments.

5. Recommendation

THAT the Audit and Governance Committee passes on any observations that will assist the Cabinet to effectively review the policy and procedures at its meeting in June 2013.

6. Key Points Summary

- The Council has a "Policy and Procedure for Making Experiences Count" which was shared with NHS Herefordshire.
- A small specialist team manages the process, maintaining contact with the complainant and co-ordinating responses from across the authority.
- Across most areas of the Council, the procedure is a single-stage: the Council will fully investigate and respond with no further levels within the Council.
- In the area of children's services a three-stage complaints process proscribed by law is operated.

- All complaints are dealt with within the policy unless an alternative, statutory framework exists: such as challenging a fixed penalty notice.

- In the financial year 2012/13 the Council received 1673 items of feedback of which 864 were complaints.

- In that financial year, 60% of complaints were responded to within the timescales set out in the Policy and Procedure for Making Experiences Count.

7. Alternative Options

7.1 There are no alternative options identified in this report.

8. Reasons for Recommendations

8.1 Cabinet will review the policy and procedure at its meeting on 13 June 2013. Audit and Governance has the right to be consulted on this review.

9. Introduction and Background

9.1 The Council has a Policy and Procedure for Making Experiences Count (attached as Appendix 1).

9.2 A small team manages complaints and is able to monitor and report on aspects of how complaints are handled (Appendix 2). Reports are sent to senior managers on a monthly basis.

9.3 The stated objectives of the policy and procedure are

9.3.1 To provide an opportunity for customers to comment on our performance against our commitments laid down in the Herefordshire Council and NHS Herefordshire Customer Charter and to ensure we improve our performance where it is not meeting those commitments.

9.3.2 To provide an effective means for a customer to make a comment about how services could be improved in the future and to provide an effective means for a customer to compliment a service or employee.

9.3.3 To provide an effective means for customers and their representatives to complain if they are dissatisfied with the service they receive.

9.3.4 To ensure complaints are dealt with in a courteous and efficient manner and are resolved without avoidable delay.

9.3.5 To obtain information about the public's perceptions about our services, to inform future policy and service planning.

9.3.6 There are 6 overriding principles to good complaints handling that will be followed at all times: 1. Being customer focused, 2. Getting it right, 3. Acting fairly and proportionally, 4. Being open and accountable, 5. Putting things right, 6. Improving services as a result.

10. Key Considerations

10.1 The Committee may wish to consider the degree to which the Council has succeeded in meeting the objectives set out in the Policy and Procedure for Making Experiences Count and the degree to which the Council is able to provide evidence that it has met its objectives.

10.2 Given that the policy and procedure was shared with NHS Herefordshire but the Council now requires a policy for itself alone, the Committee may wish to consider the degree to which the policy and procedure are fit for purpose.

10.3 The Committee may wish to consider whether there are particular aspects or particular stakeholder perspectives that should be taken in to consideration by the Cabinet when it reviews the policy and procedure.

11. Community Impact

11.1 Ultimately the policy and procedure should help customers to shape improvements in the way the Council goes about its business. A less effective policy and procedure will lead to a less effective Council and a reduction in the positive impact the organisation can make on the community.

12. Equality and Human Rights

12.1 There are no equality and human rights implications directly arising from this report but the equality and human rights implications of the application of the complaints policy are significant. The policy and procedure ensure that people have equal access to the complaints process and are treated equally by the Council when they complain. The committee may wish to consider the degree to which the current policy and procedure promotes equality of access to complaints.

13. Financial Implications

13.1 There are no direct financial implications arising from this report but the decisions the cabinet takes with regards to any revisions to the policy and procedures could have financial implications in terms of the amount of staff time the Council will allocate to the process and in terms of the costs of promoting and reporting on complaints.

14. Legal Implications

14.1 Failure to investigate and resolve complaints effectively can lead to adverse findings by Local Government Ombudsman and can also leave the Council open to legal challenge.

15. Risk Management

15.1 An effective complaints policy helps the Council mitigate the risk that at any given time its policies and procedures may not be followed or they may not be fit for purpose.

15.2 The Cabinet must be satisfied that the complaints policy and procedure are fit for purpose.

16. Consultees

16.1 The Committee is being consulted.

17. Appendices

17.1 Appendix 1 - Policy and Procedure for Making Experiences Count.

17.2 Appendix 2 - Summary of feedback from different areas of the authority 2012/13.

18. Background Papers

18.1 None identified.

Policy and Procedure for Making Experiences Count
Compliments, comments and complaints

PART 1 - POLICY

1. INTRODUCTION

1.1. This policy covers all compliments, comments and complaints about Herefordshire Council and NHS Herefordshire and Adult Social Care; it sets out how a compliment, comment or complaint will be dealt with, the timescales, and who should be involved in handling the complaint following the Making Experiences Count procedure. This policy covers all forms of customer feedback for health, adult social care, children and young people and all council services.

1.2. Complaints about NHS Herefordshire and Herefordshire Council will be handled by the Customer Insight Unit (CIU) within the corporate customer service team which will be the single point of contact for the customer. A CIU officer will agree a complaints handling plan with the customer, assign an investigating officer, assess risk, ensure that a fair investigation takes place either by a service manager or by a complaints manager, quality check all responses and communication with the customer. The CIU will carry out a full evaluation and monitor customer satisfaction, and ensure reports are made available to all service areas and service improvements are identified and made these will also be published twice a year as stipulated in the Customer Charter.

1.3. Complaints about Children's Services and Children's Social Care will be coordinated by the CIU but will be dealt with under a separate statutory procedure, which can be found in the procedure section of this document.

1.4. Complaints about schools will be managed by the school and they should be contacted directly in the first instance.

1.5. Complaints about services provided by the Wye Valley NHS Trust will be managed and responded to by Wye Valley NHS Trust, unless the complainant requests that the management of the complaint is undertaken by the CIU as part of the commissioning organisation.

1.6. Complaints about services provided by the 2gether Mental Health Foundation Trust will be managed and responded to by 2gether Mental Health Foundation Trust, unless the complainant requests that the management of the complaint is undertaken by the CIU as part of the commissioning organisation.

1.7. It is important that comments and compliments are recorded and used to understand what services customers would like to receive and how, as well as learning from compliments and making sure that best practice is recognised and used to improve services elsewhere.

1.8. The policy seeks to create a positive approach to complaints. Complaints are valued as a means to continuously review and improve the services we offer. By listening to customers and using insight into peoples experiences mistakes can be resolved faster, new ways to improve can be learned and the same problems can be prevented from happening in the future.

1.9. Our customers may find it difficult to talk about their views or concerns, they may be worried that complaining will lead to a reduction in services or care; equally they may find it difficult to speak out because of things like how their disability affects them, their language or their level of communication skills, or how their race cultural or religious background, age gender or sex are viewed. The CIU will ensure that all of these issues are taken into account and will provide a service that is fair and equitable, irrespective of an individual's needs, beliefs, age, sexual orientation or race.

2. OBJECTIVES

2.1 To provide an opportunity for customers to comment on our performance against our commitments laid down in the Herefordshire Council and NHS Herefordshire Customer Charter and to ensure we improve our performance where it is not meeting those commitments.

2.2 To provide an effective means for a customer to make a comment about how services could be improved in the future and to provide an effective means for a customer to compliment a service or employee.

2.3 To provide an effective means for customers and their representatives to complain if they are dissatisfied with the service they receive.

2.4 To ensure complaints are dealt with in a courteous and efficient manner and are resolved without avoidable delay.

2.5 To obtain information about the public's perceptions about our services, to inform future policy and service planning.

2.6 There are 6 overriding principles to good complaints handling that will be followed at all times:

1. Being customer focused
2. Getting it right
3. Acting fairly and proportionally
4. Being open and accountable
5. Putting things right
6. Improving services as a result

3. THE VALUE OF FEEDBACK

3.1 All forms of feedback will help us to:

- Understand what services people value and why;
- Share good practice;
- Make sure we learn and develop in a way which ensures we are providing a good service to customers and effects how we shape how services are delivered in the future;
- Recognise when our staff “go the extra mile”.

3.2 We believe that listening to our customers’ suggestions helps us to improve the way we provide services we welcome any suggestions about how we might do things differently or better, and are committed to taking seriously suggestions for service improvements.

3.3. Complaints give us valuable feedback in our continuing bid to develop high quality services and help to give customers confidence that they will be given a fair hearing within agreed timescales.

3.4 The CIU will receive all compliments and comments for recording and monitoring purposes.

3.5 The CIU should be notified of any informal complaints that have been resolved locally, or compliments received, so that they can be recorded and monitored. This will ensure we can share the outcomes and learning across HPS.

3.6 All formal complaints will be referred to the CIU to ensure that they are recorded, tracked and monitored; and that any learning can be shred across HPS.

4. WHAT IS A COMPLIMENT, COMMENT or COMPLAINT

4.1 A compliment, for the purpose of this policy, is defined as:

> *An expression of satisfaction about how well Herefordshire Council and NHS Herefordshire deliver services or how helpful an employee has been.*

4.2 A comment, for the purpose of this policy, is defined as:

An opinion on how Herefordshire Council and NHS Herefordshire could improve on the delivery of our services, or the service we commission.

4.3. A complaint, for the purpose of this policy, is defined as:

An expression of dissatisfaction, however made, about the standard of service, actions or lack of action by , Herefordshire Council and NHS Herefordshire our staff or contractors.

4.4 It is for the customer to decide whether or not to make a complaint. Any employee however should remember that reporting a fault or a problem is not necessarily a complaint, but may be simply a request for service. Some examples of complaints may be:

- we have not achieved the standard we say we will provide, or
- we have not provided the service to the standard which the customer/service user thinks is reasonable, or
- we are doing something which the customer did not want us to do, or
- we are carrying out our duties in an unsatisfactory way, or
- our staff or contractors are behaving in an unacceptable way (including rudeness, violence or aggression), or
- we fail to do something which we have been asked to do
- We fail to do something which the customer thinks we should have done, even if we were not actually asked to do it.

4.5 Generally speaking, a complaint has to be made within 12 months from the date on which the matter occurred, or the matter came to the notice of the complainant..

4.7 Specifically for NHS complaints, customers may choose to complain direct to the commissioner instead the organisation providing the service.

4.9 Where a complaint is made direct to the CIU about an organisation providing NHS or Adult Social Care services, the CIU will discuss with the complainant how the complaint will be handled. Decisions will be based on the complainant's wishes, but no information will be shared with the provider unless consent has been given by the complainant.

4.10 Where the CIU decides to manage the complaint, they wil notify the complainant and the provider.

4.11 If the CIU decides it is more appropriate for the complaint to be handled by the provider organisation, with the consent of the complainant it will:

- Notify the provider and the complainant
- When the provider receives the notification
  - the provider must handle the complaint in accordance within the Making Experience Count regulations, and
  - the complainant is deemed to have made the complaint to the provider
  - the CIU should be informed of the outcome

4.12 Where the complainant wishes the CIU to investigate the complaint this will be commenced in conjunction with the provider once consent has been received from the

complainant to share the information. The provider must have the opportunity to respond to the complainant**.** Once the investigation is complete, the CIU will inform the complainant of the outcomes.

4.13 Where the services are provided by NHS Herefordshire or Herefordshire Council, the complaint must be managed by the CIU

5. COMMENTS, COMPLIMENTS AND COMPLAINTS NOT COVERED BY THIS POLICY AND PROCEDURE

5.1. Internal comments, complaints and compliments are not covered by this policy and procedure.

5.2 Complaints that employees may have about Herefordshire Council or NHS Herefordshire as an employer should be made through the grievance procedure, or other internal channels. However, members of staff have the same rights to raise comments, complaints or compliments about our actions or services as other residents or members of the public.

5.3 The following are covered by different procedures and are exemptions to the complaints policy and procedure, so we may not accept these types of complaints.

- Comments, complaints or compliments from organisations that we commission where the issue is about their funding or related.
- Complaints about schools;
- From employees about issues relating to their employment.
- From councillors, unless they are complaining as ordinary members of the public or as an 'advocate', (representing the interests of someone else).
- Where legal limits are in place, for example:

    - refusing planning permission;
    - cases covered by our insurance procedures;
    - about parking and traffic offences;
    - about refusing to issue disabled badges for parking exemption;
    - about responses to Freedom of Information Act enquiries;
    - where the complaint has already been dealt with in another way.

6. SUPPORT AND ADVOCACY

6.1 All customers who receive service from Herefordshire Council and NHS Herefordshire, and those who feel they ought to, will have access to information about how to compliment, make a comment or complain about that service with appropriate support.

6.2 The Customer Service Unit and Patient Advice and Liaison Service can provide valuable advice and support to people who use services, and their representatives, this can include information about the NHS, social care and other council services and information on how to complain and how to access independent help or advice.

6.3 For NHS complaints an advocacy service is provided by the independent Complaints Advocacy Service (ICAS).

6.5. If our customers feel or appear to be at any sort of disadvantage in being able to express themselves, we will offer them the help and support they need to have their concerns listened to and understood. This may include translation or interpretation services, or referral to sources of local independent advocacy and advice. Advocacy for Children will be made available via the Children's and Young People Department when required.

6.6. Anonymous complaints will be investigated and may be acted upon at our discretion. Should the complainant fear that we will withhold services or care, or treat them less favourably if they complain openly, we will, if required, assist in finding support outside the service.

7. RIGHTS

7.1 Customers have the right

- to be treated with dignity and respect
- to confidentiality (if an investigation cannot proceed without the complainant being identified, the complainant will be given the option whether or not to continue)
- to have any complaint dealt with efficiently and have it properly investigated within agreed timescales and to be updated and consulted if those timescales need to change
- to be offered a face to face meeting to go through the detail of the complaint whenever appropriate
- to know the outcome of any investigation into their complaint
- to be kept informed of the progress of their complaints
- to receive an apology if a complaint is upheld
- to be informed of any changes to our policies or procedures arising from a complaint o suggestion
- To take their complaint to The Parliamentary and Health Service Ombudsman or the Local Government Ombudsman if they are not satisfied with the way their complaint has been dealt with.
- to make a claim for judicial review if you think you've been directly affected by an unlawful act or decision of an NHS body, and to receive compensation if you've been harmed

7.2. This complaints policy does not affect the right of an individual or organisation to approach a local councillor or Member of Parliament for advice or assistance. If this results in a complaint being made by or on behalf of an individual, it will be dealt with using this procedure.

7.3. Our staff have the right to be treated with respect and courtesy and to be spoken to without the use of abusive language at all times by both customers and other staff.

7.4 Where a complaint forms part of, or relates to any legal action being undertaken we reserve the right to delay or suspend investigation of the complaint if it could have an impact on the legal process.

8. Confidentiality

8.1 All customer information, whether held on paper, computer, visually or audio recorded, or held in the memory of the professional, must not normally be disclosed without the consent of the customer. It is irrelevant how old the customer is or what the state of their mental heath is; the duty still applies.

8.2 There are three circumstances making disclosure of confidential information lawful:

- where the individual to whom the information relates has consented
- where disclosure is in the public interest
- where there is a legal duty to do so, for example: a court order, or safeguarding concern.

8.3 The Data Protection Act makes it an offence for third parties to obtain personal data without authorisation.

In communications with other parties employees should take reasonable steps to ensure that consent is given by the individual concerned. In many cases this might be implied e.g. a MP letter on behalf of a constituent. However, if there is any doubt whether consent has been given then explicit approval should be requested, particularly where the information is of a very sensitive nature.

8.4 Herefordshire Council and NHS Herefordshire and will take care at all times throughout the complaints procedure to ensure that any information disclosed about the customer is confined to that which is relevant to the investigation of the complaint, and is only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint.

8.5 Herefordshire Council and NHS Herefordshire recognises that it is good practice to explain to the customer that information from his/her health records may need to be disclosed to certain people involved in the stages of complaints procedure (Investigating Officer, Chief Executive, , Health Service Ombudsman).

8.6 Customers will be made aware of the effect it will have on the investigation if they object to their information being disclosed, but the wishes of the customer will be respected, unless there is overriding public interest in continuing the investigation.

9. RISK MANAGEMENT

9.1 One of the key aims of this policy and procedure is to minimise risk to safety and enhance the quality of services and care provided to customers. This policy therefore is a

crucial part of the overall strategy and approach to the management and minimisation of risks identified or arising from comments, compliments, or complaints.

9.2 Specific risks related to the application of this policy and procedures are:

- Delay or failure to respond appropriately to complaints or concerns in accordance with regulations, leaving the organisation open to potential action by the Parliamentary and Health Service or Local Government Ombudsman;
- Not addressing concerns raised resulting in loss of public confidence;
- Failing to identify risk or safety issues and address or reduce them;
- Failing to identify trends or recurrent themes identified from comments and complaints and other forms of service user feedback;
- Failing to build on areas of good practice identified from compliments;
- The need for confidentiality vs the requirement to refer Safeguarding concerns appropriately.

9.3 In accordance with risk management procedures, all complaints will be graded according to the seriousness of the risk. The grading system will consider the severity or impact of risk identified within the complaint and the likelihood of this occurring in the future producing an assessment of low, medium, high to significant risk. Any risk identified will be managed in accordance with risk management procedures. All risks identified will be placed onto the risk register.

10. COMPLAINTS AGAINST STAFF

10.1. If a complaint regarding staff actions or behaviour is found to be valid, then the issue will be referred to the appropriate corporate human resource policy/procedure such as the disciplinary procedure and investigated. This will be regarded as an outcome for the complaints procedure.

11 STAFF AWARENESS AND TRAINING

11.1 All employees will have information about customer feedback at central induction courses.

11.2 The CIU will provide training to employees on how to deal with complaints, comments and compliments.

12 MONITORING, EVALUATION AND REPORTING

12.3 The CIU will keep a record of all complaints, including dates received, acknowledged, responded, category of complaint, actions taken and lessons learned. We will separately monitor complainant profiles in accordance with key equalities criteria.

12.4 All complaints, comments and compliments will be recorded on a single system (CRM) for tracking and monitoring and reporting purposes.

12.5 Regular reports will be sent to service areas and senior management indicating numbers of complaints and compliments received, how many are dealt with within the agreed timescale, what service improvements and changes have been made as an outcome to complaints received.

13 HANDLING UNREASONABLE COMPLAINTS

13.1 We operate a zero tolerance policy with regards to physical, verbal or written abuse towards our staff.

13.2 Where, despite best efforts to resolve a complaint, the complainant becomes abusive, unreasonable or vexatious, staff will follow the separate policy for dealing with unreasonable complainant behaviour.

13.3 Where a complaint is deemed vexatious, they will be informed of the decision in writing and given clear information about how they should contact HPS in the future

PART 2 - PROCEDURE

A) To be followed for all Health Adult Social Care and Council Complaints, Comments and Compliments

Anyone who wishes to make a complaint may do so in person, by telephone, or in writing (by using a complaints form, letter, fax or e-mail.) Complaints should normally be sent to the CIU, but if they are received directly into any service area covered by this policy they will be redirected to the CIU immediately. Any member of staff should be able to accept a complaint, comment or compliment.

On receipt of a verbal complaint, or where I written complaint is passed on in person, the customer should be advised that it will be sent to the CIU who will contact them to arrange how the complaint will be managed

Complaints in person can be made by calling at any of our Customer Services Centres or other offices/sites. Complainants do not need to call at the place responsible for the service about which they are complaining.

Once received, we will acknowledge any complaint within three working days.

All complaints should be referred to the CIU, even where they have been resolved immediately through local action.

1 COMPLIMENTS

If a compliment relating to service delivery is received by any employee, then the individual should forward details of the compliment to the CIU for recording (and response if required) within 1 working day of receipt.

2 COMMENTS

Where a comment is received by any member of staff, details of the comment should be sent by the employee who received it to the CIU for recording and response, within 1 working day of receipt.

3 INFORMAL COMPLAINTS

If a complaint/feedback/concern is received by any employee and they can resolve the issue, all efforts should be made to resolve the issue within one working day. The employee should record the appropriate details on ‘informal complaint form’ (to be found on intranet) or directly onto the CRM case management system (if you work in customer services) and send to the CIU. **N.B. if an issue is resolved within 24 hours it does not need to be referred, or recorded as a formal complaint.**

If the informal complaint is not resolved within 1 working day it should be sent to the Customer Insight Unit and will become a formal complaint.

4 FORMAL COMPLAINTS

4.1 Where a formal, serious or complex complaint, is received by an employee other than CIU staff, the employee should report the complaint to CIU immediately, ensuring that all the relevant details are recorded on the formal complaints form.

4.2 The CIU will send a written acknowledgement to the complainant within 3 working days of receipt into the Council or NHS, with an offer to discuss the complaint over the telephone, or in person to identify and agree clearly the points for investigation and the complainant's desired outcomes.

4.3 The CIU will ensure that appropriate consent is gained to undertake and investigation and share the complainants details with relevant parties. In addition authorisation from the person who is the subject of the complaint must be gained if a third party is acting on their behalf.

4.4 The CIU will undertake a risk assessment of the complaint. This may involve the CIU liaising with other departments to fully understand the associated risks. Complaints rated as a High risk will be escalated to the appropriate senior manager immediately. Complaints rated as Medium will be discussed with the CIU manager within 48 hours.

4.5 Where necessary a CIU officer will meet/speak with the complainant agree a complaint handling plan for investigation and response. Where complaints involve a simple investigation and response, the acknowledgement letter from the CIU will outline the proposed action and this will be the complaints handling plan.

4.6 If the complaint involves cross service issues the CIU will liaise with the other areas to agree co-ordinated plan.

4.7 The complaint handling plan will be recorded for future reference and a copy will be sent to the complainant.

4.8 The CIU will then liaise with the appropriate department to identify and appropriate investigating officer. This could be a CIU officer, manager or director where appropriate.

4.9 The investigating officer will undertake an investigation in line with the timescale agreed with complainant and recorded in complaint handling plan.

4.10 The CIU maintains contact with the complainant to give advice on progress at regular intervals.

4.11 The investigating officer will provide draft response and the results of the investigation to the CIU at least 3 working days before deadline.

4.12 The CIU will review the response and outcome before providing a formal response to the complainant. This may involve the CIU requesting further clarification or additional information from the investigating officer or the service involved. CIU officers will not send out a response to the complainant until they are satisfied that and appropriate investigation has been undertaken and that proportionate actions and learning have been identified. Where the CIU officer can not gain assurance that an appropriate investigation has been undertaken and that proportionate actions and learning have been identified the matter will be escalated to the CIU manager or assistant director to take the necessary action to find a resolution.

4.13 Complainants will be advised at this stage that they will have 10 working days to respond if they remain dissatisfied with the outcome.

4.14 If there is no further communication after the specified 10 working days is received the CIU will write to complainant to advise that the matter now closed. A complaint handling survey will be enclosed.

4.15 If the complainant is dissatisfied with the response, the CIU will review the complaint in light of any ongoing issues. This may involve a further investigation and/or a meeting with the complainant and the relevant representative(s) from the service(s) involved.

4.16 We will make every effort to resolve customers complaints and ensure that there are investigated fully and fairly. In each response we will provide the complainant with details of the Health Service Ombudsman or the Local Government Ombudsman should they wish to refer the issue.

4.17 Where we have investigated and taken all available actions and the complaint remains unresolved, we will write to advise the complainant that as a result the case will be closed and clarify what options of further redress are available to them.

4.18 The CIU will monitor action plans resulting from complaints to ensure they are implemented. The action and learning resulting from complaints will be reported to the Herefordshire Public Services Leadership Committee, directors and the relevant senior managers.

(see Diagram 1)

5 THE OMBUDSMAN

5.1 If the complaint is unable to be resolved, or a person is not satisfied with the handling of the complaint (at any stage), they will be referred to the Health or Local Government Ombudsman to review the matter.

5.2 For monitoring purposes, the customer insight staff will log the date of receipt by the Council of the LGO request and the date the information is returned to the LGO.

5.3 The CIU will liaise with the Health or Local Government Ombudsman to ensure any information they require is delivered within the agreed time scales.

5.4 Where the Health or Local Government Ombudsman uphold a complaint the CIU will undertake a Root Cause Analysis review to identify what HPS could have done differently to resolve the complaint and will adapt complaints handling policy and practice where necessary.

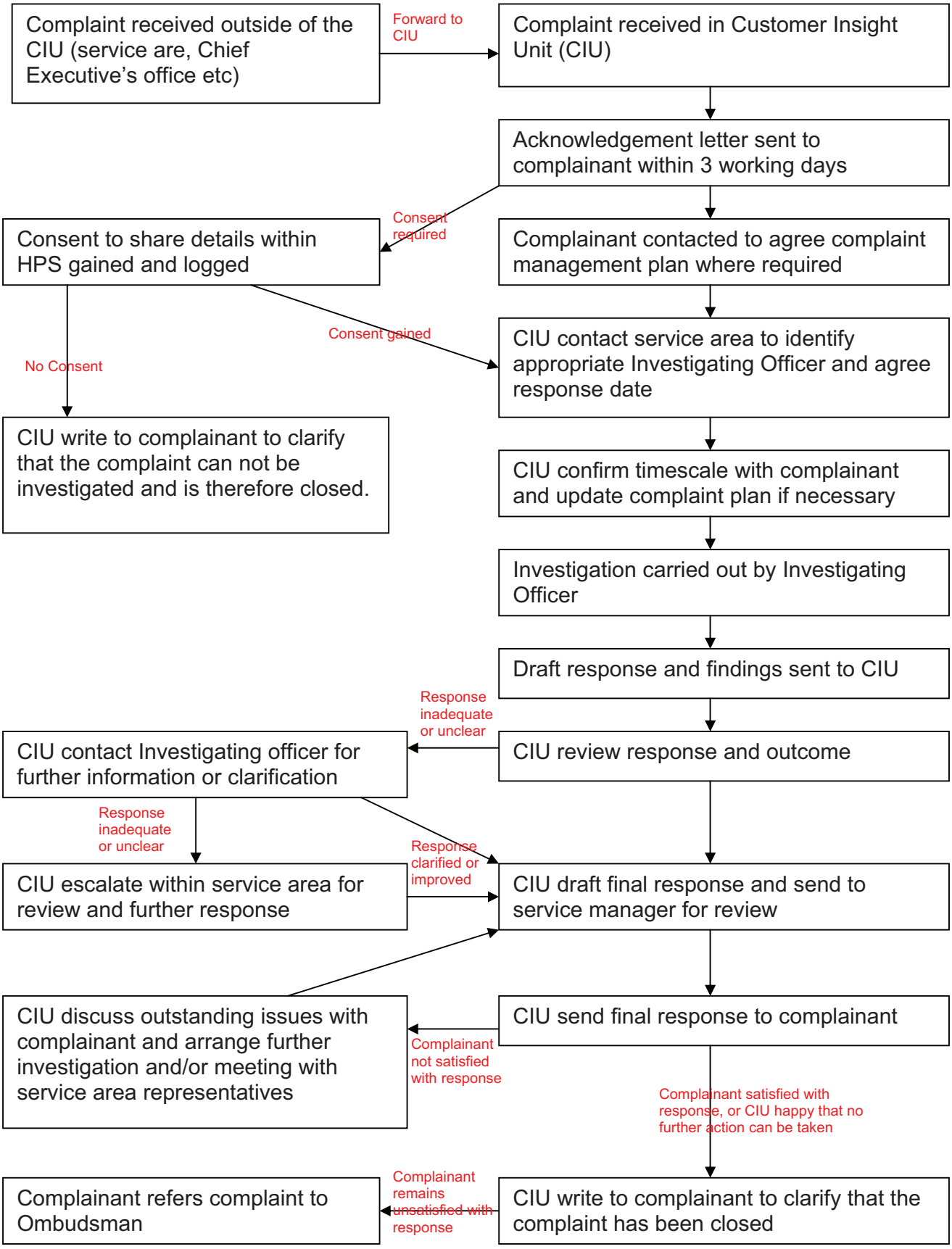
5.6 Where the Health or Local Government Ombudsman uphold a complaint the CIU will forward the outcome to the relevant senior manage and director to agree the actions to be taken by HPS. Once agreed the actions taken as a result of the ruling will be communicated to the relevant ombudsman and the complainant.

6 WITHDRAWAL OF A COMPLAINT

6.1 The complaint may be withdrawn verbally or in writing at any time by the complainant. The CIU must write to the complainant to confirm the withdrawal of the complaint. In these circumstances, it would also be good practice for the local authority to decide on whether or not it wishes to continue considering the issues that gave rise to the complaint through an internal management review. The local authority should then use this work to consider the need for any subsequent actions in the services it delivers.

Should the complainant then seek to reinstate the complaint, the local authority could use the review to produce a response as necessary.

Flow chart for Making Experiences Count Diagram 1



B. CHILDREN'S SOCIAL CARE COMPLAINTS AND REPRESENTATIONS FOR CHILDREN, YOUNG PEOPLE AND OTHERS

COMPLAINTS

Any child or Young Person who wishes to make a complaint may do so in person, by telephone, or in writing (by using the child friendly form, letter, or e-mail.) Complaints should normally be sent to the CIU, but if they are received directly into any service area covered by this policy they will be redirected to the CIU immediately for acknowledgement and tracking. Any member of staff should be able to accept a complaint, comment or compliment.

On receipt of a verbal complaint, or where I written complaint is passed on in person, the customer should be advised that it will be sent to the CIU who will contact them to arrange how the complaint will be managed

Complaints in person can be made by calling at any of our Customer Services Centres or other offices/sites. Complainants do not need to call at the place responsible for the service about which they are complaining.

Once received, we will acknowledge any complaint within three working days.

All complaints should be referred to the CIU, even where they have been resolved immediately through local action.

COMPLIMENTS

If a compliment relating to service delivery is received by any employee, then the individual should forward details of the compliment to the CIU for recording (and response if required) within 1 working day of receipt.

COMMENTS

A comment is received by any member of staff. Details of the comment should be sent by the employee who received it to the CIU for recording and response. within 1 working day of receipt.

1. COMPLAINT STAGE 1 – LOCAL RESOLUTION

1. 1 A complaint is made on the date on which it is first received by the local authority.

1.2 The expectation is that the majority of complaints should be considered (and resolved) at Stage 1. However, if the local authority or the complainant believes that it would not be appropriate to consider the complaint at Stage 1, they should discuss this together. Where both parties agree, the complaint can move directly to Stage 2.

1.3 The CIU will undertake a risk assessment of the complaint. This may involve the CIU liaising with other departments to fully understand the associated risks. Complaints rated as a High risk will be escalated to the appropriate senior manager immediately. Complaints rated as Medium will be discussed with the CIU manager within 48 hours.

1.4 The complaint will be acknowledged within 3 days of receipt and officially recorded by the CIU. They will act as the single point of contact for the child or young person. The CIU will liaise with the Children's and Young Peoples Directorate to establish the most appropriate independent reviewing officer.

1.5 At Stage 1, staff at the point of service delivery – including the Independent Reviewing Officer where appropriate – and the child or young person should discuss and attempt to address the complaint as quickly as possible. This will be coordinated by the CIU. They should discuss the issue and exchange information and thinking behind decisions and try to agree a way forward.

1.6 Regulation 14(1) places a 10 working day time limit for this part of the process. Most Stage 1 complaints should ideally be concluded within this time limit.

1.7 Where the local authority cannot provide a complete response it can implement a further 10 days' extension (regulation 14(5)). If necessary, the local authority may also suspend Stage 1 until an advocate has been appointed (regulation 14(3)). The maximum amount of time that Stage 1 should take is 20 working days. After this deadline the complainant can request consideration at Stage 2 if they wish.

1.8 The CIU will inform the complainant that they have the right to move on to Stage 2 if the time scale has elapsed for Stage 1 and the complainant has not received an outcome. It may be that the complainant is happy to put this off for the time being (for example, if the reason that resolution is delayed due to a key person being off sick or on leave), so this period can be extended with the complainant's agreement or request.

1.9 If the matter is resolved, the CIU must write to the complainant confirming the agreed resolution and the relevant Children's and Young Peoples Directorate manager should be informed of the outcome as soon as possible. Otherwise, a letter should be sent by the CIU to the complainant (or a meeting offered, if this is more appropriate) responding to the complaint.

1.10 Where the matter is not resolved locally, the complainant has the right to request consideration of the complaint at Stage 2. There is no time-limit within which they must request this, but CIU may wish to recommend that the complainant does this within 20 working days so that momentum in resolving the complaint is not lost. The local authority is under a duty to operate expeditiously throughout the complaints handling process (regulation 10).

(see Diagram 2)

2. COMPLAINT STAGE 2

2.1 If the complainant wishes to have their complaint investigated further they should contact the CIU to request this.

2.2 Consideration of complaints at Stage 2 is normally achieved through an investigation conducted by an investigating officer and an independent person. Stage 2 commences either when the complainant requests it or where the complainant and the local authority have agreed that Stage 1 is not appropriate (regulation 17(1)).

2.3 If the complaint has been submitted orally, the CIU must ensure that the details of the complaint and the complainant's desired outcome are recorded in writing and agreed with the complainant on a complaints handling plan. This may be achieved either by correspondence or by meeting the complainant to discuss, followed by a written record of what was agreed. The CIU may wish to do this in conjunction with the Investigating Officer and Independent Person appointed to conduct Stage 2 (see below). Should the complainant amend the written record of his complaint, the Stage 2 timescale will start from the date that the complaint is finalised.

2.4 The CIU should request that the Children's and Young Peoples Directorate should arrange for a full and considered investigation of the complaint to take place without delay. They may also request (in writing) any person or body to produce information or documents to facilitate investigation, and consideration should be given to matters of disclosure and confidentiality. Consideration of the complaint at Stage 2 should be fair, thorough and transparent with clear and logical outcomes.

2.5 The CIU should ensure that the authority appoints an Investigating Officer (IO) to lead the investigation of the complaint and prepare a written report for adjudication by a senior manager. The IO may be employed by the local authority or be brought in from outside the authority, appointed specifically for this piece of work. The IO should not, however, be in direct line management of the service or person about whom the complaint is being made.

2.6 An Independent Person (IP) must be appointed to the investigation (regulation 17(2)) (see Annex 1 on Definition of Roles). This person should be in addition to the IO and must be involved in all aspects of consideration of the complaint including any discussions in the authority about the action to be taken in relation to the child.

2.7 A copy of the complaint should be sent to any person who is involved in the complaint, unless doing so would prejudice the consideration of the complaint. Where this may be the case, the CIU should advise senior management, who should inform staff of the details of the complaint through normal line management.

2.8 The IO should have access to all relevant records and staff. These should be released within the bounds of normal confidentiality and with regard to relevant legislation in the Freedom of Information Act, 2000 and the Data Protection Act, 1998.

2.9 The investigation should be completed and the response sent to the child or young person from the CIU within 25 working days (regulation 17(3)). However, this may be

impractical in some cases, e.g. where the complaint involves several agencies, all or some of the matters are the subject of a concurrent investigation (such as a disciplinary process), if the complaint is particularly complicated or if a key witness is unavailable for part of the time.

2.10 Where it is not possible to complete the investigation within 25 working days, Stage 2 may be extended to a maximum of 65 working days (regulation 17(6)). All extensions should be agreed by the CIU and communicated to the complainant. The important thing is to maintain dialogue with the complainant and where possible reach a mutual agreement as to what is reasonable where a response in 25 working days is not feasible.

2.11 The CIU must inform the child or young person as soon as possible in writing of:

- the reason for the delay; and
- the date by which he should receive a response (regulation 17(6)).

2.12 Where one or more agencies are involved in considering the complaint, it would be good practice for these bodies to aim for whichever is the shorter of the timescales to produce their final responses.

3 STAGE 2 INVESTIGATION REPORT

3.1 On completion of his consideration of the complaint, the IO should write a report on his investigations including:

- details of findings, conclusions and outcomes are against each point of complaint (i.e. “upheld” or “not upheld”; and
- recommendations on how to remedy any injustice to the complainant as appropriate.

The report should be written in plain language, avoiding jargon, so that everyone can understand it. It should distinguish between fact, feelings and opinion.

Good practice suggests that the IP should also provide a report to the local authority once he has read the IO’s final report. He may wish to comment on:

- whether he thinks the investigation has been conducted entirely in an impartial, comprehensive and effective manner;
- whether all those concerned have been able to express their views fully and fairly;
- whether the IO’s report provides an accurate and complete picture of the investigation; and
- the nature of the recommendations or make his own recommendations as necessary.

(See Diagram 3)

4 THE ADJUDICATION PROCESS

4.1 Once the IO has finished the report, a senior manager should act as Adjudicating Officer

and consider the complaints, the IO's findings, conclusions, and recommendations, any report from the IP and the complainant's desired outcomes.

4.2 The purpose of adjudication is for the local authority to consider the reports and identify:

- its response;
- its decision on each point of complaint; and
- any action to be taken (with timescales for implementation).

4.3 The Adjudicating Officer should normally be a senior manager, reporting to the Director responsible for Children's Services. The Adjudicating Officer will prepare a response to the reports, with his decision on the complaint, actions he will be taking with timescales for implementation – this is the adjudication.

4.4 The Adjudicating Officer may wish to meet the Complaints Manager, IO and IP, to clarify any aspects of the reports. The Adjudicating Officer should also consider liaising with the Complaints Manager in drafting the adjudication.

4.5 The Adjudicating Officer may wish to meet the child or young person as part of the adjudication process or afterwards to explain the details of the adjudication i.e. the outcome of the complaint and any actions that he proposes.

4.6 The CIU should then write to the complainant with their response containing:

- a complete copy of the investigation report;
- any report from the IP; and
- the adjudication.

This response must contain details of the complainant's right to have the complaint submitted to a Review Panel if they are dissatisfied and that the complainant has 20 working days to make this request to the CIU (regulation 17(8).

4.7 The Adjudicating Officer should ensure that any recommendations contained in the response are implemented. The CIU should monitor implementation and report to the Director on what action has been taken, on a regular basis.

5 STAGE 3 – REVIEW PANELS

5.1 Where Stage 2 of the complaints procedure has been concluded and the complainant is still dissatisfied, they will be eligible to request further consideration of the complaint by a Review Panel (regulation 18). This request should be made to the CIU. As it is not possible to review a complaint that has not yet been fully considered at Stage 2 (including providing the report(s) and adjudication to the complainant), it is essential that the local authority does not unnecessarily delay the conclusion of Stage 2.

5.2 Further consideration of the complaint can include, in a limited number of cases, early referral to the Local Government Ombudsman. Otherwise, the complainant retains the right

to proceed to a Review Panel.

5.3 The CIU will assess requests for the Review Panel as they are presented on a case by case basis. The Complaints Manager should also confer with the Chair, following the Chair's appointment, regarding arrangements for the Panel.

(See Diagram 4)

6 PURPOSE OF REVIEW PANELS

6.1 Review Panels are designed to:

- listen to all parties;
- consider the adequacy of the Stage 2 investigation;
- obtain any further information and advice that may help resolve the complaint to all parties' satisfaction;
- focus on achieving resolution for the complainant by addressing his clearly defined complaints and desired outcomes;
- reach findings on each of the complaints being reviewed;
- make recommendations that provide practical remedies and creative solutions to complex situations;
- support local solutions where the opportunity for resolution between the complainant and the local authority exists;
- to identify any consequent injustice to the complainant where complaints are upheld, and to recommend appropriate redress; and
- recommend any service improvements for action by the authority.

6.2 As a general rule, the Review Panel should not reinvestigate the complaints, nor should it be able to consider any substantively new complaints that have not been first considered at Stage 2.

6.3 Ideally, no party should feel the need to be represented by lawyers at the Review Panel. The purpose of the Panel is to consider the complaint and wherever possible, work towards a resolution. It is not a quasi-judicial process and the presence of lawyers can work against the spirit of openness and problem-solving. However, the complainant has the right to bring a representative to speak on his behalf.

7 GENERAL PRINCIPLES

7.1 The Review Panel should be alert to the importance of providing a demonstrably fair and accessible process for all participants. Many complainants, particularly children and young people, may find this stage to be a stressful experience. It is important that the Panel is customer-focused in its approach to considering the complaint and child or young person-friendly. This may include limiting the total number of local authority representatives attending to a workable minimum to avoid the possibility of overwhelming the complainant.

7.2 In particular, the following principles should be observed for the conduct of the panel:

- The local authority should recognise the independence of the Review Panel and in particular, the authority of the Chair;
- Panels should be conducted in the presence of all the relevant parties with equity of access and representation for the complainant and local authority;
- Panels should uphold a commitment to objectivity, impartiality and fairness, and ensure that the rights of complainants and all other attendees are respected at all times;
- The local authority should consider what provisions to make for complainants, including any special communication or mobility needs or other assistance;
- Panels should observe the requirements of the Human Rights Act 1998, the Data Protection Act 1998, and other relevant rights-based legislation and conventions in the discharge of their duties and responsibilities;
- The standard of proof applied by Panels should be the civil standard of 'balance of probabilities' and not the criminal standard of 'beyond all reasonable doubt.' This standard will be based on evidence and facts; and
- It will be at the Chair's discretion to suspend or defer proceedings in exceptional circumstances where required, including the health and safety of all present.

7.3 The local authority should be mindful of the specific needs of children and young people either using or affected by complaints. Local authorities should ensure that:

- the Review Panel acts in accordance with the United Nations Convention on the Rights of the Child;
- the Review Panel safeguards and promotes the rights and welfare of the child or young person concerned;
- the wishes and feelings of such children and young people are ascertained, recorded and taken into account;
- the best interests of such child or young person are prioritised at all times; and
- where the complaint is made by a person deemed to have a sufficient interest in the child's welfare, they should where appropriate, seek the child or young person's views with regard to the complaint.

8 REDRESS

8.1 Under Section 92 of the Local Government Act 2000, local authorities are empowered to remedy any injustice arising from maladministration. Further details on remedies and redress are discussed in section 6.2.

8.2 The Review Panel must set out its recommendations to the local authority on any strategies that can assist in resolving the complaint. These may include financial compensation or other action within a specified framework to promote resolution.

9 MAKE UP OF THE PANEL

9.1 The Panel must consist of three independent people (regulation 19(2)). Independent means a person who is neither a member nor an officer of the local authority to which the representations have been made, nor the spouse or civil partner of such a person. The Independent Person appointed to Stage 2 may not be a member of the Panel (regulation 19(3)).

9.2 In selecting the Panel the local authority should consider:

- the profile of the local population;
- how best to demonstrate independence of the procedure;
- the needs and circumstances of the individual complainant and the need for specialist skills, knowledge, or awareness regarding the presenting complaint;
- any real or perceived conflict of interest raised by either the substance of the complaint or the Panel process for considering that complaint; and
- due care regarding political sensitivity.

9.3 One member of the Panel should be assigned as Chair of the panel. The Chair's role is described in Annex 1. Good practice suggests that the person appointed as Chair should not have been an officer or a Member of the local authority during the three years preceding the Panel.

9.4 In order that the Chair may contribute to the organisation of the panel, the Complaints Manager should appoint the Chair first – ideally within ten working days of the complainant's request to proceed to Stage 3 – before identifying other panel members.

10 ADMINISTRATION OF THE PANEL

10.1 The local authority will:

- Confirm references, Criminal Records Bureau referrals, confidentiality and disclosure protocols, declarations of interest, and provide other support as required;
- Provide Panellists with a letter of appointment explaining the Review Panel process, their role as a Panellist and describing the expenses and other payment to which they may be entitled. Attention should also be drawn to important issues such as confidentiality;
- Reimburse Investigating Officers, Independent Persons and any other external people involved in the earlier stages for their attendance at the Panel, as appropriate;
- Provide complainants with information on attending the Panel and assistance that they can draw on; and
- Facilitate the administrative support and advisory functions on the day of the Panel.

10.2 The Panel must be held within 30 working days of the receipt of a request for a Review (regulation 19(4)). The local authority should acknowledge the complainant's request for a Review in writing within 2 days of receiving it. The Panel Review should be provided locally and with due regard to the complainant's availability and convenience. The complainant should be notified of the Panel's date and location in writing at least 10 working days before

the Review Panel meets and be invited to attend.

10.3 Panel papers should be sent to panellists and other attendees as soon as these have been agreed by the Chair and no later than ten working days before the date of the Panel. These should normally include: information on Stage 1 (as relevant), the Stage 2 investigation report(s), the local authority's adjudication, any policy, practice or guidance information relevant to the complaint, and any comments that the complainant has submitted to the Panel. The papers should also include information on any local practice around Panels, such as conduct, roles and responsibilities.

10.4 If any other written material is submitted for consideration by the panel outside of these timescales, it will usually be at the Chair's discretion whether it is accepted.

10.5 If any complaint is logged on the day by the complainant about the proceedings, the local authority should record it and the Panel should take a view on the need for further action and should record their decision.

11 ATTENDANCE AT THE PANEL

11.1 The complainant has a right to attend the Panel and should be assisted in attending as appropriate. The complainant should also be informed of his entitlement to be accompanied by another person and for this person to speak on his behalf.

11.2 Those persons involved with the investigation at Stage 2 (e.g. the Investigating Officer, and the Independent Person) should be invited to attend and contribute as relevant to their roles. Should any of these persons' unavailability cause an inordinate delay in holding the Panel; the Chair should take a view on proceeding without them. The local authority can also proceed with the Panel in the complainant's absence at the complainant's request.

11.3 The Adjudicating Officer should attend as the authority's representative if he has rejected any of the Investigating Officers findings at Stage 2. Where he has accepted all of them, it is usually acceptable to delegate this responsibility.

11.4 The Chair should make the final decision on attendees (including asking the local authority to make specific members of staff available to provide specialist advice or opinion). He should also decide whether additional policies or procedures should be circulated with the Panel's papers.

11.5 The Complaints Manager and anyone providing administrative support should also attend the Panel.

12 CONDUCT OF THE PANEL

12.1 The Panel should be conducted as informally as possible, but in a professional manner and in an atmosphere that is accommodating to all attendees. This is particularly important where the complainant might be a child or young person. The need for other support in response to diversity and disability issues should be catered for, including (but not limited to)

provision for sensory impairment, translation and interpretation.

12.2 Panels should normally be structured in three parts: pre-meeting; presentations and deliberation.

12 PRE-MEETING

12.1 This is an opportunity for the Panellists and their administrative support to meet in closed session to discuss the order of business and any other relevant issues (e.g. taking legal advice). No deliberations on the complaint should commence at this meeting.

13 PRESENTATIONS

13.1 Once all attendees are present, the Chair should commence the Review by explaining its purpose and the need for confidentiality. The Chair should advise the complainant of the respective roles and responsibilities of those present and address any questions or concerns that the complainant may have about the process.

13.2 The Chair should ensure that the Panel's focus is on the agreed complaint and the complainant's desired outcomes from the Stage 2 investigation. The purpose of hearing the presentations is to understand each party's opinion of the complaint rather than an opportunity to cross-examine attendees. The Chair should also indicate how long the Panellists anticipate that the presentations should last.

13.3 The full Panel meeting should begin with presentations on the points of complaint and desired outcomes by the complainant and the local authority. Normally, the first presentation should be by the complainant (or advocate/representative) who should be invited to 'talk' to the complaint and expand upon any relevant themes that should aid the Panel's deliberation. The Chair should ensure that this presentation is reasonable and relevant, exercising discretion in limiting its scope, substance or duration.

13.4 Panellists should then have sufficient opportunity to ask questions of all present and seek clarification on the issues being discussed so they are in a position to make recommendations regarding the outcome. The Chair should also invite the complainant, the local authority and other attendees to ask questions and raise points of information and opinion as relevant to the complaint.

14 DELIBERATIONS

14.1 The Panel should then go into closed session to deliberate on their findings and conclusions. The Panel may need administrative support at this stage, but this should not unduly influence the Panel's deliberations and no conflict of interest should arise.

14.2 The Panel is required to produce a written report containing a brief summary of the representations and their recommendations for resolution of the issues (regulation 20(1)). They must send this to the complainant, the local authority, the independent person from Stage 2 and any other person with sufficient interest within 5 working days of the Panel

meeting (regulation 20(2)). The written record should set out simply and clearly a brief summary of the representations; their recommendations for the resolution of the issues and the reasons for them. If a Panellist disagrees with the majority recommendation, this should also be recorded and the reason for it given.

15 AFTER THE PANEL

15.1 The local authority must send its response to the Panel's recommendations via the CIU to the complainant (and other participants as necessary) within 15 days of receiving the Panel's report (regulation 20(3)). The response should be developed by the relevant Director / Director of Children's Services setting out how the local authority will respond to the recommendations and what action will be taken. If the Director deviates from the Panel's recommendations he should demonstrate his reasoning in the response. In developing his response he should invite comment from all the attendees including the Independent Person from Stage 2 (regulation 20(3)).

15.2 The complainant should be advised of his right to refer his complaints (if still dissatisfied) to the Local Government Ombudsman (regulation 20(3)).

15.3 Summary of stage 3 timescales

Action	**Time**
Complainant requests Review Panel	Up to 20 working days after receipt of the Stage 2 adjudication
CIU acknowledges request	Within 2 working days
CIU appoints Chair and confirms attendees and content of Panel papers with Chair	Within 10 working days of the complainant's request for Review Panel
Local authority agrees the other Panellists and date for Review Panel	Within 30 working days of the complainant's request for Review Panel
Local authority circulates Panel papers	Within 10 working days of the date for the Review Panel
Review Panel produces its written report (including any recommendations)	Within 5 working days of the Review Panel
Relevant Director issues his response	Within 15 working days of receiving the Review Panel's report

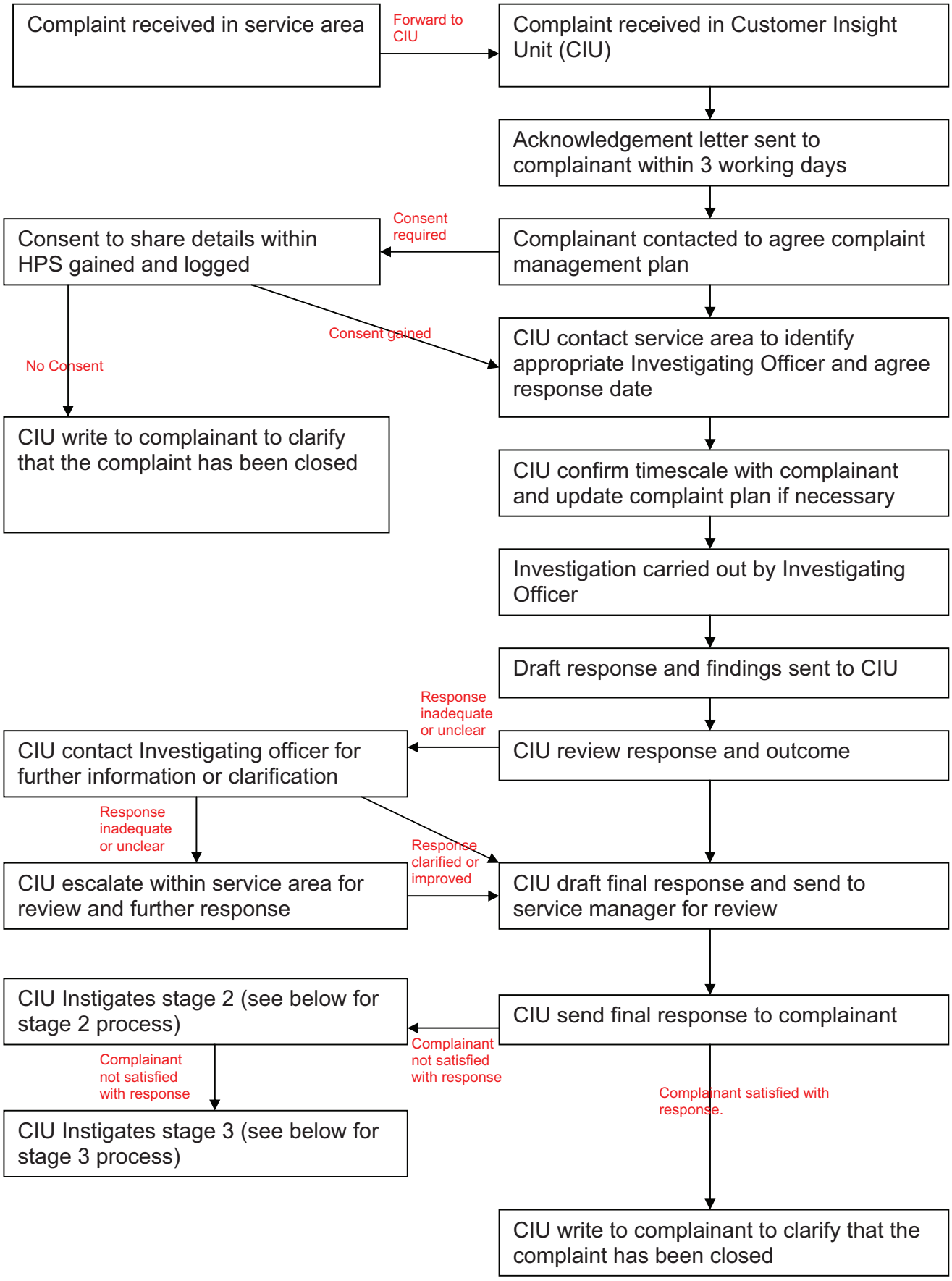
16 WITHDRAWING A COMPLAINT

16.1 The complaint may be withdrawn verbally or in writing at any time by the complainant (regulation 7). The CIU must write to the complainant to confirm the withdrawal of the

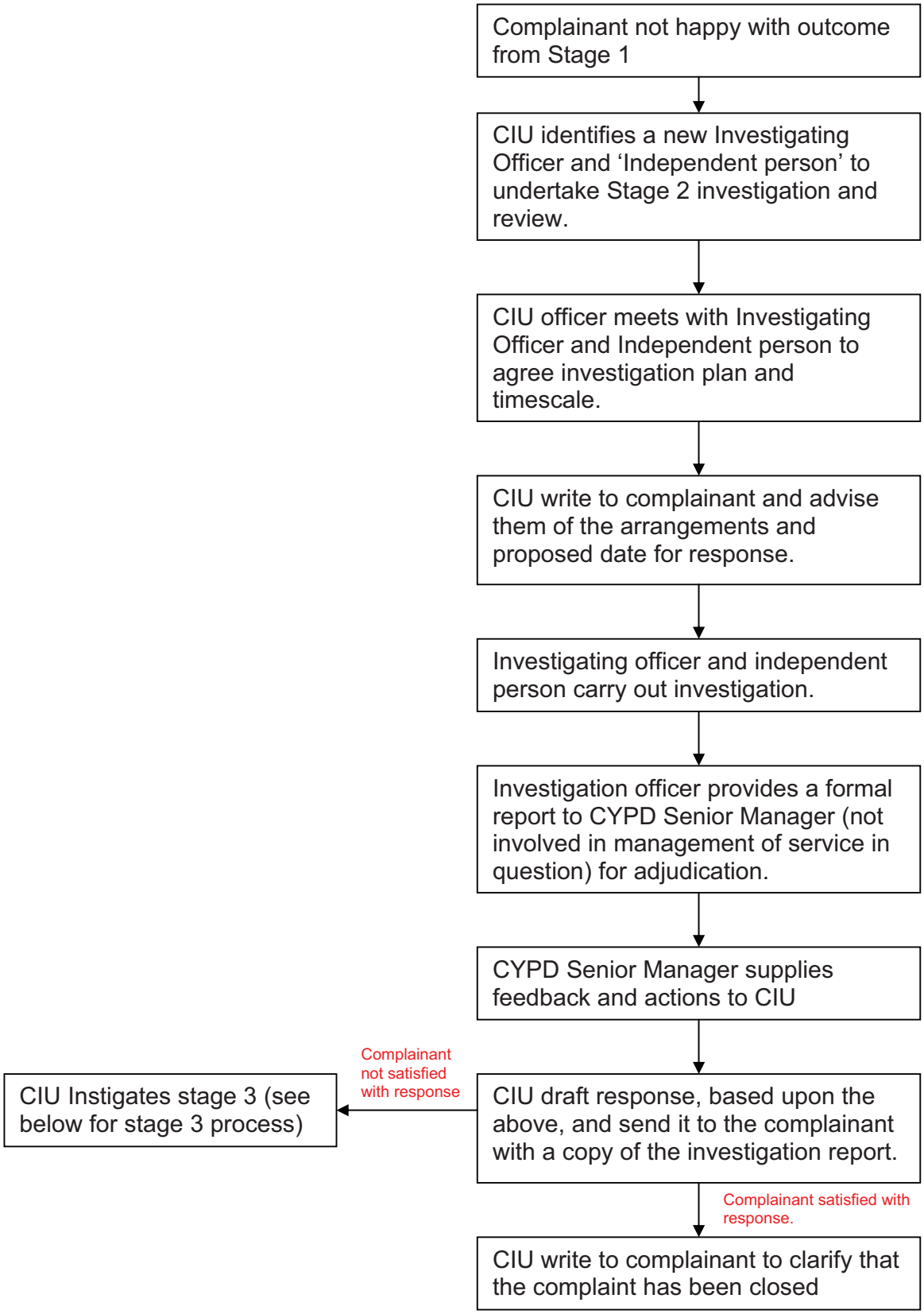
complaint. In these circumstances, it would also be good practice for the local authority to decide on whether or not it wishes to continue considering the issues that gave rise to the complaint through an internal management review. The local authority should then use this work to consider the need for any subsequent actions in the services it delivers.

16.2 Should the complainant then seek to reinstate the complaint, the local authority could use the review to produce a response as necessary.

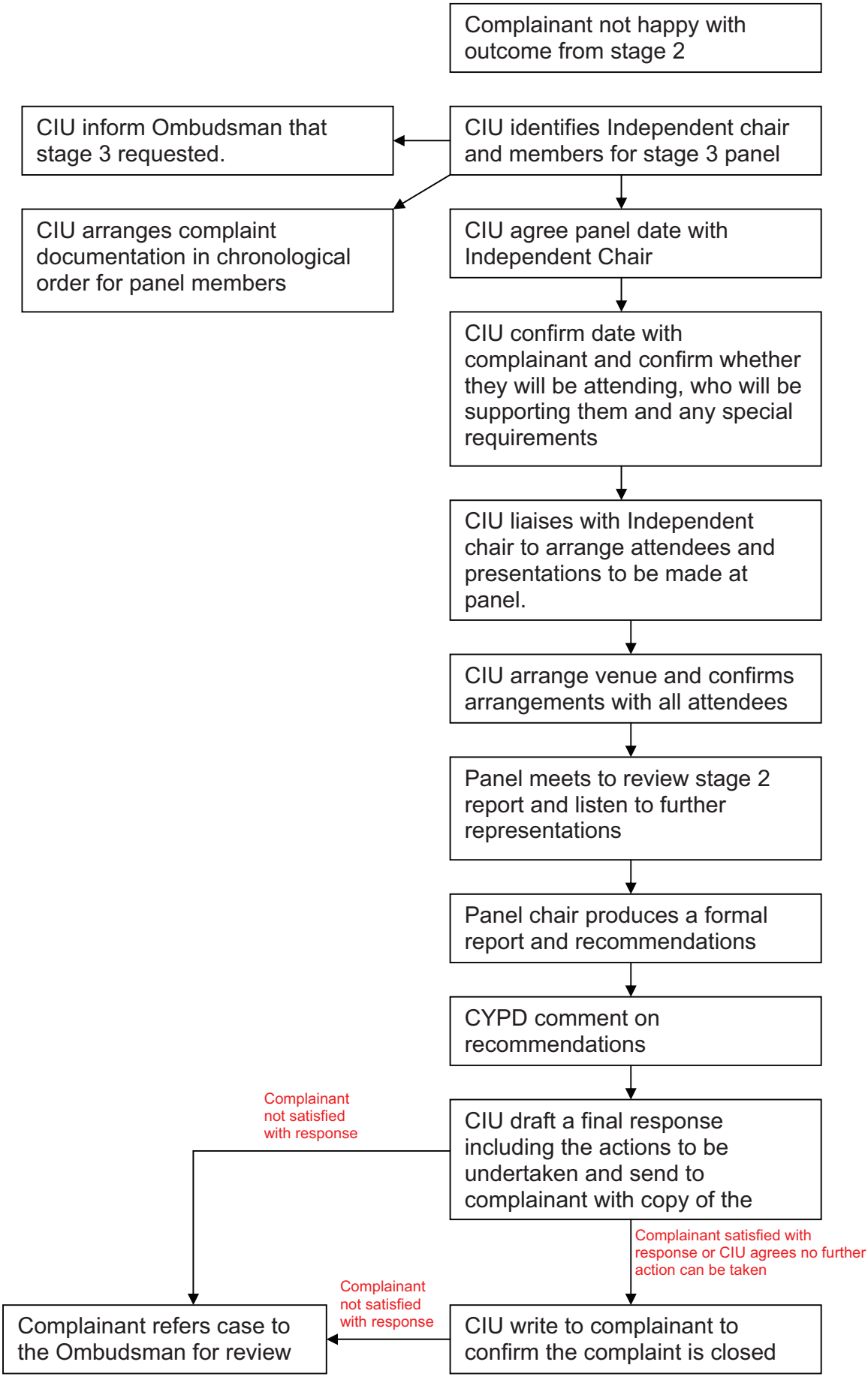
Stage 1 process **Diagram 2**



Stage 2 process **Diagram 3**



Stage 3 process **Diagram 4**



Annual CIU Report - 2012/2013

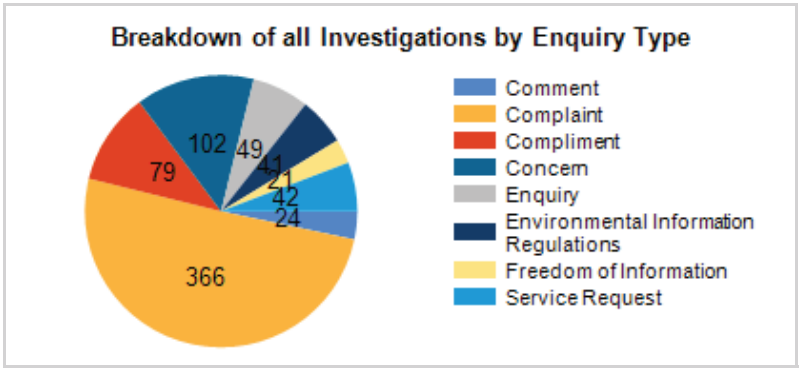
Organisation - Contractor

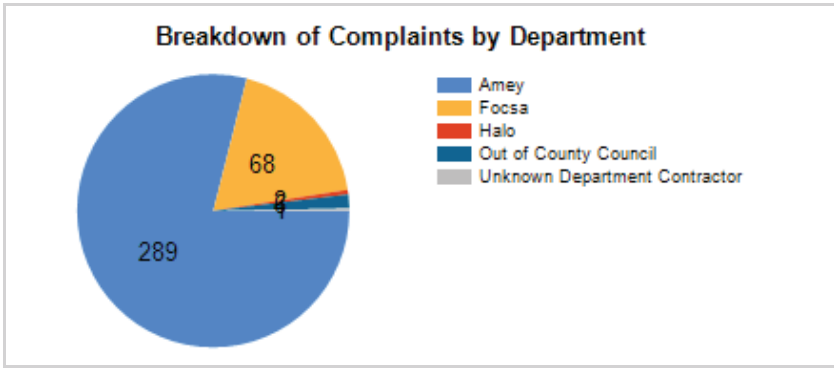
Report run at 09:16:15 on 10 April 2013

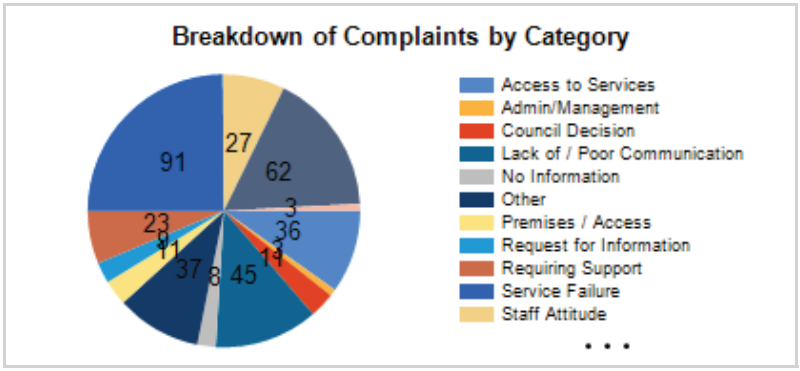
Performance Indicators

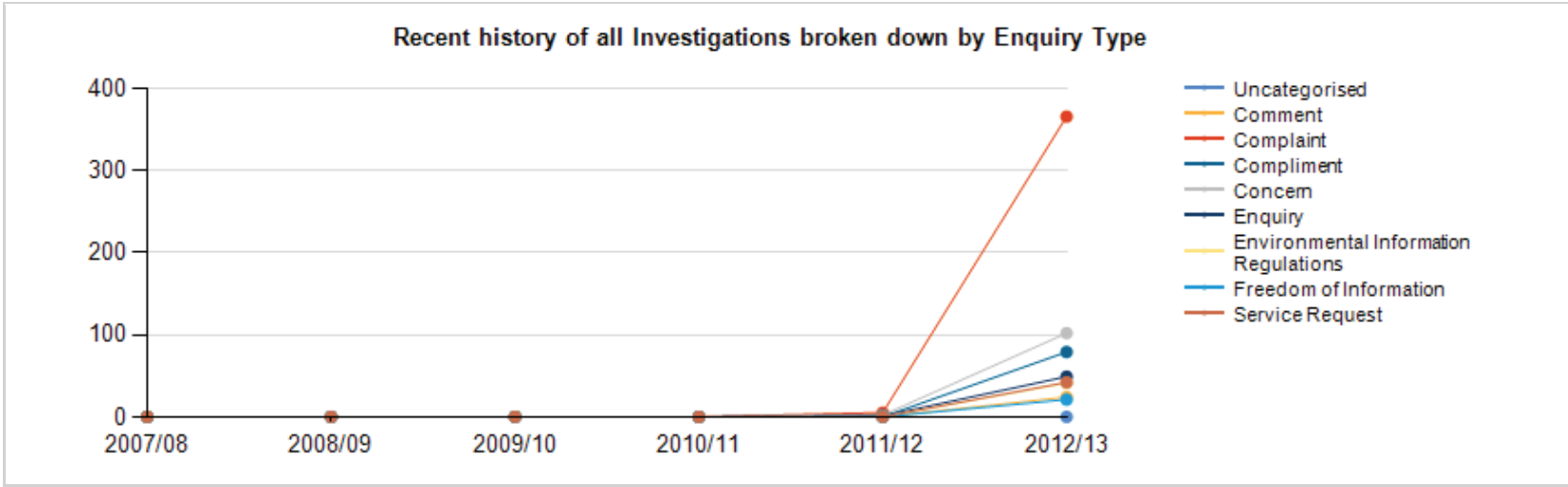
Type	2012/2013	In SLA *	YTD	In SLA *
Comment	24	63 %	24	63 %
Complaint	366	59 %	366	59 %
Compliment	79	65 %	79	65 %
Concern	102	67 %	102	67 %
Enquiry	49	51 %	49	51 %
Environmental Information Regulations	41	51 %	41	51 %
Freedom of Information	21	71 %	21	71 %
Service Request	42	64 %	42	64 %
Total	**724**	**60 %**	**724**	**60 %**

* % of Investigations where the Case Closed Date is before the Case Due Date, or the Case Due Date has not yet passed. See column headed "Within SLA?" below.








Recent history of all Investigations broken down by Enquiry Type
400
300
200
100
0
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
Uncategorised
Comment
Complaint
Compliment
Concern
Enquiry
Environmental Information Regulations
Freedom of Information
Service Request

Annual CIU Report - 2012/2013

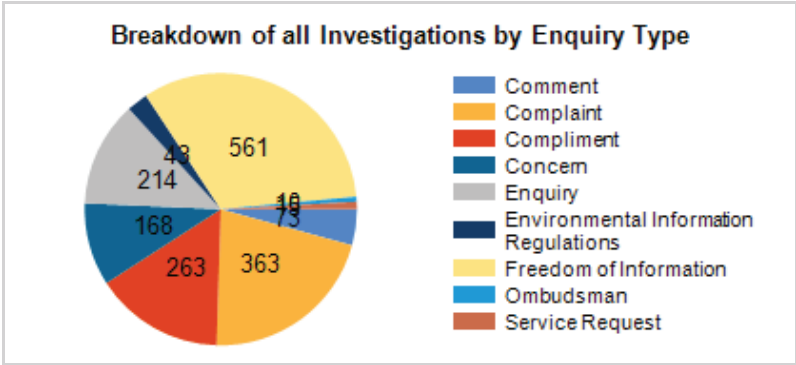
Organisation - Council

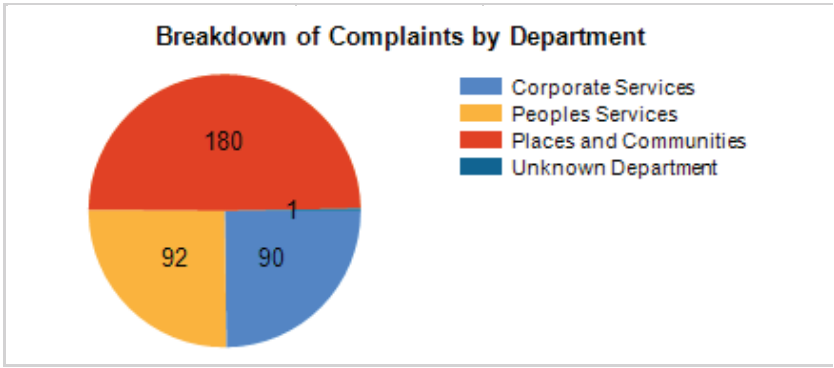
Report run at 09:21:01 on 10 April 2013

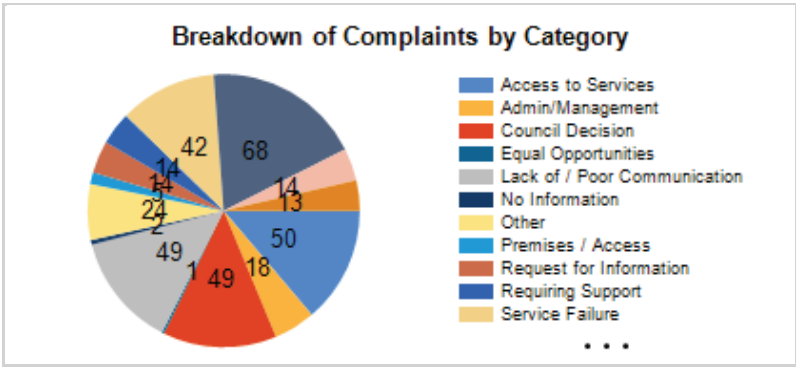
Performance Indicators

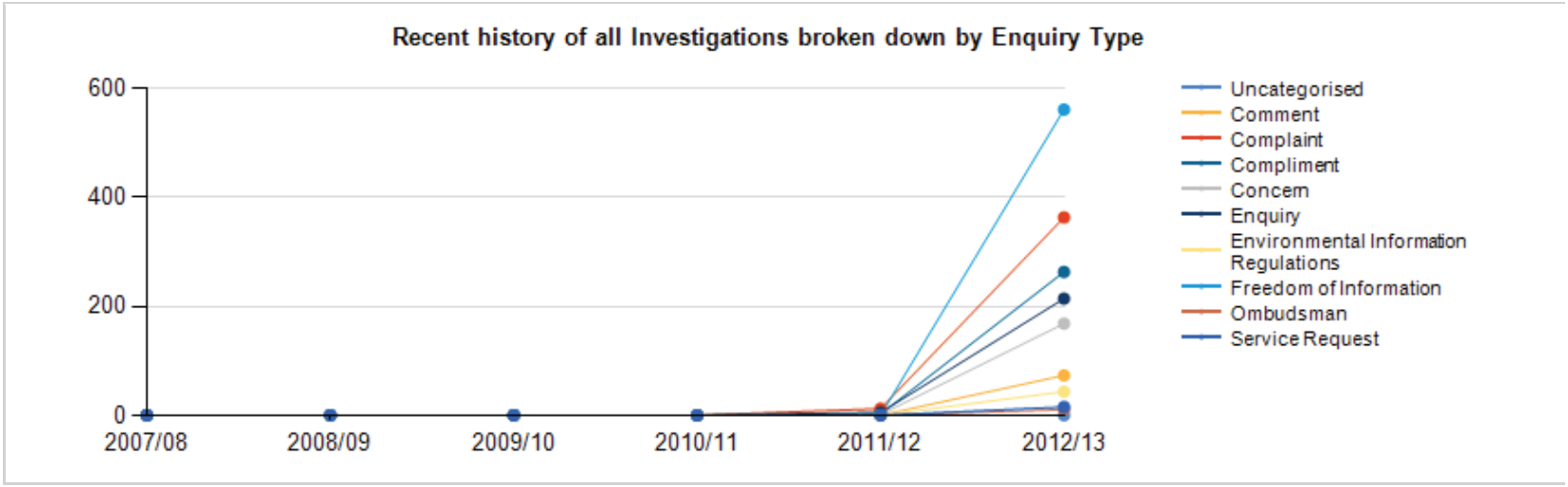
Type	2012/2013	In SLA *	YTD	In SLA *
Comment	73	73 %	73	73 %
Complaint	363	67 %	363	67 %
Compliment	263	67 %	263	67 %
Concern	168	73 %	168	73 %
Enquiry	214	72 %	214	72 %
Environmental Information Regulations	43	86 %	43	86 %
Freedom of Information	561	82 %	561	82 %
Ombudsman	10	0 %	10	0 %
Service Request	15	47 %	15	47 %
Total	**1710**	**73 %**	**1710**	**73 %**

* % of Investigations where the Case Closed Date is before the Case Due Date, or the Case Due Date has not yet passed. See column headed "Within SLA?" below.








Recent history of all Investigations broken down by Enquiry Type
600
400
200
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2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
Uncategorised
Comment
Complaint
Compliment
Concern
Enquiry
Environmental Information Regulations
Freedom of Information
Ombudsman
Service Request

Annual CIU Report - 2012/2013

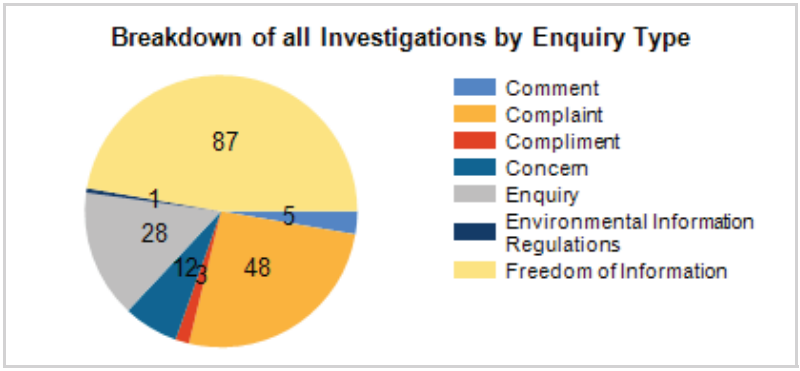
Organisation - Hoople

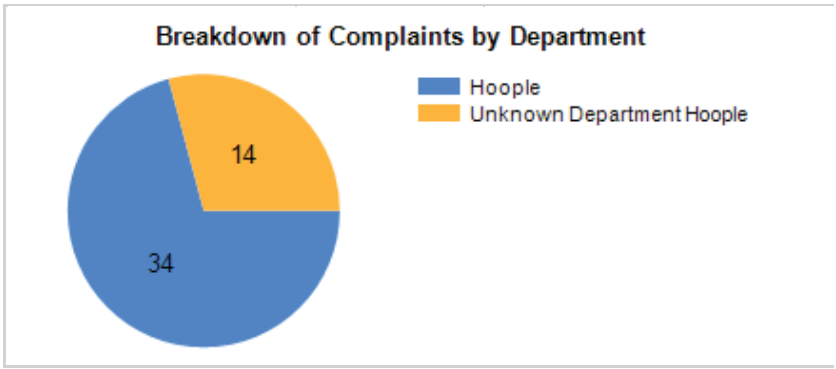
Report run at 09:43:46 on 10 April 2013

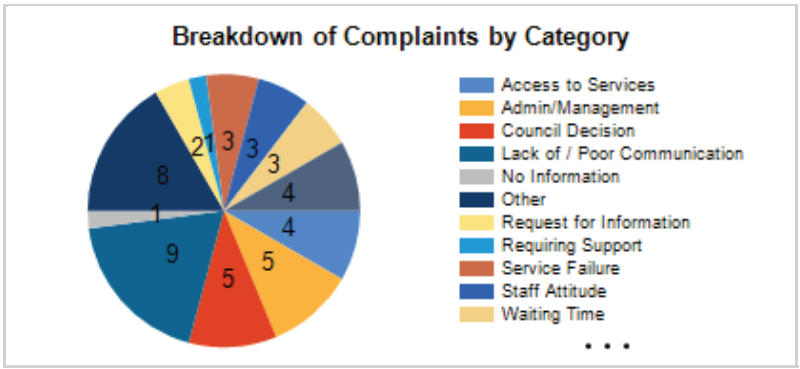
Performance Indicators

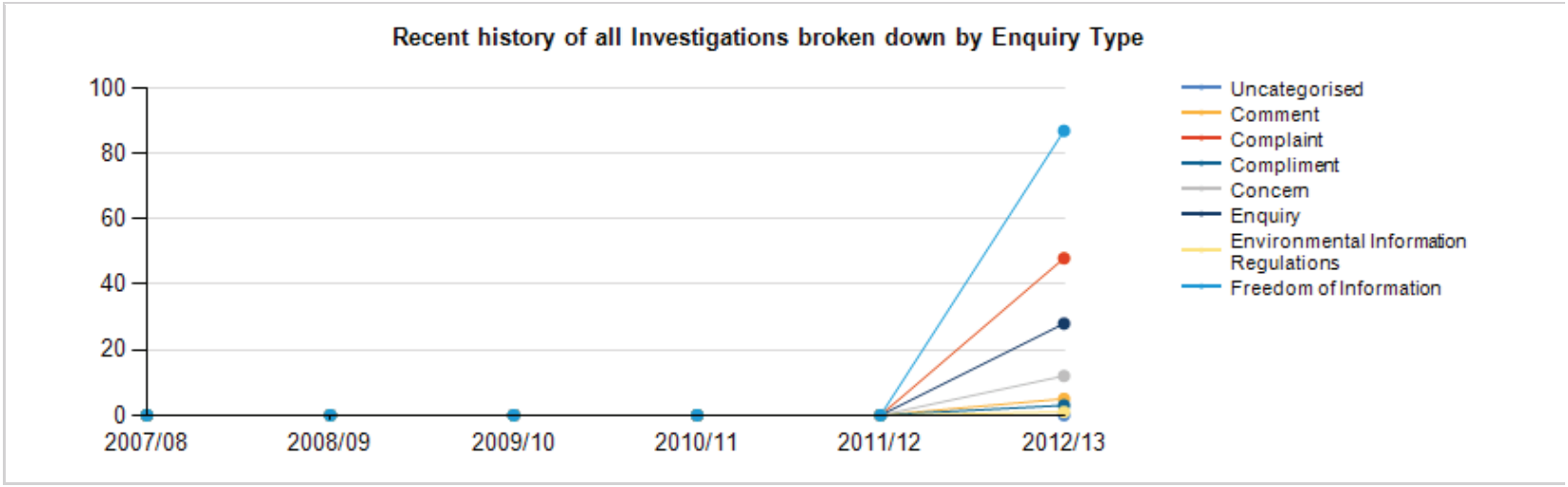
Type	2012/2013	In SLA *	YTD	In SLA *
Comment	5	100 %	5	100 %
Complaint	48	56 %	48	56 %
Compliment	3	100 %	3	100 %
Concern	12	58 %	12	58 %
Enquiry	28	64 %	28	64 %
Environmental Information Regulations	1	0 %	1	0 %
Freedom of Information	87	87 %	87	87 %
Total	**184**	**74 %**	**184**	**74 %**

* % of Investigations where the Case Closed Date is before the Case Due Date, or the Case Due Date has not yet passed. See column headed "Within SLA?" below.








Recent history of all Investigations broken down by Enquiry Type
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40
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2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
Uncategorised
Comment
Complaint
Compliment
Concern
Enquiry
Environmental Information Regulations
Freedom of Information

Annual CIU Report - 2012/2013

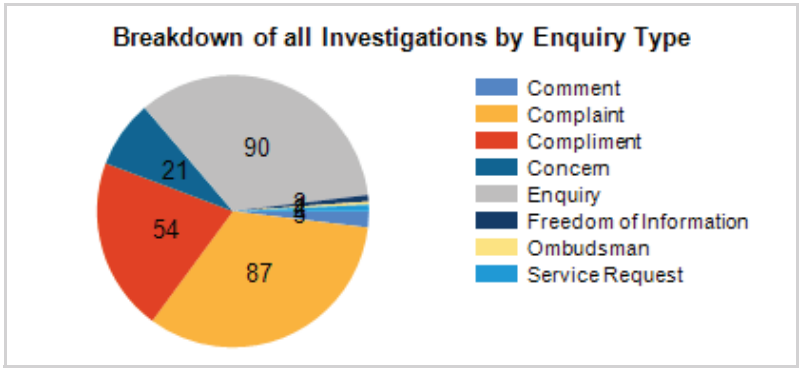
Department - NHS / Wye Valley NHS Trust

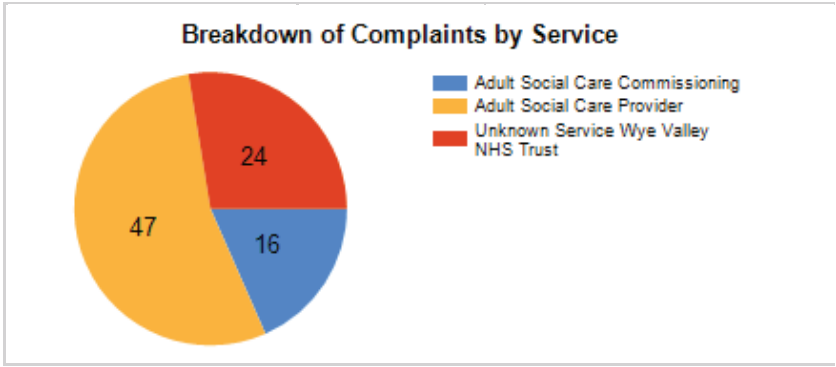
Report run at 09:48:18 on 10 April 2013

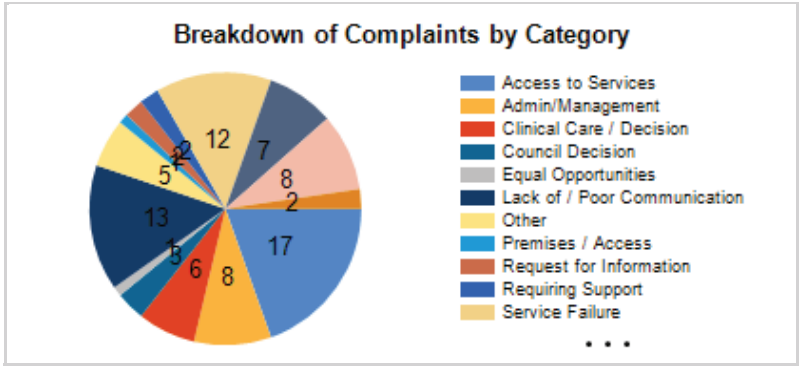
Performance Indicators

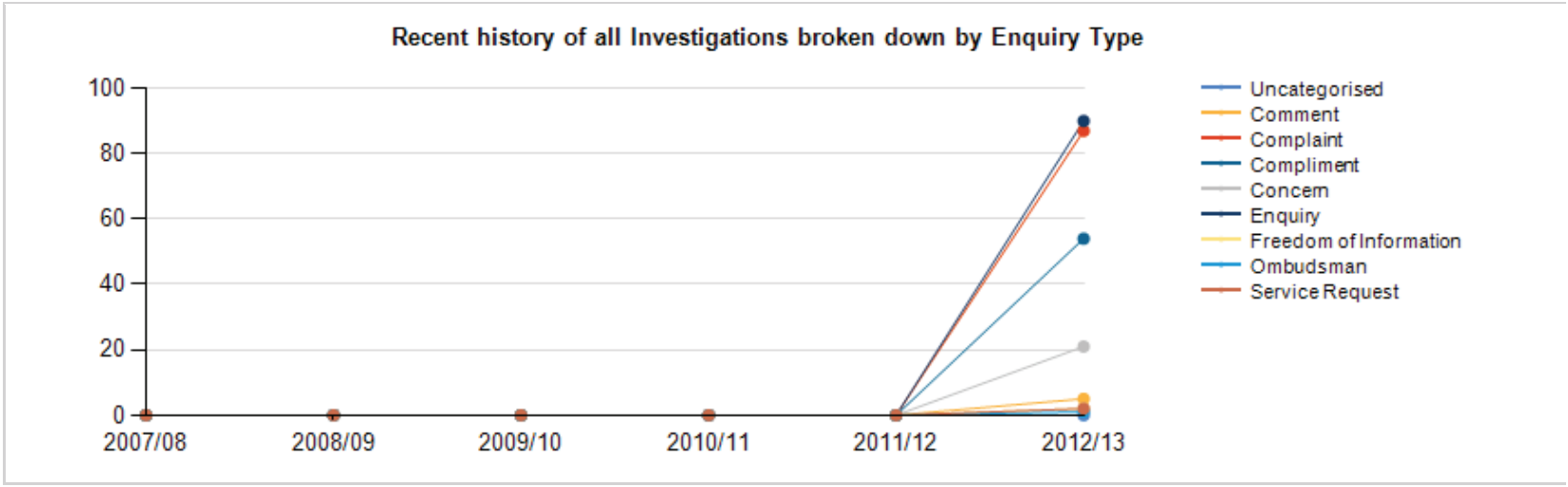
Type	2012/2013	In SLA *	YTD	In SLA *
Comment	5	80 %	5	80 %
Complaint	87	41 %	87	41 %
Compliment	54	76 %	54	76 %
Concern	21	62 %	21	62 %
Enquiry	90	58 %	90	58 %
Freedom of Information	2	100 %	2	100 %
Ombudsman	1	0 %	1	0 %
Service Request	2	100 %	2	100 %
Total	**262**	**57 %**	**262**	**57 %**

* % of Investigations where the Case Closed Date is before the Case Due Date, or the Case Due Date has not yet passed. See column headed "Within SLA?" below.








Recent history of all Investigations broken down by Enquiry Type
100
80
60
40
20
0
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
Uncategorised
Comment
Complaint
Compliment
Concern
Enquiry
Freedom of Information
Ombudsman
Service Request

Annual CIU Report - 2012/2013

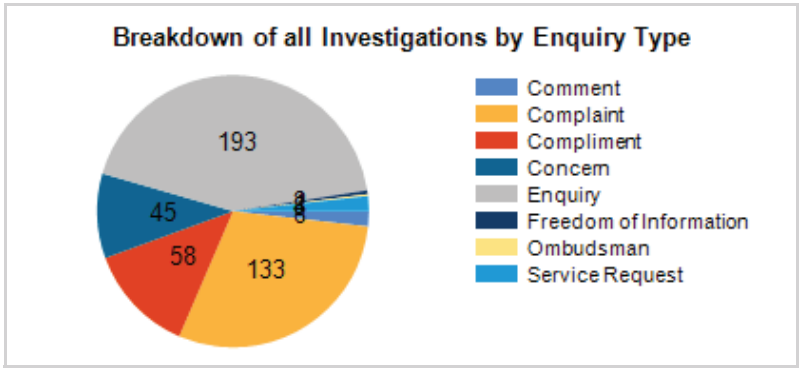
Organisation - NHS

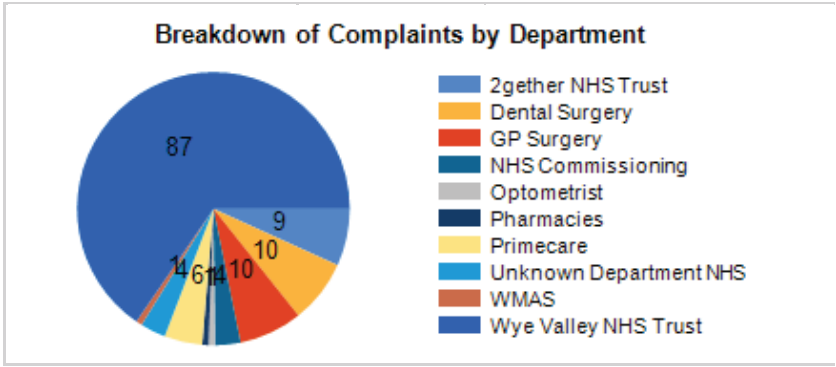
Report run at 09:46:25 on 10 April 2013

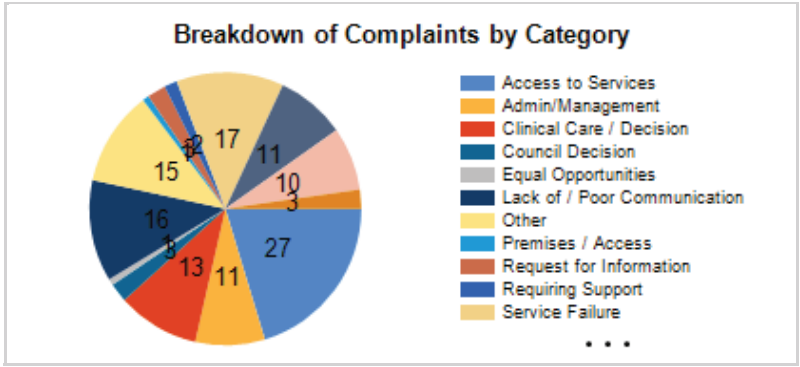
Performance Indicators

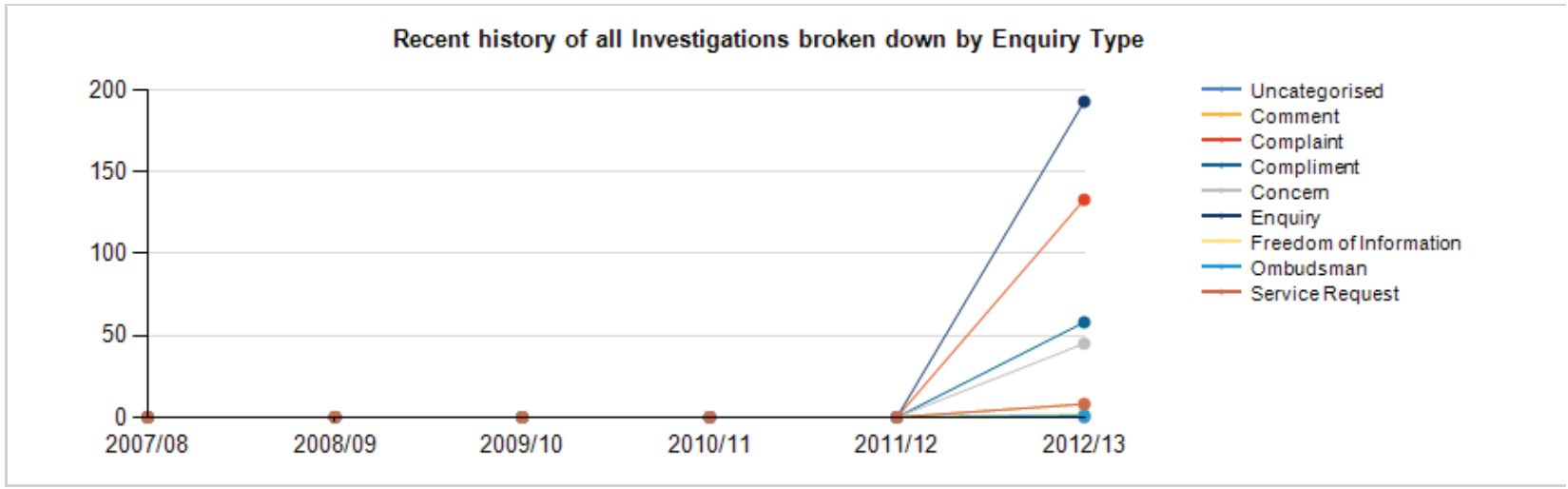
Type	2012/2013	In SLA *	YTD	In SLA *
Comment	8	75 %	8	75 %
Complaint	133	39 %	133	39 %
Compliment	58	76 %	58	76 %
Concern	45	56 %	45	56 %
Enquiry	193	67 %	193	67 %
Freedom of Information	2	100 %	2	100 %
Ombudsman	1	0 %	1	0 %
Service Request	8	63 %	8	63 %
Total	**448**	**59 %**	**448**	**59 %**

* % of Investigations where the Case Closed Date is before the Case Due Date, or the Case Due Date has not yet passed. See column headed "Within SLA?" below.








Recent history of all Investigations broken down by Enquiry Type
200
150
100
50
0
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
Uncategorised
Comment
Complaint
Compliment
Concern
Enquiry
Freedom of Information
Ombudsman
Service Request

Herefordshire Council

MEETING:	**AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**13 MAY 2013**
TITLE OF REPORT:	**COMMERCIAL CONFIDENTIALITY**
REPORT BY:	**HEAD OF GOVERNANCE**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

To provide the Audit and Governance Committee with a briefing on commercial confidentiality.

5. Recommendation

THAT the contents of this briefing report are noted.

6. Key Points Summary

- Commercial confidentiality is a legal concept which deals with the protection of a business' commercial interests and trade secrets.
- Breach of confidence is actionable under civil law and can have serious consequences if a breach of confidential information is established and damage has occurred.
- Commercial confidentiality is also referred to within the context of requests for Freedom of Information.
- It arises within the Council when dealing with external partners or agencies.
- Section 41 and 43 Freedom of Information Act 2000 set out exemptions from the right to know if the information requested was provided to the public authority in confidence (S41); or if the information requested is a trade secret or the release of the information is likely to prejudice the commercial interests of any person (S43).

7. Alternative Options

7.1 There are no alternative options identified in this report.

8. Reasons for Recommendations

8.1 The issue of commercial confidentiality was raised at a meeting of the General Overview and Scrutiny Committee on 14 January 2013. This report gives a brief overview of the concept of commercial confidentiality and its impact on relationships between Herefordshire Council and external agencies.

9. Introduction and Background

9.1 On 14 January 2013 the Economic Development Manager Hereford Futures presented a report to the General Overview and Scrutiny Committee. The report was an update on the governance and oversight arrangements of Hereford Futures. At this meeting a number of questions were raised regarding the supplying of information requested under the Freedom of Information Act 2000. Namely, that Freedom of Information requests had been sent to Herefordshire Council asking for minutes of board meetings of Hereford Futures. The Committee heard that the Leader of the Council viewed the minutes of the board meeting prior to attendance at the next one. The minutes were not kept at the Council offices. Hereford Futures is a not for profit private company limited by guarantee. The company are advising and assisting the physical redevelopment of 100 acres of land immediately to the north of the historic centre of Hereford. The information was not supplied in response to the request and the issue of commercial confidentiality was raised.

9.2 The Freedom of Information Act 2000 has specific exemptions provided to ensure that 'trade secrets' or 'commercial interests' are protected by non-disclosure of information that may have a prejudicial effect on an individual. This has been commonly referred to as 'commercial confidentiality'.

9.3 Herefordshire Council have a number of private sector partners who undertake projects or services on behalf of the Council. This may result in the Council holding information about that private sector partner that is commercially confidential. This information may also be subject to requests for information under the Freedom of Information Act 2000.

9.4 The purpose of this report is to give a briefing on commercial confidentiality including information of breach of confidence and the exemption under Freedom of Information Act.

10. Key Considerations

10.1 The law governing the breach of commercial confidence is used to protect a business' commercial information and its trade secrets.

Breach of Confidence

What information can be treated as confidential?

10.2 For information to be treated as confidential three elements must be present. Firstly, that the information has the necessary quality of confidence. This means that it cannot be information that is already in the public domain. Secondly, it must have been given under circumstances placing an obligation of confidence. This could be achieved through a

number of circumstances, the most obvious being where one party tells the other that the information that they are giving is to remain confidential. It is worth noting however that if the first element of confidence is not satisfied then a person cannot make the information confidential just by saying so. Finally, if disclosure of the information were to take place it would result in harm to an individual or an interest.

10.3 There can be express confidentiality agreements signed between persons where it is agreed that the information is confidential and cannot be disclosed. However, it is not necessary for an agreement to be in place for there to be an implied confidentiality agreement. For example, it would not be a defence for a person to state that they had not signed a confidentiality agreement and were therefore able to disclose the information, if the circumstances implied that the information given was confidential or misread the impact disclosure would have.

When can a breach occur?

10.4 A breach of duty of confidence occurs when a confidee, without permission of the confider, uses the confidential information for his own benefit or discloses it to another party. It need not matter whether the information was used innocently ie the confidee forgot that that the information was confidential.

Are there any defences to a breach of confidence?

10.5 There are two defences to a breach of confidence. These are:

1. To deny that the information was confidential.
2. To claim that disclosure was justified. For example, disclosure was in the public interest such as disclosing the information to the Police. However, disclosure will never be justified for 'commercial exploitation' of the information.

What remedies are available to a party whose confidence has been breached?

10.6 Where a breach of confidence has been identified, the confider will be able to seek remedies. These could be an injunction, damages or an ability to see the amount of profit made by the use of the confidential information.

10.7 The Human Rights Act 1998 gives individuals a right to freedom of expression but these rights would have to be carefully balanced with the current laws on confidentiality.

Commercial Confidentiality and the Freedom of Information Act 2000

10.8 Commercial confidentiality refers to safeguarding the privacy of sensitive information of companies. It is a concept developed since the introduction of the Freedom of Information Act 2000.

Section 41

10.9 Section 41 of the Freedom of Information Act 2000 sets out an exemption from the 'right to know' where the information requested was provided to the local authority in confidence. For this exemption to apply then the following two components must be present:

1. The information must have been given to the local authority by another person. (In this context a person may be an individual, a company, a local authority or any other 'legal entity').

2. Disclosure of the information would give rise to an actionable breach of confidence. (As referred to in 10.2 of this report)

Can confidential information be disclosed?

10.10 There are three circumstances where the disclosure of confidential information can be disclosed. These are:

1. Disclosure with consent of the person to whom the obligation of confidentiality is owed;
2. Disclosures which are required by law such as statutes, court orders etc;
3. Disclosure where there is an overriding public interest. This shall not be the overriding public interest test within the Freedom of Information Act exemptions, it is a consideration required by the development of common law. The courts have taken the view that the grounds for breaching confidentiality must be valid and very strong. A duty of confidence should not be overridden lightly.

Section 43

10.11 Section 43 of the Freedom of Information Act 2000 sets out an exemption from 'the right to know' if the information requested is a trade secret or the release of the information is likely to prejudice the commercial interests of any person. A person can be an individual, a company, the public authority itself or any other legal entity.

10.12 Within the Freedom of Information Act there is a duty on a public authority to confirm or deny whether or not it holds the information requested. With regards to trade secrets this duty shall still apply. However with commercial interests the public authority is exempt from the duty to confirm or deny.

What type of information could be subject to this exemption?

10.13 There are many different types of commercial information that a public authority may possess which could affect commercial interests. These may include, not only:

Procurement - this could contain future procurement plans, information provided during a tendering process, how contractors have performed under a contract.

Regulation - public authorities may be supplied with information in order to perform their regulatory functions e.g. issuing of licences or whilst investigating potential breaches of regulations that they are responsible for.

Public authority's own commercial activities - some public authorities are permitted to engage in commercial activities.

Policy development - during policy development information could be gained from companies in a specific business sector.

Policy implementation - public authorities may hold information in relation to the assessment of the business proposals when awarding grants.

Private Finance Initiative/Public Private Partnerships - this is the most developing area of public authority models throughout the United Kingdom. This is where private sector partners are involved in the financing and delivering of public sector projects and services. A public authority would be privy to much information on both the project that the private partner are involved with and more general information on the private partner's business.

How to determine whether this information is exempt?

10.14 The next step in the process after identifying the commercially sensitive information would be to apply the test of prejudice. This would involve asking a number of questions to see whether the giving of the commercially sensitive information is likely to prejudice the commercial interests of any person. The questions likely to be considered are:

1. **Does the information relate to, or could it impact on a commercial activity?**
2. **Is that commercial activity conducted in a competitive environment?**
3. **Would there be damage to reputation or business confidence?**
4. **Whose commercial interests are affected?** For example, the releasing of information regarding budgets could impact on a public authority's bargaining power.
5. **Is the information commercially sensitive?** For example, information revealing profit margins is likely to be more commercially sensitive than a final price charged.
6. **What is the likelihood of the prejudice being caused?** While prejudice need not be certain, there must be a significant risk rather than a remote possibility of prejudice.

The Overriding Public Interest Test

10.15 In determining whether to disclose information with a commercial interest, the public authority must weigh up the prejudice caused by the possible disclosure against the likely benefit to the applicant and the wider public.

10.16 Although there is a strong public interest in openness, this will not override all other considerations.

10.17 Some of the factors that would need to be taken into consideration are:

1. **The accountability for the spending of public money**
2. **The protection of the public** - For example, there may be circumstances where a public authority holds commercial information on the quality of products.
3. **The circumstances under which the public authority obtained the information**
4. **Competition issues**

Time Limits

10.18 A section 43 exemption would not apply beyond 30 years as this is the point at which information becomes a 'historical record'.

Minutes of the board meetings of Hereford Futures

10.19 This report was requested as a result of a discussion of minutes of the Hereford Futures board not being divulged to a member of the public under the notion of 'commercial confidentiality'. This report has provided a brief explanation of the concept of commercial confidentiality. It is clear that information given at the board meetings may be classed as commercially confidential information, subject to the tests as outlined above. It must be noted that each individual case must be based on its own merits. Therefore any disclosure of such information must be carefully considered ensuring that the Council is not breaching any law by doing so.

11. Community Impact

11.1 There are no community impacts in this briefing report.

12. Equality and Human Rights

12.1 There are none.

13. Financial Implications

13.1 If the Council were to be found in breach of confidence then a successful claimant could be awarded damages. There may also be significant court costs for the Council.

14. Legal Implications

14.1 Failure to follow the rules of confidence may result in a Claimant bringing an action against the Council. Should the Council fail to give information under a Freedom of Information Act 2000 exemption then a person may refer the refusal to the Information Commissioner. Should the referral be successful then a judgement would be made against the Council which would be made public. The Council would also be compelled to release the withheld information.

15. Risk Management

15.1 This recommendation asks Members to note the contents of this report which sets out the general background and principles to commercial confidentiality. Failure of the Council to adhere to the rules of confidence may result in a Claimant bringing an action in Court against them. If the Council wrongly withholds information under the Freedom of Information Act 2000 then a person may refer the matter to the Information Commissioner.

16. Consultees

16.1 N/A.

17. Appendices

17.1 N/A.

18. Background Papers

18.1 None identified.