AUDIT AND GOVERNANCE COMMITTEE

AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 12 March 2020

at 10.00 am

in Committee Room B
Civic Centre, Hartlepool

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Black, Hall, Hamilton, Harrison, James, Loynes and Ward.

Standards Co-opted Independent Member: Ms Clare Wilson.

Standards Co-opted Parish Council Representatives: Parish Councillor John Littlefair (Hart) and Parish Councillor Alan O'Brien (Greatham).

Local Police Representative: Superintendent Alison Jackson.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 5 March 2020 (to follow).

4. **AUDIT ITEMS**

   4.1 Mazars Report- Audit Strategy Memorandum – *Assistant Director, Finance and Customer Services*
   4.2 Mazars Report- Request for Declarations – *Assistant Director, Finance and Customer Services*
   4.3 Internal Audit Plan 2019/20 Update – *Head of Audit and Governance*
   4.4 Internal Audit Plan 2020/21 – *Head of Audit and Governance*
   4.5 Health and Safety Update – *Assistant Director (Corporate Services)*

5. **STANDARDS ITEMS**

5.1 Regulation of Investigatory Powers Act 2000 (RIPA) – Quarterly Update – *Chief Solicitor*

6. **STATUTORY SCRUTINY ITEMS**

Crime and Disorder

6.1 Update from the Tees Serious Violence Summit – *Statutory Scrutiny Manager*

Health

6.2 Draft Quality Accounts 2019/20 – Covering Report – *Statutory Scrutiny Manager*

Presentations by -
(a) North Tees and Hartlepool NHS Foundation Trust
(b) North East Ambulance Service NHS Foundation Trust
(c) Tees, Esk and Wear Valleys NHS Foundation Trust

7. **MINUTES FROM THE RECENT MEETING OF THE HEALTH AND WELLBEING BOARD**

No items.

8. **MINUTES FROM THE RECENT MEETING OF THE FINANCE AND POLICY COMMITTEE RELATING TO PUBLIC HEALTH**

8.1 To receive an extract of Minute 103 of the minutes of the meeting held on 10 February 2020.

9. **MINUTES FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

No items.

10. **MINUTES FROM RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP**

No items.

11. **REGIONAL HEALTH SCRUTINY UPDATE**

12. **DURHAM, DARLINGTON AND TEESSIDE, HAMBLETON, RICHMONDSHIRE AND WHITBY STP JOINT HEALTH SCRUTINY COMMITTEE**

No items.

13. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

Report of: Assistant Director, Finance and Customer Services

Subject: MAZARS REPORT- AUDIT STRATEGY MEMORANDUM

---

1. PURPOSE OF REPORT

1.1 To inform Members of the Audit and Governance Committee that arrangements have been made for representatives from Mazars to be in attendance at this meeting, to present the content of the report Audit Strategy memorandum.

2. BACKGROUND

2.1 The report sets out Mazars audit plan in respect of the audit of the financial statements of Hartlepool Borough Council for the year ending 31 March 2020. The plan sets out the proposed audit approach and is prepared to assist the Audit and Governance Committee in fulfilling its governance responsibilities.

3. FINDINGS OF MAZARS

3.1 Details of key messages are included in the main body of the report attached as Appendix 1.

4. RISK IMPLICATIONS

4.1 There is a risk that Members of the Audit and Governance Committee do not receive the information needed to enable a full and comprehensive review of governance arrangements at the Council, leading to the Committee being unable to fulfil its remit.

5. FINANCIAL CONSIDERATIONS

5.1 There are no financial considerations.

6. LEGAL CONSIDERATIONS

6.1 There are no legal considerations.

7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 There are no child and family poverty considerations.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 There are no equality and diversity considerations.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations.

11. RECOMMENDATIONS

11.1 That the Audit and Governance Committee:

i. Note the report of Mazars.

12. REASON FOR RECOMMENDATIONS

12.1 To ensure the Audit and Governance Committee is kept up to date with the work of our External Auditor.

13. BACKGROUND PAPERS

13.1 Audit Strategy Memorandum.

14. CONTACT OFFICER

14.1 John Morton
Assistant Director, Finance and Customer Services
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: John.Morton@Hartlepool.gov.uk

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

Report of: Assistant Director, Finance and Customer Services

Subject: MAZARS REPORT- REQUEST FOR DECLARATIONS

---

1. PURPOSE OF REPORT

1.1 To inform Members of the Audit and Governance Committee that arrangements have been made for representatives from Mazars to be in attendance at this meeting, to present the content of the report Request for Declarations.

2. BACKGROUND

2.1 International Auditing Standards require auditors to ask management and those charged with governance about arrangements the body has put in place:

· to prevent and detect fraud; and
· to comply with applicable law and regulations.

This requirement applies each year subject to audit.

2.2 For Hartlepool Borough Council, Mazars consider the Audit and Governance Committee to be those charged with governance, in line with the scheme of delegation in the Constitution. Mazars have requested responses to the questions detailed in the attached report and would be grateful for a response at the next committee meeting in July 2020.

2.3 To meet this request a report detailing a suggested reply to the questions posed will be brought before Members at July's Audit and Governance Committee meeting for consideration.

3. FINDINGS OF MAZARS

3.1 Details of key messages are included in the main body of the report attached as Appendix 1.

4. RISK IMPLICATIONS

4.1 There is a risk that Members of the Audit and Governance Committee do not receive the information needed to enable a full and comprehensive review of governance arrangements at the Council, leading to the Committee being unable to fulfil its remit.

5. FINANCIAL CONSIDERATIONS

5.1 There are no financial considerations.

6. LEGAL CONSIDERATIONS

6.1 There are no legal considerations.

7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 There are no child and family poverty considerations.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 There are no equality and diversity considerations.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations.

11. RECOMMENDATIONS

11.1 That the Audit and Governance Committee:

i. Note the report of Mazars.
ii. Review the suggested response to the questions posed by Mazars at July's Audit and Governance Committee.

12. REASON FOR RECOMMENDATIONS

12.1 To ensure the Audit and Governance Committee is kept up to date with the work of our External Auditor.

13. BACKGROUND PAPERS

13.1 Request for Declarations.

14. CONTACT OFFICER

14.1 John Morton
Assistant Director, Finance and Customer Services
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: John.Morton@Hartlepool.gov.uk

Request for Declarations

Hartlepool Borough Council

March 2020

MAZARS

CONTENTS

1. PURPOSE OF THIS DOCUMENT

International Auditing Standards require auditors to ask management and those charged with governance about arrangements the body has put in place:

- to prevent and detect fraud; and
- to comply with applicable law and regulations.

This requirement applies each year subject to audit.

For Hartlepool Borough Council, we consider the Audit and Governance Committee to be those charged with governance, in line with the scheme of delegation in the Constitution. We request your responses to the questions detailed below and would be grateful for a response at the next Committee meeting in July 2020.

Our request also covers the appropriateness of the going concern assumption and consideration of related parties.

2. QUESTIONS ABOUT ARRANGEMENTS FOR PREVENTING AND DETECTING FRAUD

- How does the Audit and Governance Committee assess the risk that the financial statements may be materially misstated due to fraud?
- Is the Audit and Governance Committee aware of management's process for identifying and responding to the risks of fraud generally and specific risks of misstatement in the financial statements?
- Is the Audit and Governance Committee aware of the arrangements in place for management to report about fraud to the Audit and Governance Committee?
- Is the Audit and Governance Committee aware of the arrangements management have in place, if any, for communicating with employees, lay members, partners and stakeholders regarding ethical governance and standards of conduct and behaviour?
- Does the Audit and Governance Committee have knowledge of actual or suspected fraud, and if so is it aware of what actions management is taking to address it?
- What arrangements are in place for the Audit and Governance Committee to oversee management arrangements for identifying and responding to the risks of fraud and the establishment of internal control?

3. QUESTIONS ABOUT ARRANGEMENTS FOR COMPLYING WITH LAW AND REGULATIONS RESPONSIBILITIES

- Has management provided a clear statement which confirms its consideration of relevant laws and regulations and its compliance with them?
- How does the Audit and Governance Committee satisfy itself that all relevant laws and regulations are being complied with?
- Is the Audit and Governance Committee aware of any instances of non-compliance with laws or regulations?
- Has management provided a list of litigation and claims?
- Has as assessment been made of the outcome of the litigation or claim and its estimate of the financial implications, including costs involved?
- Has the reasonableness of management's assessments been considered and additional information provided to the auditor where necessary?

4. QUESTIONS ABOUT THE APPROPRIATENESS OF THE GOING CONCERN ASSUMPTION

- Has a report been received from management forming a view on going concern?
- Are the financial assumptions in that report (e.g. future levels of income and expenditure) consistent with the strategic business plan and the financial information provided to the Audit and Governance Committee throughout the year?
- If not, does the report contain a clear explanation, with supporting evidence, for the assumptions used, and are those assumptions appropriate? This should include written evidence of agreed income and expenditure for major funding streams.
- Are the implications of statutory or policy changes appropriately reflected in the business plan, financial forecasts and report on going concern?
- Have there been any significant issues raised with the Audit and Governance Committee during the year (e.g. adverse comments raised by internal and external audit regarding financial performance or significant weaknesses in systems of financial control, or significant variances to activity levels compared to those planned), which could cast doubts on the assumptions made?
- Has an analysis been undertaken of the Council's projected or actual performance against its financial plan? If so, is it robust and does it identify any areas of potential concern?
- Where there are potential concerns what action is being taken to address those areas of potential weakness?
- Does the organisation have sufficient staff in post, with the appropriate skills and experience, particularly at senior management level, to ensure the delivery of the organisation's objectives? If not, what action is being taken to obtain those skills?

5. QUESTIONS ABOUT THE CONSIDERATION OF RELATED PARTIES

- What controls are in place to identify, authorise, approve and account for and disclose related party transactions and relationships?

- Can you confirm that you have:
  - Disclosed to the auditor the identity of the entity's related parties and all the related party relationships of which you are aware; and
  - Appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of the framework?

6. CONTACT DETAILS

Please let us know if you would like further information on any items in this report.
www.mazars.co.uk

Gavin Barker
Director
0191 383 6300
gavin.barker@mazars.co.uk

Cath Andrew
Senior Manager
0191 383 6300
cath.andrew@mazars.co.uk

Address:
Salvus House,
Aykley Heads,
Durham,
DH1 5TS
0191 383 6300

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT PLAN 2019/20 UPDATE

---

1. PURPOSE OF REPORT

1.1 To inform Members of the progress made to date completing the internal audit plan for 2019/20.

2. BACKGROUND

2.1 In order to ensure that the Audit and Governance Committee meets its remit, it is important that it is kept up to date with the ongoing progress of the Internal Audit section in completing its plan. Regular updates allow the Committee to form an opinion on the controls in operation within the Council. This in turn allows the Committee to fully review the Annual Governance Statement, which will be presented to a future meeting of the Committee, and after review, will form part of the statement of accounts of the Council.

3. PROPOSALS

3.1 That members consider the issues within the report in relation to their role in respect of the Councils governance arrangements. Table 1 of the report detailed below, sets out the school audits that have been completed and the recommendations made. Recommendations to mitigate the risks identified have been agreed and a follow up audit will be carried out to ensure satisfactory implementation.

Table 1

Audit	Objectives	Recommendations	Agreed
Sacred Heart Primary	Ensure school finance and governance arrangements are in line with best practice.	- A register of business interests (including 'nil' returns) should be maintained for all governors and those staff who can influence purchasing decisions. The register should be updated at least annually. - Copies of budget monitoring statements should be retained to	Y Y

Audit	Objectives	Recommendations	Agreed
		provide evidence as to the accuracy of such reports.	
		- Orders should be used for all goods and services with a few limited exceptions. These orders should be committed to the school's financial system to prevent overspending.	Y
		- Adequate income records should be used to record all income received by the school, the date on which it was banked and entered onto the school's financial system. Two members of staff should be involved in the collection and counting of cash income received and the income record should be signed by the two members of staff to verify that the amount collected agrees to the amount banked.	Y
		- The school should check the insurance limit for monies held and ensure that the value of cash and cheques held does not exceed this limit. The school should consider purchasing a safe if income exceeds insurance limits.	Y
		- The Emergency Plan should be finalised and communicated to the relevant staff and governors who should sign to confirm that they have seen the plan and understand their responsibilities. A timetable should be established to carry out exercises to test / validate the plan. Results of such exercises should be reported to Governors and any lessons learnt incorporated into future emergency planning.	Y
Pupil Referral Unit (PRU)	Ensure school finance and governance arrangements are in line with best practice.	- PRU should attempt to bring the website up to date as soon as is possible and ensure that it includes all relevant information as required by statute.	Y
		- PRU should retain all recruitment files for a period of at least 6 months.	Y
		- Specific fund allocation information should be updated annually and relevant statements of usage published on the PRU website.	Y
		- The PRU should retain copies of all lease and SLA agreement.	Y
		- Contract Procedure Rules should be followed when acquiring goods/services at the PRU.	Y
		- Reconciliations between invoices and meals ordered should be undertaken to ensure that charges are correct.	Y
		- An Emergency Plan should be developed according to 'Coping with Emergencies' guidance and approved by Governors. A copy of the plan should	Y

Audit	Objectives	Recommendations	Agreed
		be communicated to relevant staff and governors who should sign to confirm that they have seen the plan and understand their responsibilities. A timetable should be established to carry out exercises to test / validate the plan. Results of such exercises should be reported to Governors and any lessons learnt incorporated into future emergency planning.	
Throston Primary	Ensure school finance and governance arrangements are in line with best practice.	-The school should develop or adopt the LA version of the Anti-Fraud & Corruption Policy. -The register for governor's interests should be published on the website. - All data for specific funding should be publicised on the schools website. - The school should have an emergency plan which is subject to testing / exercises with debrief reports of such documented and any lessons learnt reported to the Governing Body and incorporated into a revised plan. - Contract Procedure Rules should be followed when acquiring goods / services in excess of £5000. - All items of equipment costing in excess of £500 or of a portable and attractive nature should be recorded in the inventory record. A stock check should be undertaken on an annual basis. The person undertaking the stock take should be independent of the day to day maintenance of the inventory and should sign and date the inventory.	Y Y Y Y Y Y

3.2 In terms of reporting internally at HBC, Internal Audit produces a draft report which includes a list of risks currently faced by the client in the area audited. It is the responsibility of the client to complete an action plan that details the actions proposed to mitigate those risks identified. Once the action plan has been provided to Internal Audit, it is the responsibility of the client to provide Internal Audit with evidence that any action has been implemented by an agreed date. The level of outstanding risk in each area audited is then reported to the Audit and Governance Committee.

3.3 The benefits of this reporting arrangement are that ownership of both the internal audit report and any resulting actions lie with the client. This reflects the fact that it is the responsibility of management to ensure adequate procedures are in place to manage risk within their areas of operation, making managers more risk aware in the performance of their duties. Greater assurance is gained that actions necessary to mitigate risk are implemented and less time is spent by both Internal Audit and management in ensuring audit reports are agreed. A greater breadth of assurance is given to management with the same Internal Audit resource and the approach to risk assessment mirrors the corporate approach to risk classification as

recorded in covalent. Internal Audit can also demonstrate the benefit of the work it carries out in terms of the reduction of the risk faced by the Council.

3.4 Table 2 summarises the assurance placed on those audits completed with more detail regarding each audit and the risks identified and action plans agreed provided in Appendix A.

Table 2

Audit	**Assurance Level**
Flexi Scheme	Satisfactory
Payroll	Satisfactory
Internet/Email Controls	Limited
Direct Payments	Limited
Public Health Contracts	Limited
Energy Management	Satisfactory
Housing Benefit	Satisfactory
Open Spaces	Satisfactory
Local Council Tax Support Scheme	Satisfactory
Discretionary Housing Payments	Satisfactory
Employee Code of Conduct	Satisfactory
Catering	Satisfactory
Public Health Grant Overheads	Satisfactory
Operator's License	Satisfactory
Main Accounting System	Satisfactory
Job Evaluation Process	Satisfactory
Centre for Excellence in Creative Arts	Satisfactory
Transparency Code of Conduct	Satisfactory
Routes to Work Grant	Satisfactory

For Members information, Table 3 below defines what the levels of assurance Internal Audit places on the audits they complete and what they mean in practice:

Table 3

Assurance Level	**Meaning**
Satisfactory Assurance	Controls are operating satisfactorily and risk is adequately mitigated.
Limited Assurance	A number of key controls are not operating as intended and need immediate action.
No Assurance	A complete breakdown in control has occurred needing immediate action.

As indicated in table 2, three 'limited assurance' audit reports have been issued and information on this is provided in paragraph 3.5 – 3.10.

3.5 Internet/email Controls was assessed as limited assurance due to a number of issues that have been identified across the programme of testing undertaken which included the following:

- It was not possible to confirm that all live email accounts were for current employees or approved persons;
- Signed Employee Forms of Undertaking (which set out internet / email policies/ responsibilities) are not in place for all of the sample tested;
- Difficulties experienced monitoring internet usage due to the new flexi procedures;
- Ability to access Internet sites which should be prohibited;
- There are two types of Forms of Undertaking in use.

3.6 In order to mitigate the risks identified the following actions were taken immediately:

- Inactive accounts are suspended after 40 days of inactivity. If the user contacts CICT, they will be required to go through a series of questions before their account can be reinstated. This will remove any active directory accounts that should not be live. In addition, the leaver policy will be refreshed to add this step in and will be recommunicated to staff via an all staff email from the Assistant Director, Corporate Services.
- Discussion have taken place between ICT Manager and Head of HR to ensure the Email and Internet Use Form of Undertaking is a single document and is included with the bundle of documents to sign and return electronically as part of the recruitment process.
- Review the access rights to specific sites such as those identified in the audit, in conjunction with Northgate.
- A documented process in place to investigate any misuse of internet.

3.7 Adult Services Direct Payment Agreements were assessed as limited assurance due to the lack of fully completed and signed agreements available for the sample of cases reviewed.

3.8 In order to mitigate the risks identified the following actions were taken immediately:

- A project is underway to cleanse the Direct Payment system and update agreements. Each team/manager has been sent a list of 'unsigned' agreements and have started to action this. Regular quarterly data will be produced and provided to the relevant Heads of Service, who will liaise with the Team Manager to ensure that agreements are signed and saved to Iclipse. The latest workforce development plan includes Bitesize Learning Sessions monthly for all staff to ensure this issue is managed going forward. At each annual review staff will ensure the agreement is up to date, signed and saved to Iclipse.
- Social workers will complete a very light touch review of the Direct Payment. The Department is currently reviewing Direct Payment processes and the contract for support services alongside a restructure of User Property Finance Team support/service. It is anticipated that reconciliation services will be introduced as part of this restructure during 2020. Within the care management cycle the support plan is authorised by a Manager; the support plan is then sent electronically to

the relevant Head of Service who checks the support plan and Direct Payment.

3.9 Public Health Contracts were assessed as limited assurance due to a lack of monitoring information available for the drugs and alcohol service contract that was included within the sample of contracts reviewed.

3.10 In order to mitigate the risks identified the following action has been taken immediately:

- A Full review of drugs and alcohol service has been undertaken with new provider being appointed. Officers will establish a review of the contract monitoring arrangements and ensure that robust monitoring arrangements are in place for the end of the current contract and new contract.

3.11 As well as completing the audits previously mentioned, Internal Audit staff have been involved with the following working groups:

- Information Governance Group.
- Performance and Risk Management Group.

3.12 Table 4 below details the audits that were ongoing at the time of compiling the report.

Table 4

Audit	**Objectives**
Information Protection Policy	Ensure adequate policies/procedures are in place in line with statutory requirements.
Sport England Grant	Ensure grant is expended and any claims made are in line with terms and conditions.
Eclipse IT System	Ensure adequate IT controls are in operation.
I World IT System	Ensure adequate IT controls are in operation.
Health and Safety	Ensure adequate policies/procedures are in place in line with statutory requirements.
Council Tax	Liability for Council Tax is assigned to the correct parties. The application of discounts/exemptions to liability is valid, accurate and supported. Council Tax bills are issued in accordance with regulations and are accurate and complete. Personal data is secure from unauthorised loss/harm. Effective arrangements are in place to ensure all payments received in respect of Council Tax are identified promptly and accurately posted to the correct accounts. Systems in place monitor the Council Tax collection rate. Refunds are valid, accurate and appropriately authorised.
Business Rates	The correct liable party has been identified and informed of the amount due. Liabilities are correctly calculated and adequate & appropriate reviews take place to ensure that any reliefs have been correctly awarded.
Risk Management	Ensure adequate policies/procedures are in place in line with best practice requirements.
Creditors	Review the systems and procedures in place for ordering, receiving and paying for goods and services to ensure that the supplies of goods and services are properly authorised and comply with Authorities Financial Procedure Rules.
Recruitment	Ensure adequate policies/procedures are in place in line with statutory employment requirements.

Disaster Recovery	Ensure adequate policies/procedures are in place in line with statutory/best practice requirements.
Computer Audit – Virus Checker Defence Systems	Arrangements are in place that ensure adequate security arrangements are in place in respect of defence against malicious IT attack.
Ground Maintenance	Ensure adequate arrangements are in place to manage budgets and operate in line with Council procedures.
Borough/Town Hall	Ensure policies/procedures protect Council assets and income.

3.13 The work completed and currently ongoing is in line with expectations at this time of year, and audit coverage to date has allowed Mazars to place reliance on the scope and quality of work completed when meeting their requirements under the Audit Code of Practice.

4. RISK IMPLICATIONS

4.1 There is a risk that if Members of the Audit and Governance Committee do not receive the information needed to enable a full and comprehensive review of governance arrangements at the Council, this would lead to the Committee being unable to fulfil its remit.

5. FINANCIAL CONSIDERATIONS

5.1 There are no financial considerations.

6. LEGAL CONSIDERATIONS

6.1 There are no legal considerations.

7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 There are no child and family poverty considerations.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 There are no equality and diversity considerations.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations.

11. RECOMMENDATIONS

11.1 It is recommended that Members note the contents of the report.

12. REASON FOR RECOMMENDATIONS

12.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it is kept up to date with the ongoing progress of the Internal Audit section in completing its plan.

13. BACKGROUND PAPERS

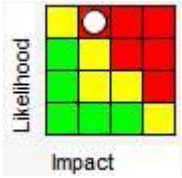
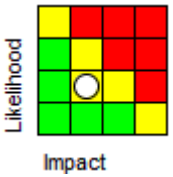
13.1 Internal Audit Reports.

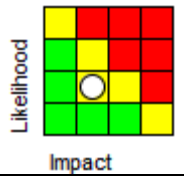
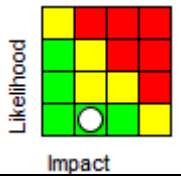
14. CONTACT OFFICER

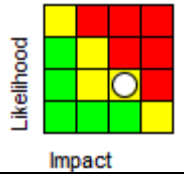
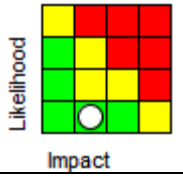
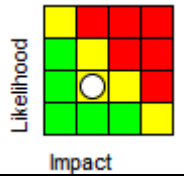
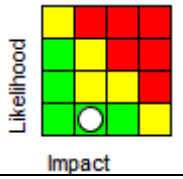
14.1 Noel Adamson
Head of Audit and Governance
Civic Centre
Victoria Road
Hartlepool
T24 8AY

Tel: 01429 523173
Email: noel.adamson@hartlepool.gov.uk

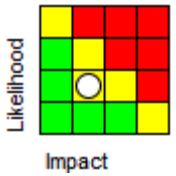
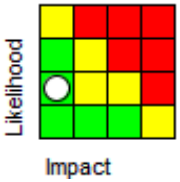
Appendix A

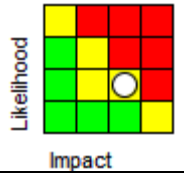
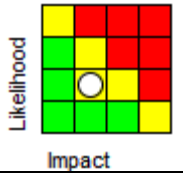
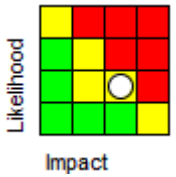
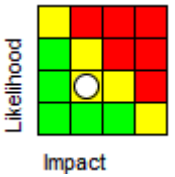
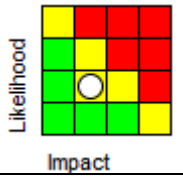
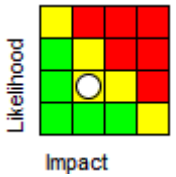
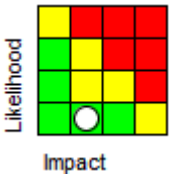
Audit	Objective		Assurance Level
Flexi Scheme	Ensure Council procedures are adhered to.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Flexitime Policy & Procedure was not rolled out to all staff in an effective manner and/or insufficient instruction/training was provided to enable compliance.		The use of finite HR resources has to be considered and applied appropriately, in order to support the key risks to the authority. It was not felt that training/briefings were required for the roll out and the vast majority of managers have complied with the requirements of the policy. For the avoidance of doubt, an all staff email will be circulated with an update of the key findings of this audit, an updated flexi sheet and an updated FAQ document.	

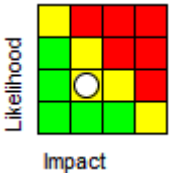
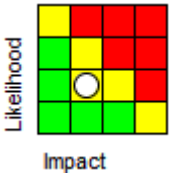
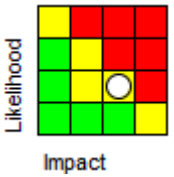
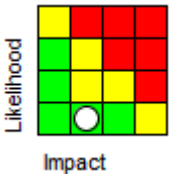
Audit	Objective		Assurance Level
Payroll	Ensure all payments made are in line with statutory and HBC policies and procedures.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Non-compliance with Data Protection legislation (including GDPR) may result in data loss and large fines imposed, reputational damage and distress to individuals.		Document to be completed and updated for all Payroll related information	

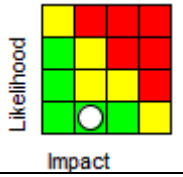
Financial penalties may be incurred if personal data is not secure from loss and/or harm.		Retention document to be reviewed and updated.	
Inaccurate payroll parameter data will result in incorrect payments being made.		Input document to be produced and operational arrangements introduced to ensure verification checks had taken place	

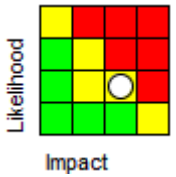
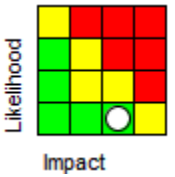
Audit	**Objective**	**Assurance Level**
Internet/Email Controls	Arrangements are in place that ensure adequate security in the use of Internet//email.	**Limited**

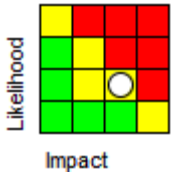
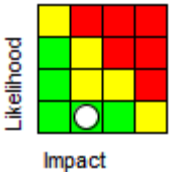
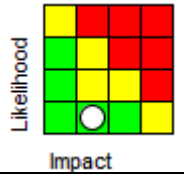
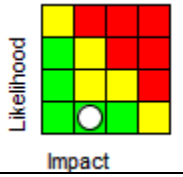
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Access to the internet and email is not adequately controlled resulting in potential misuse & inappropriate use of facilities.		It is acknowledged that CICT is reliant on managers to inform them of leavers ensuring that the leaver's policy is followed, which is available on the intranet. Failing that, a report from Payroll is sent to CICT on a monthly basis as a 'safety net'. However, there are still accounts that remain live, despite these 2 processes. In an attempt to put in place a further risk control, a new process will be enacted where inactive accounts are suspended after 40 days of inactivity. If the user contacts CICT, they will be required to go through a series of questions before their account can be reinstated. This will remove any active directory accounts that should not be live. In addition, the leaver policy will be refreshed to add this step in and will be recommunicated to staff via an all staff email from the Assistant Director, Corporate Services.	

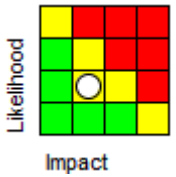
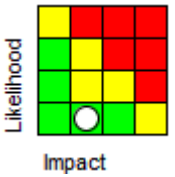
Inappropriate use of Internet facilities, resulting in non-compliance with the Internet Acceptable Use policy.		Undertake a review of the pop ups in conjunction with Northgate.	
The Authority does not have an up to date policy in respect of internet and email usage. Staff are not aware of their roles and responsibilities to ensure compliance with policies.		Review undertaken of the 7 missing forms and to be put in place if not on file. Discussion to take place between ICT Manager and Head of HR to ensure the Email and Internet Use Form of Undertaking is a single document and is included with the bundle of documents to sign and return electronically as part of the recruitment process.	
Inappropriate use of Internet facilities, resulting in non-compliance with the Internet Acceptable Use policy.		Review the access rights to specific sites such as those identified in the audit, in conjunction with Northgate.	
Inappropriate use of Internet facilities, resulting in non-compliance with the Internet Acceptable Use policy.		A list is now in place capturing the following information: Name, job title and department of the person who is subject to the investigation. Date requested by HR/department and date approval given by AD, Corporate Services. Any action taken as a result – please note that this is from an IT perspective only and it would not be appropriate to share any disciplinary detail with the CICT manager.	

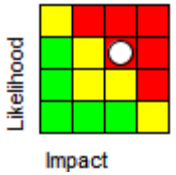
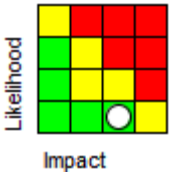
Audit	**Objective**		**Assurance Level**
Direct Payments	Ensure payments are made in line with Council and statutory guidance.		**Limited**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The misuse or mismanagement of direct payments by individuals in receipt of direct payments, whether they are the direct beneficiary, the nominated suitable person or someone who unofficially takes over the management of the funds.		A project is currently being undertaken to cleanse the DP system and update agreements. Each team/manager has been sent a list of 'unsigned' agreements and have started to action this. Regular quarterly data will be pulled from the system by the MIT Team and provided to the relevant Heads of Service, who will liaise with the Team Manager to ensure that agreements are signed and saved to Iclipse. The latest workforce development plan includes Bitesize Learning Sessions monthly for all staff to ensure this issue is managed going forward. Where there are regular changes to a DP package which would generate multiple agreements on the DP system it would not be proportionate to request a new signed agreement as long as there is an existing agreement clarifying contractual arrangements re: the DP has been discussed and agreed by the Department and service user. At each annual review staff will ensure the agreement is up to date, signed and saved to Iclipse.	
The misuse or mismanagement of direct payments by individuals in receipt of direct payments, whether they are the direct beneficiary, the nominated suitable person or someone who unofficially takes over the management of the funds		Social workers complete a very light touch review of the DP (this is not a reconciliation). Part of their role in review is to ensure the package is working well, efficiently and within the allocated budget therefore a light touch review is proportionate. Indeed the CIPFA guidance outlines that the review of the DP should be light touch and proportionate to risks. A reconciliation system of DP's is necessary for those who do not have Penderels to manage the account. The Department is currently reviewing DP processes and the contract for support services alongside a restructure of User Property Finance Team support / service and it is anticipated that reconciliation services will be introduced	

		as part of this restructure during 2020 as we also feel it is a necessary development. Within the care management cycle the support plan is authorised by a Manager; the support plan is then sent electronically to the relevant Head of Service who checks the support plan / DP etc. There are numerous checks, balances and risk assessment around the provision of a DP.	
Non-compliance with Data Protection legislation (including GDPR) may result in data loss and large fines imposed, reputational damage and distress to individuals.		GDPR issues in relation to the finding will be explored by the Council's Caldecott Guardian in liaison with legal services.	

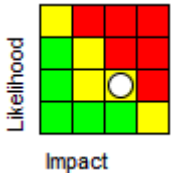
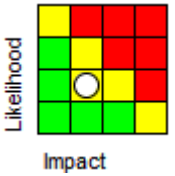
Audit	**Objective**		**Assurance Level**
Public Health Contracts	Ensure contracts are awarded and monitored adequately.		**Limited**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Local Authority providers and partners may not comply with the terms of agreements or contracts resulting in the required service not being received, the consequences of this will be dependent on the nature of the service.		Full review of drugs and alcohol service has been undertaken with new provider being appointed. Officers will establish a review of the contract monitoring arrangements and ensure that robust monitoring arrangements are in place for the end of the current contract and new contract.	

Audit	Objective			Assurance Level
Energy Management	HBC has adequate strategic and operational arrangements in place for the management of energy consumption.			**Satisfactory**
Risk Identified		**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
If a strategic approach to energy management is not in place, there may not be full understanding of the Council's consumption, identification of energy saving projects and effective monitoring arrangements to ensure achievement of desired standards and compliance with energy and climate change regulations.			A Climate Emergency and Climate Change Project Group has been established and the first meeting will be held on Tuesday 17th December 2019, which will be chaired by the Director of Regeneration and Resources to consider what actions we need to consider and look to implement, and part of this working group and subsequent actions is likely include energy efficiency within our own assets.	
Payments for energy charges may not be correct. Payments may not be authorised appropriately.			There was an departmental error with these particular cases which has been addressed by the service by ensuring all staff are aware of the correct recording and storing of invoices.	

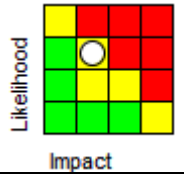
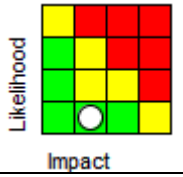
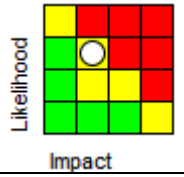
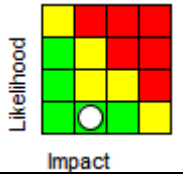
Audit	Objective			Assurance Level
Housing Benefit	Ensure all awards made are compliant with statutory requirements.			**Satisfactory**
Risk Identified		**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Bank details may be amended either in error or for fraudulent purposes.			A new control will be introduced to check for duplicate bank accounts within the I World payment file Any duplicates that relate to different landlords will be investigated before payments are released.	

The Council may be exposed to significant financial penalties if it does not manage data in accordance with GDPR requirements.		Approximately 500,000 Revs & Bens Iclipse records covering a range of document types have been identified for deletion and passed to CICT for actioning. In addition document retention / deletion principles covering current live benefit claims and Council Tax/ Business Rates accounts have been agreed and also forwarded to CICT to allow deletion of records no longer required. The deletion of Iclipse records will be part of the cleansing exercise in advance of moving to the new corporate document management system in 2020.	

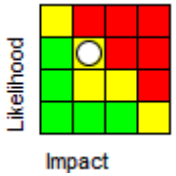
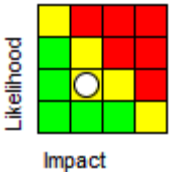
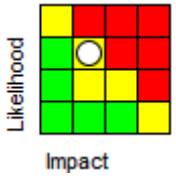
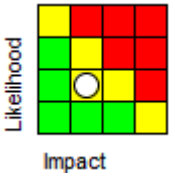
Audit	**Objective**	**Assurance Level**
Open Spaces	Ensure adequate arrangements are in place to manage budgets and operate in line with Council procedures.	**Satisfactory**

Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Problems within open spaces (excluding playgrounds) may not be promptly identified resulting in a health and safety risk to members of the public. Open spaces may not be used in accordance with covenants and by laws. The use of open spaces for organised events may result in additional wear and tear and maintenance issues resulting in budget pressures and require specific health and safety issues to be addressed.		In response to the identified risk, in the past open spaces were inspected on a regular basis however due to the loss of staff these inspections were ceased. It is acknowledged that as a result there may be instances where issues are not identified promptly however it is considered that the introduction of services such as Firmstep should assist in providing an easily accessible way in which members of the public, officers and Members can report concerns. It is proposed that inspections of Parks, Recreation grounds (with parts of Grayfields being excluded that are the responsibility of Adult & Community Based Services) and Bowling Greens will be carried out. A proforma will be developed in the coming months with the first inspections completed in the new year with subsequent assessments completed on a quarterly basis.	

Audit	Objective		Assurance Level
Local Council Tax Support Scheme	Ensure all awards made are compliant with statutory requirements and the local scheme.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.			

Audit	Objective		Assurance Level
Discretionary Housing Payments	Ensure all payments made are compliant with statutory and local requirements.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Payment may be made when not required.		Clients in receipt of legacy benefits will produce a copy of their tenancy agreement before a bond is confirmed. Clients in receipt of Universal Credit / Housing Element will already have confirmed their tenancy information with DWP and therefore a copy of their tenancy agreement is not required.	
Determinations may not be made in a consistent and transparent manner.		Team will be reminded of the need to accurately record their reasons for not providing evidence.	

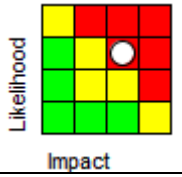
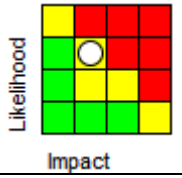
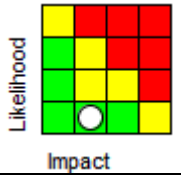
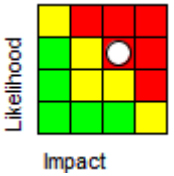
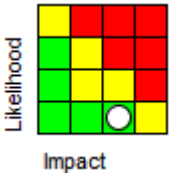
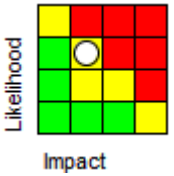
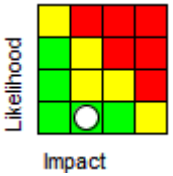
Audit	Objective	Assurance Level
Employee Code of Conduct	Ensure processes and procedures in place regarding Paid Work Outside of The Council and employee compliance with the Code regarding the personal use of social networking sites.	**Satisfactory**

Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Employees take outside employment without obtaining the required formal approval which conflicts with the Council's interests and may result in: -employees putting themselves in a position where duty and private interests conflict or could appear to conflict; -employees seeking to gain business in the course of carrying out their Council duties; -employees carrying out any outside work of a private interest during working hours, including making/sending or receiving telephone calls, emails, correspondence and goods; and/or -use of any council facilities or equipment or confidential information in relation to commitments outside of work.		Since the Code of Conduct was revised in January 2018, a number of changes have taken place both to the Constitution and to the array of policies and procedures within the Council. A full review of the Code of Conduct will be undertaken and aligned with the Constitution and associated policies and procedures, including those referenced in this internal audit report. The review will also look to include but not be limited to the following: -Correct paragraph references to Paid Work in the Constitution and the Single Status Agreement (SSA). -Correct links to Internet Usage Policy. -Updating of terms in relation to the Information Protection Policy. -Review of the Social Media Policy to include personal use.	
Employees take outside employment without obtaining the required formal approval which conflicts with the Council's interests and may result in: -employees putting themselves in a position where duty and private interests conflict or could appear to conflict; -employees seeking to gain business in the course of carrying out their Council duties; -employees carrying out any outside work of a private interest during working hours, including making/sending or receiving telephone calls, emails, correspondence and goods; and/or -use of any council facilities or equipment or confidential information in relation to commitments outside of work.		Departmental PA teams to create and maintain logs of Forms processed as a result of this Code of Conduct to ensure an audit trail is kept for audit and governance purposes.	

Audit	Objective		Assurance Level
Catering	Ensure the following processes are in place; Policies and procedures, bookings, Income, Purchases, Stock, and Monitoring.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.			

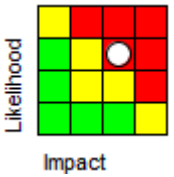
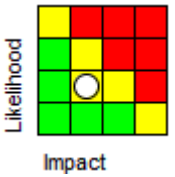
Audit	Objective		Assurance Level
Public Health Grant Overheads	Ensure the reasonableness of the overheads charged against the Public Health Grant for services provided.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.			

Audit	**Objective**	**Assurance Level**
Operator's License	Ensure the Council has procedures in place that ensure compliance with Operator Licence requirements.	**Satisfactory**

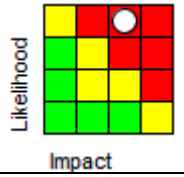
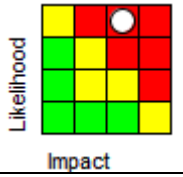
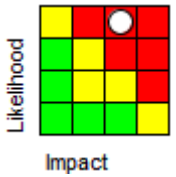
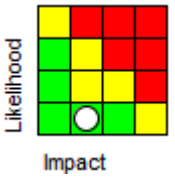
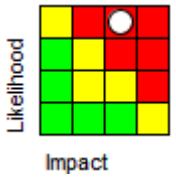
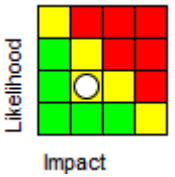
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Asset useful economic life may not be optimised if they are not adequately maintained.		Senior fitters to carry out quality checks and record findings onto spreadsheet initially but also add to Integra Fleet Management software.	
Asset useful economic life may not be optimised if they are not adequately maintained.		A workshop daily workload booking in log is already implemented on an Excel spreadsheet. Also included in the Integra Fleet Management software.	
Failure to comply with licence terms and conditions if employees are not aware of legislative requirements and robust systems are not in place to monitor compliance.		-Missing data – this is each drivers daily/weekly attendance details when not driving eg duty time, holidays and sickness, which is unknown to fleet, this data is to be updated by departments who manage the drivers. -Driver infringements - Weekly ongoing process and is managed by monitoring and training. -Driving without 'Digicards' – This is legal and there are exemptions from card use eg Workshop staff carrying out maintenance, yard movement of vehicles and drivers driving on record books. All instances are investigated and dealt with accordingly	
Failure to comply with licence terms and conditions if employees are not aware of legislative requirements and robust systems are not in place to monitor compliance.		The system is monitored on a weekly basis for infringements by the operator licence holder and monthly by the Freight Transport Association (FTA). All findings are dealt with by meeting with driver and / or additional training.	

Audit	Objective		Assurance Level
Main Accounting System	Ensure identified risks are managed at an acceptable level with regard to legislative and regulatory requirements and financial accounts are accurate and complete.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.			

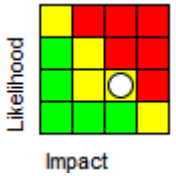
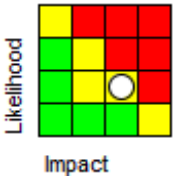
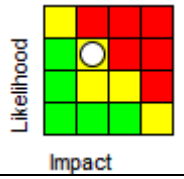
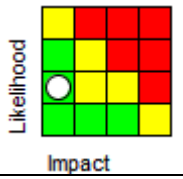
Audit	Objective		Assurance Level
Job Evaluation Process	Verify that the documented process has been followed, or where a deviation from the framework has been necessary that this is suitably recorded and authorised where appropriate.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.			

Audit	Objective		Assurance Level
Centre for Excellence in Creative Arts	To give assurance in the following areas; Governance Structure, Policies & Procedures, Claim submissions, verification of quarterly grant claim data & quarterly claim payments from TVCA, Other funding streams, Financial planning and Performance Monitoring.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Board may not be executing their roles and responsibilities as per the agreed Terms of Reference. Financial & non-financial targets are not being met which may result in a loss of income and non-compliance with the funding agreement.		Discussions are currently taking place with the Chair of the Board and the Development Manager to put processes in place to ensure that the Board acts as a critical friend to the centre (including a skills audit). Following the outcome of the consultant's report, the Board will meet on 4th Feb 2020 to discuss any amendments to the centre business plan which will then be implemented as soon as possible.	

Audit	Objective	Assurance Level
Transparency Code of Conduct	Ensure identified risks are managed at an acceptable level with regard to legislative and regulatory requirements and financial accounts are accurate and complete.	**Satisfactory**

Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Non-compliance with the Local Government Transparency Code of Practice 2015		Strategic Asset Management to add additional information relating whether assets are held Freehold (owner occupied), or Leasehold. NB. The type of lease will not be indicated on the Asset Register due to degree of detail needed to be meaningful.	
Non-compliance with the Local Government Transparency Code of Practice 2015		The note on the Transparency Code web page will be amended to better reflect the current status until the link is activated (as per the action below). The link from the Transparency Code web page is not presently live but will be made so linking the viewer to the current Hartlepool Borough Council Financial Report/Year End accounts which includes Social Housing Asset Value.	
Non-compliance with the Local Government Transparency Code of Practice 2015		The old ICT system used for monitoring parking did not readily and easily provide the information needed to produce the reports. A new system is being implemented which is nearing completion, and will allow production of the necessary reports. In relation to the parking spaces information, some of this information available can be pulled together for publication.	

Audit	Objective	Assurance Level
Routes to Work Grants	Ensure Route to Work 2019/20 claim submissions provide assurance that grant conditions have been met and data submitted relating to the claim are accurate, have supporting evidence and are in accordance with grant conditions.	**Satisfactory**

Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Non-compliance with Data Protection legislation (including GDPR) may result in data loss and large fines imposed, reputational damage and distress to individuals.		Ensure there has been a response from Information Governance.	
Performance outcomes may be claimed without sufficient supporting documentation resulting in the full value not be reimbursed or a delay in income being received financial penalties being incurred.		Key Workers have been reminded of the need to ensure all paperwork in the file to be completed within guidelines. This will be monitored at the end of January.	

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT PLAN 2020/21

---

1. PURPOSE OF REPORT

1.1 To inform Members of the direction of internal audit activity, and to seek approval of the annual operational Internal Audit Plan for 2020/2021 (Appendix A).

2. BACKGROUND

2.1 Under the Accounts and Audit Regulations 2015, the Council must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, in compliance with Public Sector Internal Audit Standards (PSIAS). At Hartlepool, the authority for ensuring this responsibility is met has been delegated to the Director of Finance and Policy.

2.2 To accord with PSIAS and to assist in ensuring the objectives of Internal Audit are achieved, audit activity must be effectively planned to establish audit priorities and ensure the effective use of audit resources.

2.3 Given available audit resources, all aspects of the Council's systems and arrangements cannot be audited in one year. In recognition of this a Strategic Audit Plan has been prepared using a risk model based on the model accredited by the Chartered Institute of Public Finance and Accountancy, which factors include:

- System Factors
- Managerial and Control environment
- Value of transactions
- Volume of transactions
- Opinion critical
- May incur legal penalties

2.4 The Strategic Audit Plan is produced in a way that ensures all relevant risk areas are covered. This allows the most relevant and comprehensive annual opinion on the Councils control environment to be given to the Audit and Governance Committee. Additionally, the audit plan has been tailored to add value to the Council following a process of discussion and consideration by Corporate Management Team, of their current operational issues.

3. INTERNAL AUDIT RESOURCES 2020/2021

3.1 Hartlepool Borough Council Internal Audit establishment consists of a Head of Audit and Governance and 5 FTE audit staff. When taking into account operational costs of providing the service and income generated, the net budget for the provision of Internal Audit is £230,000, which equates to approximately £225 per audit day provided.

3.2 A total of 66 planned areas of audit coverage will form the basis of the mainstream Internal Audit work for 2020/21. The plan includes fundamental systems such as salaries, debtors, creditors, risk management etc., which are identified, for the purpose of the plan, as single audits. However, these will include system and probity audits in each or some of the departments, in support of the main system reviews.

3.3 In addition to the planned audit work, advice and support will be provided on an ad hoc basis throughout the financial year together with unplanned reactive work wherever necessary and appropriate.

3.4 For 2020/21, we are contracted to provide 100 days of audit work to the Cleveland Fire Authority.

3.5 Further details are provided in Appendix A of the focus of coverage across the council. In order to support members in the process of reviewing proposed audit coverage, the Better Governance Forum guidance on approving Internal Audit plans is also attached for information. This takes the form of a number of questions members may want to consider when reviewing the plan.

4. DELIVERING THE AUDIT

4.1 Regular liaison is an essential feature of an effective and responsive audit function. In this context, Internal Audit will:

- Have frequent meetings with departments to discuss the short term audit program, any current departmental issues which may benefit from an audit review and provide the opportunity to raise any concerns with the audit services provided;

- Following audit reviews agree action plans, identifying responsibilities and timescales for action;

- Carry out follow up work to monitor the effectiveness of management in implementing action plans;

- Ensure action plans are focused on improving controls and delivering benefits to the Council;

- Provide feedback to the Director of Finance and Policy and Members on progress on the audit plan and the outcomes of audit work.

5. INTEGRATION

5.1 Although Internal Audit and Mazars carry out their work with different objectives, it is good professional practice that both parties should work closely together, which is a principle that the Council has always been committed to.

5.2 The arrangements for ensuring effective joint working are formalised into a Joint Protocol Agreement, which ensured that the overall audit resources are most effectively focused and duplication is minimised.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations.

12. RECOMMENDATION

12.1 It is recommended that Members review and approve the 2020/21 Internal Audit Plan and note the Internal Audit budget for 2020/21 of £230,000.

13. REASON FOR RECOMMENDATIONS

13.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it satisfies itself that Internal Audit coverage is adequate and effective.

14. BACKGROUND PAPERS

14.1 - Accounts and Audit Regulations 2015
- UK Public Sector Internal Audit Standards (PSIAS).

15. CONTACT OFFICER

15.1 Noel Adamson
Head of Audit and Governance
Civic Centre
Victoria Road
Hartlepool
TS24 8AY
Tel: 01429 523173
Email: noel.adamson@hartlepool.gov.uk

Appendix A

Department Name		Assistant Director/ Director	20/21
Adults and Community Based	Information Management/Performance Reporting Review	Danielle Swainston	15
Adults and Community Based	Social Care - Nursing and Residential Care	John Lovatt	10
Adults and Community Based	Social Care - Financial Assessments	John Lovatt	20
Adults and Community Based	Social Care - Direct Payments	John Lovatt	10
Adults and Community Based	Sport England Families Fund	Gemma Ptak	10
Chief Executives	Benefits - Housing	John Morton	25
Chief Executives	Budgetary Control	Chris Little	15
Chief Executives	Cash/Bank	Chris Little	10
Chief Executives	Communication - Mobile Phones	Claire McLaren	10
Chief Executives	Computer Audit	Claire McLaren	50
Chief Executives	Council Tax	John Morton	15
Chief Executives	Creditors	John Morton	15
Chief Executives	Data Quality – General Data Protection Regulations	Claire McLaren	15
Chief Executives	Debtors	John Morton	15
Chief Executives	Employee Protection/Violence Register	Claire McLaren	10
Chief Executives	Fraud Awareness	Chris Little	20
Chief Executives	Insurances	John Morton	10
Chief Executives	Loans and Investments (Treasury Management)	Chris Little	5
Chief Executives	Local Council Tax Support Scheme	John Morton	15
Chief Executives	Main Accounting	Chris Little	15
Chief Executives	Members Allowances/Travel/Subsistence	Chris Little	5
Chief Executives	Members Code of Conduct/Declarations	Haley Martin	5
Chief Executives	National Fraud Initiative (NFI)	Chris Little	20
Chief Executives	National Non Domestic Rates	John Morton	15
Chief Executives	Officers Expenses	John Morton	10
Chief Executives	Procurement	Chris Little	25
Chief Executives	Risk Management	Claire McLaren	5
Chief Executives	Salaries and Wages	John Morton	15
Chief Executives	V.A.T.	Chris Little	5
Children's and Joint Commissioning	Bluebell Meadow Primary School Academy	Amanda Whitehead	5
Children's and Joint Commissioning	Childrens Homes	Jane Young	15
Children's and Joint Commissioning	Eskdale Academy	Amanda Whitehead	5
Children's and Joint Commissioning	GP Referral Service	Danielle Swainston	10
Children's and Joint Commissioning	Golden Flatts Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	Holiday Hunger Scheme	Craig Blundred	10
Children's and Joint Commissioning	In House Looked After Allowances	Jane Young	10
Children's and Joint Commissioning	Jesmond Gardens Primary Academy	Amanda Whitehead	5
Children's and Joint Commissioning	Kingsley Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	Leaving Care Allowances	Jane Young	10
Children's and Joint Commissioning	Lynnfield Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	Public Health Contracting Arrangements	Danielle Swainston	10
Children's and Joint Commissioning	Public Mental Health Services	Craig Blundred	10
Children's and Joint Commissioning	Pupil Support/Admissions	Amanda Whitehead	10
Children's and Joint Commissioning	Rift House Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	Section 17 Payments	Jane Young	10
Children's and Joint Commissioning	Special Educational Needs	Amanda Whitehead	10
Children's and Joint Commissioning	St. Cuthberts Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	St. Helens Primary School	Amanda Whitehead	6

Children's and Joint Commissioning	St. Hilds Secondary School	Amanda Whitehead	6
Children's and Joint Commissioning	St. John Vianney Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	St. Josephs Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	St. Teresa's Primary School	Amanda Whitehead	6
Children's and Joint Commissioning	Stranton Primary School Academy	Amanda Whitehead	5
Children's and Joint Commissioning	Troubled Families Grant	Jane Young	20
Regeneration and Neighbourhood	BIS Centre	Andrew Carter	10
Regeneration and Neighbourhood	Car Parking - Income	Tony Hanson	5
Regeneration and Neighbourhood	Environmental Enforcement - Abandoned Vehicles/Fly Tipping	Tony Hanson	5
Regeneration and Neighbourhood	Environmental Enforcement - Dog Fouling Income	Tony Hanson	5
Regeneration and Neighbourhood	Environmental Enforcement - Dog Warden Service	Tony Hanson	5
Regeneration and Neighbourhood	Energy Management	Tony Hanson	10
Regeneration and Neighbourhood	Housing Revenue Account/Services	Andrew Carter	15
Regeneration and Neighbourhood	Licencing	Tony Hanson	10
Regeneration and Neighbourhood	Routes to Work	Andrew Carter	20
Regeneration and Neighbourhood	Staff Lottery	Denise McGuckin	5
Regeneration and Neighbourhood	Trading Standards	Tony Hanson	10
Regeneration and Neighbourhood	Waste Data Flow	Tony Hanson	10
Regeneration and Neighbourhood	Youth Employment Initiative Grant	Andrew Carter	20
	ADMINISTRATION		
Corporate	Training/Development		60
Corporate	Administration		75
Corporate	Contingency/Advice/Support/Special Investigations		100
	CFA		100
	TOTAL		**1085**
	Holidays		155
	Contingency		25
	Bank Holidays		40

Reviewing the Audit Plan

At least once a year, but possibly more frequently, both your internal and external audit teams will ask you to review their audit plans and approve them. If you aren't familiar with audit plans, you may well be asking yourself how to do this and how you can add value. In this article, I will discuss:

- Why draw up an audit plan?
- Who is involved?
- How is the audit plan produced?
- What does the audit plan cover?
- When is the audit plan written?
- Your role in relation to the audit plan

I will finish with a "dashboard" of key questions for you to ask to satisfy yourself that the plan has been drawn up appropriately and will deliver the assurance that you need as an audit committee member. While I concentrate on your role in relation to internal audit, many of these points also relate to external audit.

Why draw up an audit plan?
An audit plan is needed to ensure that your auditors address all the main areas of risk within your organisation and can provide assurance to support your Annual Governance Statement or Statement on Internal Control. At the end of each year the head of internal audit provides an opinion on the effectiveness of the control environment so it is vital that the plan is sufficient to support that opinion. It is also needed to ensure auditors use their limited resources (budget, time, people and expertise) to best effect. Almost inevitably audit needs outstrip audit resources and the plan will help your audit team set its priorities, in discussion with you.

Who is involved?
The audit plan is normally drawn up by the head of internal audit, in consultation with directors and members of the audit team. As the internal audit plans and external audit plans should be aligned, each should consult the other as part of this process.

How is the audit plan produced?
The audit plan is 'risk-based' to address the financial and non-financial risks faced by your organisation and your key priorities. Your organisation's risk register and the effectiveness of risk management will be reviewed to help develop the plan. The plan may also include work to be undertaken on behalf of your external auditor. The identified audits will be balanced against the resources available and the plan drawn up accordingly.

What does the audit plan cover?
The audit plan should show how your internal audit strategy is going to be achieved in accordance with the section's terms of reference. Plans include a combination of planned work and allowances for reactive work. They are always flexible so that they can reflect the changing risks and priorities within your organisation. Plans will also include allowances for "non-chargeable" time.

Planned audit work consists of a series of reviews of different aspects of your organisation's operations. The plan will include some high risk areas, for example areas of significant financial risk or high profile projects or programmes. Or they could be areas where there are concerns about poor performance, fraud or emerging risks. Some higher risk audits may feature annually in audit plans. Other areas, particularly financial systems, may be audited regularly even if they are well controlled because of their significance to the financial statements. The

frequency will usually be agreed with the external auditor. Other parts of the plan will reflect the risks and priorities of the organisation and the judgement of the head of internal audit.
Reactive audit work may include investigations, giving advice, supporting working groups and other such matters. Non-chargeable time includes annual leave, training, administration, team meetings etc. A working year is approximately 260 days. A typical auditor (not a trainee or a manager) will carry out about 200 audit days/year.

When is the audit plan written?
Detailed audit plans normally cover the organisation's financial year, although this is not mandatory. The audit plan is, therefore, generally written a few months before the start of the audit year for approval by the audit committee at the meeting before the start of that year. As the plan has to be flexible, you should be kept informed of minor changes and receive a revised plan for approval if there are any significant changes during the year.

There may also be a strategic plan that outlines the main direction for the audit team over a longer period than a year (perhaps three years). This is particularly useful to understand the wider coverage of risks and controls.

The audit committee's role
The audit committee should be both challenging of the plan and supportive in its delivery. You need to be sure that the organisation's risks and priorities are considered, that the plan is aligned with the audit strategy and terms of reference, that internal and external audit have liaised in drawing up their plans and that your auditors have exercised their independence and have not been unduly influenced by others in deciding what they will or (even more importantly) will not examine. You could review the audit strategy and terms of reference at the same time to ensure that they are still relevant and appropriate.

You also need to consider how the plan relates to other sources of assurance to support the Annual Governance Statement or Statement on Internal Control, for example assurance from the risk management process or management assurances. Taken as a whole, will you get the assurance you need?

Once the plan has been approved, your role is then to monitor activity and outcomes against that plan. Is it being delivered? Is the audit work delivering the expected outcome? You may also need to support your auditors, if they are struggling to get auditee engagement or experience a shortfall in resources. Above all, you are there to get action as a result of audit work.

Key questions to ask:

1. Who did the head of internal audit liaise with in drawing up this plan? Did this include external audit?

2. How does this audit plan link to our risk register and our strategic plans?

3. What audits have you left off this plan and why? When do you plan to carry out this work?

4. How does the audit plan fit with other assurance work? Are there any gaps or is there duplication?

Elizabeth Humphrey
Senior Associate, CIPFA Better Governance Forum

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

HARTLEPOOL BOROUGH COUNCIL

Report of: Assistant Director (Corporate Services)

Subject: HEALTH AND SAFETY UPDATE

---

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide members with an update on the Council's Health and Safety Framework, following a report presented to the Committee by the Head of Audit and Governance in July 2019 which identified this area as having 'limited assurance'.

2. BACKGROUND

2.1 The Council is required to have in place a robust Health and Safety System that ensures compliance with the Health and Safety at Work (etc) Act 1974. The Council will ensure, so far as reasonably practicable:

- Safe plant, equipment and systems of work that are safe, without risks to health and which are adequately supervised.
- Safe arrangements for the use, handling, storage and transportation of articles and substances that ensure the absence of risk.
- The provision of information, instruction, training and supervision as is necessary to ensure the health and safety of its employees whilst at work.
- Work environments, including access to and egress from them, are maintained in a condition that is safe and without risks to health.
- Adequate facilities and welfare arrangements.
- The health and safety of other people not employed by the Council, but who may be affected by its activities.

2.2 A review undertaken by the Council's Internal Audit in January 2019 identified a number of areas requiring improvement which gave the Health and Safety audit a 'limited' assurance.

2.3 Consequently a significant amount of work has been progressed to address the concerns highlighted by Internal Audit, with arrangements having been reviewed to reflect current best practice.

Improvements include:

- Streamlining of each Departmental and Corporate Health and Safety Committee agendas, with consistent performance information reports provided by the Health, Safety and Risk Manager.
- All audit reports now reported to the appropriate Assistant Director and Assistant Director for Corporate Services to maintain an overview, clearly outlining the assurance level and actions that need to be taken.
- Trends are reported through the Departmental and Corporate Committee reports and also to CMT on a quarterly basis with recommendations for action.
- Risk assessment training is now more robust and easily available.
- Fire Risk Assessments are up to date and an audit programme of proactive audits is in place based on an up to date premises list.
- Remedial actions are monitored and followed up.
- Safety Concern campaign - "See it, report it, Sort it" leading to an increase in near miss/signs of safety reporting.
- Development of a new online incident reporting system which creates a single process for recording a near miss/sign of safety; incident; accident or EPR entry. This reduces duplication and is easier to navigate.
- Development of a new staff forum focusing on staff safety, comprising of 7 task and finish groups led by staff which are developing work with a view to reporting to CMT in January 2020.
- Significant improvements to the EPR process and system.
- Creation of a Chief Officer Safety Panel to cases of serious concern that may pose a risk to staff with the objective of sharing information and agreeing a timely strategic response. This meets on an 'as and when' basis. Since it's creation, the panel has mobilised on three occasions.
- Development of Mental Health 1st Support service for employees.
- Mental Health Awareness Training developed.

3. PROPOSALS/ISSUES FOR CONSIDERATION

3.1 The Council will review and refine its Health and Safety arrangements in line with current best practice, ensuring that statutory responsibilities are met under the Health and Safety at Work Act (1974).

4. RECOMMENDATIONS

4.1 It is recommended that members note the work done to ensure that robust Health and Safety arrangements are in place, which addresses the concerns highlighted in the Audit report.

5. REASONS FOR RECOMMENDATIONS

5.1 To ensure that robust arrangements for Health and Safety are in place, and address the concerns raised by the recent audit.

6. BACKGROUND PAPERS

6.1 Audit and Governance Committee, Internal Audit Plan Update, 25 July 2019.

7. CONTACT OFFICER

7.1 Claire McLaren
Assistant Director (Corporate Services)
Civic Centre
Victoria Road
Hartlepool
TS24 8AY
Email claire.mclaren@hartlepool.gov.uk
Tel: 01429 523003

AUDIT AND GOVERNANCE COMMITTEE

12 MARCH 2020

Report of: Chief Solicitor

Subject: REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA) QUARTERLY UPDATE

---

1. PURPOSE OF REPORT

1.1 To provide members with a quarterly update on activities relating to surveillance by the Council and policies under the Regulation of Investigatory Powers Act 2011.

2. BACKGROUND

2.1 Hartlepool Borough Council has powers under the Regulation of Investigatory Powers Act 2000 (RIPA) to conduct authorised covert surveillance.

2.2 This report is submitted to members as a result of the requirement to report to members under paragraph 4.47 of the Covert Surveillance and Property Interference Revised Code of Practice (August 2018) which states that:

Elected members of a local authority should review the authority's use of the 1997 Act and the 2000 Act and set the policy at least once a year. They should also consider internal reports on use of the 1997 Act and the 2000 Act on a regular basis to ensure that it is being used consistently with the local authority's policy and that the policy remains fit for purpose.

2.3 As from 1 November 2012 Local Authorities may only use their powers under the Regulation of Investigatory Powers Act 2000 to prevent or detect criminal offences punishable by a minimum term of 6 months in prison (or if related to underage sale of alcohol and tobacco – not relevant to this Council). The amendment to the 2000 Act came into force on 1 November 2012.

2.4 Examples of where authorisations could be sought are serious criminal damage, dangerous waste dumping and serious or serial benefit fraud. The surveillance must also be necessary and proportionate. The 2012 changes

mean that authorisations cannot be granted for directed surveillance for e.g. littering, dog control, fly posting.

2.5 As from 1 November 2012 any RIPA surveillance which the Council wishes to authorise must be approved by an authorising officer at the council and also be approved by a Magistrate; where a Local Authority wishes to seek to carry out a directed surveillance or make use of a human intelligence source the Council must apply to a single Justice of the Peace.

3. RIPA AUTHORISATIONS

3.1 In the quarter to the date of this meeting:

Communications Data	Nil
CHIS	Nil
Directed Surveillance	Nil

4. RECOMMENDATION

4.1 That the quarterly report be noted.

5. REASONS FOR RECOMMENDATIONS

5.1 To enable the Council to monitor the RIPA system effectively and as required by law and guidance.

6. CONTACT OFFICER

6.1 Hayley Martin
Chief Solicitor and Senior Responsible Officer for RIPA
Hayley.Martin@hartlepool.gov.uk
01429 523003

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

HARTLEPOOL BOROUGH COUNCIL

Report of: Statutory Scrutiny Manager

Subject: TEES SERIOUS VIOLENCE SUMMIT

---

1. PURPOSE OF REPORT

1.1 To provide Members of the Committee with feedback from the Tees Serious Violence Summit held jointly by the Police and Crime Commissioner for Cleveland and Local Authority in Hartlepool on 14 February 2019.

2. ISSUES FOR CONSIDERATION

2.1 The Chair and Vice Chair of the Committee were invited to the event which brought together key and strategic professionals from community safety partnerships including police, health, education, social services, youth offending services, housing and the voluntary sector with the aim of supporting and galvanising local action on tackling serious violence. A number of key note speakers provided updates on the following key areas:

- Raise awareness of serious violence on a national and local perspective;
- Look at delivering a public health approach to serious violence;
- National Homocide Service;
- NHS Violence Navigators Project;
- An overview of youth zones;
- Results of Cleveland Youth Consultation;
- Identify local partnership action that can be taken to tackle serious violence; and
- Provided an opportunity to network and share best practice.

2.2 In addition to the above, Theresa and Tom Cave from the Chris Cave Foundation were in attendance and gave a very poignant presentation on the background, the work of the Foundation and feedback from the Youth Conference. The Foundation supports and educates families and local communities affected by violent crimes, whilst providing an outlet for young people influenced by violent crime to focus their energy and gain new skills.

2.3 The presentations from the event will be circulated to Members of the Committee once they are made available.

3. RECOMMENDATIONS

3.1 That the Committee note the update to be provided by Members who attended the Tees Serious Violence Summit and seek clarification where required.

4. BACKGROUND PAPERS

5. Contact Officer:-

Joan Stevens – Statutory Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

AUDIT AND GOVERNANCE COMMITTEE

12 March 2020

HARTLEPOOL BOROUGH COUNCIL

Report of: Statutory Scrutiny Manager

Subject: DRAFT QUALITY ACCOUNTS 2019/20 – COVERING REPORT

---

1. PURPOSE OF REPORT

1.1 To introduce representatives from the following organisations who will be in attendance at today's meeting to engage with Members in respect of their Draft Quality Accounts for 2019/20:

- North Tees and Hartlepool NHS Foundation Trust;
- North East Ambulance Service NHS Foundation Trust; and
- Tees, Esk and Wear Valleys NHS Foundation Trust (report attached at **Appendix A**).

2. BACKGROUND INFORMATION

2.1 In November 2009 the Government published the Health Bill which required all providers of NHS healthcare services to provide an annual Quality Account. The Department of Health made a legal requirement on all NHS healthcare providers to send their Quality Accounts to an Overview and Scrutiny Committee in the local authority area where the provider has a registered office.

2.2 Subsequently, representatives from each of the Trusts identified in Section 1.1 of this report will be present at today's meeting to give the Committee an opportunity to:

i) Consider and comment on:

- Performance against the priorities identified in the 2018/19 Quality Account ; and

- Priorities identified for quality improvement within the draft Quality Account for 2019/20.

ii) Formulate views / comments to inform the Committee's Third Party Declaration, to be included in the published version of the Quality Accounts for 2019/20.

3. RECOMMENDATIONS

3.1 That for each of the Trusts, identified in Section 1.1, the Audit and Governance Committee:-

i) Consider and comment on:

- Performance against the priorities identified in the 2018/19 Quality Account; and
- Priorities identified for quality improvement within the draft Quality Account for 2019/20.

ii) Formulate views / comments to inform the Committee's Third Party Declaration, to be included in the published version of the Quality Accounts for 2019/20.

Contact Officer:- Joan Stevens – Statutory Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

No background papers were used in preparation of this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Headlines

Progress on Quarter 3 actions has been good, with 50/56 (89%) either completed or on track for their planned completion date (see Appendix 1)

In terms of Quality Metrics, **4** of **10** (**40%**) are reporting green. We are reporting red on **6** of **10** metrics (**60**%). This is an identical position to last quarter. (see Appendix 2)

We have agreed our Quality Improvement Actions with our stakeholders and are working up the final detail of the actions to support these which will feature in the Quality Account document to be shared with stakeholders for comment in mid-April.

Progress – 19/20 Quality Improvement Actions

The most significant delays are for the personalising care planning priority. The planned further roll out of training has been paused until the new documentation is available on CITO in Q2 20/21. Focus groups with service users have confirmed that the proposed DIALOG system is a positive step towards more personalised care planning from their viewpoint.

Although the Quarter 3 action has been delivered, it is likely that some of the Dual Diagnosis Quarter 4 actions may not be delivered by the end of March. Support is being given to the clinical lead for this priority to re-plan the quarter 4 actions and to accelerate progress where possible.

All of the actions for the other two quality improvement priorities have been delivered on time.

Quality Improvement Metrics

The improvement seen in the % of patients feeling safe on the ward seen in Q2 has not been sustained. Addressing this issue will be a Quality Account improvement priority for 20/21.

The improvement in the use of physical restraint is linked to the closures of the Children and Young People's wards at West Lane during Q2. However, there is further work to do to reduce restraints, particularly in wards where there have been high levels of acuity and service users with behaviours which challenge.

- Clinical guidance on the safe use of mechanical restraint will be completed during March 2020
- Information for patients around the use of restrictive interventions has been developed and is currently being reviewed by ward staff and patients
- Specialist training in Positive Behavioural Support (PBS) for staff working in Learning Disabilities will commence in April 2020
- A feasibility study to assess the benefits of the use of Body Cameras is ongoing. Locality agreements are now in place for services to pilot the approach. Final technical checks are currently ongoing, following final approval, the pilot is expected to commence on the 1st April 2020

On other metrics there continue to be minor quarter to quarter variations. The most positive of these is that 'Percentage of patients who reported their overall experience as excellent or good' metric, was only 0.1 percent below target in Q3 (and better than target in Teesside and Forensics).

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Quality Improvement Actions for 2020

During 2019/20 TEWV held two Quality Account events for stakeholders. These took place in July 2019 and February 2020. The output from these meetings has influenced our choice of quality improvement priorities for 2020/21.

These priorities are shown below with some explanation about why these are important and what our actions will focus upon:

CYP to Adult Service Transitions
The preparation and planning around moving 17 year olds on to services for people 18+ can be an uncertain time for them. There is evidence of service gaps where there is a lack of appropriate services for Young People to transition into, and evidence that Young People may fail to engage with services without proper support. TEWV has had useful input from the national NHS Transitions Collaborative and is keeping this as a Quality Account priority so that we can implement their recommendations. We will also be improving how transitions panel operate.

Reduce the Number of Preventable Deaths
Sometimes healthcare teams can make mistakes, or parts of the system do not work as well together as well as they could. This means that when things go wrong, a death may have been preventable. In order to reduce preventable deaths, it is also important that learning from deaths is shared and acted on with an emphasis on engaging families and carers in this learning. The recent Safety Summit and forthcoming Family Involvement event will form the basis of our detailed plans. We will also be updating our zero suicide plan and introducing automatic follow up with service users within 48 hours of discharge from hospital.

Personalising Care Plans
NHSE advises mental health providers to 'Recognise people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'.

Feedback from service users shows that our current approach to Care Planning does not always promote personalised approach. We are about to implement the DIALOG system and so have made this one of our Quality Account priorities again for 2020/21.

Increasing the % of inpatients who feel safe on our wards
Feedback from our Stakeholders during 2019/20 has indicated that they see the percentage of inpatients who feel safe when they are on our wards as very important and so we have agreed to include this as our fourth Quality Account priority for 2020/21. This is also identified as a priority for Trusts in the NHS Long-Term Plan (2019).

This has been one of our key quality strategy targets – but of all the key targets it is the one where our actual performance is regularly the furthest away from our desired performance. It is also an area where the current processes to encourage improvement have not had sufficient impact and so we think a renewed and concentrated focus on it is required.

Our plans include trialling technology such as sensors (Oxehealth), bodycams for staff and increased use of drugs dogs, all of which should improve inpatients' perceptions.

Detailed Improvement Plans
Our Quality Account includes our detailed improvement plans. This will be circulated to stakeholders for comment on 14th April.

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Appendix 1 – Review of Progress on Actions in the current Quality Account 30/09/2019

Green: Action is on track
Red: Action is not on track and has either been extended or wording amended
Grey: Action is not on track but is due to circumstances outside of the Trust's control

Priority	Green Actions	Red Actions	Grey Actions	Comment
Make Care Plans more Personal	6	5	0	• As at end December 2019, there have been 231 people who have undertaken the CPA training. However, this training has been paused with no sessions of the original co-produced training package held during Q3 2019/20. This is because it will be more effective once the new DIALOG system and CITO can be shown to clinicians as part of the training. • The embedding of the DIALOG product as a solution to the simplification of some of the processes associated with the CPA (i.e. assess, plan, review) has taken longer than first anticipated. There is now a consensus that DIALOG needs to be used where possible, but that for a truly consistent approach we may need to adopt a DIALOG 'style' approach but further develop this product to make it more accessible and meaningful to more people. This needs to be discussed in the CITO development group, and also the Clinical Outcomes Group, as it could impact on the potential for using DIALOG as an outcome measure. • The first pilot of CITO in a live environment is currently scheduled for Summer 2021, with non-live User Acceptance Testing just prior to this around Easter 2021 • The audit is now 'live' within the Central Audit Team and the registration has been approved. All cases to be audited are a repeat audit from the previous sample and they have all been identified and ready for data collection via an Excel workbook. Data collection will be early Q4 and the audit report will be produced by the end of Q4

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH Services	12	0	0	
Reduce the number of Preventable Deaths	7	0	0	
Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services	15	1	0	• A report on the findings of the Dual Diagnosis network review has not been undertaken, although the review is now complete. Learning actions from the review are however embedded into the work surrounding the networks, for example, regularly reviewing attendance at network meetings, identifying gaps and proactively encouraging attendance from under-represented groups • There are a number of actions due for completion in Quarter 4 but there is a risk that some of these might not be completed on time based on the level of progress at the end of Q3. These will be re-profiled into 20/21
Review our urgent care services and identify a future model for delivery	9	0	0	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Appendix 2: **Performance against Quality Metrics at Quarter 3**

	Quarter 1 19/20		Quarter 2 19/20		Quarter 3 19/20		18/19	17/18	16/17
Patient Safety Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	88.00%	65.59%	88.00%	79.17%	88.00%	66.48%	61.50%	62.30%	N/A
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.10	0.35	0.21	0.35	0.19	0.18	0.12	0.37
Metric 3: Number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	38.18	19.25	31.03	19.25	24.25	33.81	30.65	20.26
	Quarter 1 19/20		**Quarter 2 19/20**		**Quarter 3 19/20**		**18/19**	**17/18**	**16/17**
Clinical Effectiveness Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Actual**	**Actual**	**Actual**
Metric 4: Existing percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	>95%	95.5%	>95%	98.23%	>95%	97.43%	96.49%	94.78%	98.35%
Metric 5: Percentage of clinical audits of NICE Guidance completed	100%	100%	100%	100%	100%	N/A	100%	100%	100%
Metric 6a: Average length of stay for patients in Adult Mental Health Assessment and Treat-ment Wards	<30.2	23.25	<30.2	25.47	<30.2	25.64	24.70	27.64	30.08
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment wards	<52	69.89	<52	64.69	<52	68.42	66.53	67.00	78.08
	Quarter 1 19/20		**Quarter 2 19/20**		**Quarter 3 19/20**		**18/19**	**17/18**	**16/17**
Patient Experience Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 7: Percentage of patients who reported their overall experience as excellent or good	94.00%	92.12%	94.00%	90.76%	94.00%	93.90%	91.41%	90.50%	90.53%
Metric 8:Percentage of patients that report that staff treated them with dignity and respect	94.00%	88.07%	94.00%	89.16%	94.00%	85.66%	85.70%	85.90%	N/A
Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94.00%	86.60%	94.00%	86.56%	94.00%	86.78%	86.9%	87.20%	86.58%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 3)

Local Authority Update – March 2020 –

Appendix 1: Performance against Quality Metrics by Locality

Quality Metric	Trust	Durham & Darlington	Teesside	North Yorkshire & York	Forensic Services
Patient Safety Measures					
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	66.48%	68.03%	64.52%	57.55%	75.00%
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) - for inpatients	0.19	0.18	0.20	0.39	0.06
Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days	24.25	14.19	49.50	16.79	14.57
Clinical Effectiveness Measures					
Metric 4: Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:	97.43%	N/A	N/A	N/A	N/A
Metric 5: Percentage of Clinical Audits of NICE Guidance completed:	N/A	N/A	N/A	N/A	N/A
Metric 6a: Average length of stay for patients in Adult Mental Health Services Assessment and Treatment Wards:	25.64	19.95	25.10	27.27	N/A
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment Wards:	68.42	66.06	63.54	76.59	N/A
Patient Experience Measures					
Metric 7: Percentage of patients who reported their overall experience as 'excellent' or 'good'	93.90%	92.66%	96.00%	91.17%	100.00%
Metric 8: Percentage of patients that report that staff treated them with dignity and respect	85.66%	84.91%	89.10%	82.66%	84.00%
Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	86.78%	87.67%	88.31%	86.24%	79.41%

103. Accommodation Strategy for Drug and Alcohol Treatment and Recovery Services (*Director of Regeneration and Neighbourhoods, Director for Children and Joint Commissioning Services and Director of Public Health*)

Type of decision

Non-key decision.

Purpose of report

The purpose of the report was to seek approval to take a new lease of space within the One Life Centre in Park Road to re-locate the Council's Drug and Alcohol Treatment Service to the property; and to advise of the contract award for the provision of specialist substance misuse services in Hartlepool.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods reported in March 2019 Finance and Policy Committee considered a report of Director, Children and Joint Commissioning Services and Director of Public Health entitled Reshaping Drug and Alcohol Treatment Services and the Committee agreed a model based on an enhancement of the current service model with a relocation to a higher quality better located facility.

Following a comprehensive competitive tendering and procurement process, the 'clinical' treatment contract was awarded to Foundations; an NHS provider of primary care and specialist substance misuse based in Middlesbrough. The availability of potentially suitable alternative premises having been considered, the former Minor Injuries Unit at the One Life Centre in Park Road was identified some time ago as a very good option. There would also be centralisation of the needle exchange service from the individual pharmacies that currently provided the service. Other changes in service delivery would see the recovery services currently provided at The Willows move to Gladstone House in Victoria Road with the building being operational from early March.

The Chair of the Regeneration Services Committee wished to record his thanks to all the officers that had been working on the new service model now reported and commended the selection of the new location for the services at the One Life Centre. The Chair supported the comments indicating that some of the changes already made to the services were being welcomed by the service users.

A resident from Waldon Street was present at the meeting and voiced the objections of the residents of Waldon Street to the proposal to relocate the drug and alcohol treatment services to the One Life Centre. Residents were concerned at the lack of consultation and the imposition of a service that would bring, what they saw as an undesirable element to their

neighbourhood. The resident stated that he had a petition from the residents of Waldon Street against the location of the drug and alcohol services at the One Life Centre. Members objected to some of the language used by the resident to describe the service users of the new facility and considered that the One Life Centre provided the ideal location to support people who required the support the services that would be based there.

The following decision was unanimous.

Decision

1. That the relocation of the Drug and Alcohol Treatment Service to the premises at the One Life Centre be approved together with the taking of the lease of the premises on the terms set out in Confidential Appendix 2 to the report which contained exempt information under Schedule 12A Local Government Act 1972 (as amended by the Local Government (Access to Information) (Variation) Order 2006) namely (para 3), information relating to the financial or business affairs of any particular person (including the authority holding that information).

2. The Committee noted the award of the 'clinical' treatment contract to Foundations; an NHS provider of primary care and specialist substance misuse based in Middlesbrough.