AUDIT AND GOVERNANCE COMMITTEE

AGENDA

HARTLEPOOL BOROUGH COUNCIL

1 APRIL 2025

at 5PM

in Council Chamber
Civic Centre, Hartlepool

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Boddy, Darby, Hall, Holbrook, Jorgeson, Moore (C), Morley, Roy, Thompson and Vacancy.

Standards Co-opted Independent Members: - Mr Martin Slimings.

Standards Co-opted Parish Council Representatives: Parish Councillor Kane Forrester (Wynyard) and Parish Councillor Patricia Andrews (Headland)

Local Police Representative

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 25th February 2025.

4. **AUDIT ITEMS**

   4.1 Limited, No Assurance Audit Update – *Head of Audit and Governance*

   4.2 Internal Audit Plan 2024/25 Update - *Head of Audit and Governance*

   4.3 External Quality Assurance Update – *Head of Audit and Governance*

   4.4 Internal Audit Charter Strategy and Plan 2025/26 - *Head of Audit and Governance*

CIVIC CENTRE EVACUATION AND ASSEMBLY PROCEDURE

In the event of a fire alarm or a bomb alarm, please leave by the nearest emergency exit as directed by Council Officers. A Fire Alarm is a continuous ringing. A Bomb Alarm is a continuous tone.
The Assembly Point for everyone is Victory Square by the Cenotaph. If the meeting has to be evacuated, please proceed to the Assembly Point so that you can be safely accounted for.

5. **STANDARDS ITEMS**

5.1 None

6. **STATUTORY SCRUTINY ITEMS**

Crime and Disorder Issues

6.1 Safer Hartlepool Partnership Action Plan 2024/25 – *Assistant Director of Neighbourhoods (Regulatory Services)*

Health Scrutiny Issues

6.2 Scrutiny Investigation – Recommendation Update – *Scrutiny and Legal Support Officer*

7. OTHER ITEMS FOR DECISION

7.1 None

8. MINUTES FROM RECENT MEETINGS FOR RECIEPT BY THE COMMITTEE

8.1 Health and Wellbeing Board – 2 December 2024

8.2 Finance and Policy Committee relating to Public Health issues – None

8.3 Tees Valley Health Scrutiny Joint Committee – 9 January 2025

8.4 Safer Hartlepool Partnership – None

8.5 Tees Valley Area Integrated Care Partnership – 8 November 2024

8.6 Regional Health Scrutiny – None

8.7 Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee - None

9. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

25 FEBRUARY 2025

The meeting commenced at 5pm in the Civic Centre, Hartlepool.

Present:

Councillor: Moore (In the Chair).

Councillors: Boddy, Darby, Hall, Jorgeson, Morley.

Standards Co-opted Members: Martin Slimings - Independent Member

Also present: James Collins, Director, Forvis/Mazars

Officers: James Magog, Director of Finance, IT and Digital
Joan Stevens, Statutory Scrutiny Manager
Gemma Jones, Scrutiny and Legal Support Officer

Prior to commencement of business the Chair advised that a document in relation to an amendment to item 4.1 had been tabled and Members were given time to read this document.

73. Apologies for Absence

Apologies for absence were received from:

- Councillors Holbrook, Thompson
- Parish Councillor Forrester
- Chief Inspector Andrew Liddell

74. Declarations of Interest

None.

75. Minutes

Minutes from the meeting held on the 28th January 2025 were confirmed.

76. Audit Completion Report 2023/24 – *Director of Finance, IT and Digital*

The Director of Forvis/Mazars presented to the Committee the Audit Completion Report which contained a summary of work completed on the financial statement for the year end of the 31st March 2024. Reference was made to pg 5 of the report

that set out the main responsibilities as the external auditor and the audit opinion. Key messages were also outlined in the Appendix 1 of the report. The Forvis/Mazars Representative explained that, in relation to the Teesside Pension Fund, it is unlikely that they would have sufficient appropriate audit evidence to conclude the work on the valuation of the defined benefit asset. This was due to the work on asset valuations that was unlikely to be completed before the 28th February 2025 backstop date. This was noted as being outside the control of the Council. Information concerning value for money was also detailed within section 7 of the report.

Reference was made to the matter concerning the review of the Pension Fund auditor response which was detailed on page 2 of the tabled amendment document. This had identified a difference between the benefits payable figure used by the Actuary in their calculation and the actual benefits payable per the Teesside Pension Fund. This was deemed to have no impact on the balance sheet and the Council position would remain the same however, a change in note 45 was required and had been enacted by the Council.

The audit had also identified some key risk areas that were highlighted as requiring more attention. Although no particular risk identified, these areas were the management override of controls and the estimation of valuation of land, buildings and investment property and pensions. A historic issue in relation to the accounting for external care costs was also highlighted.

In the discussion that followed Members queried the Teesside Pension Fund and its robustness given that Mazars/Forvis had not received the assurance they had expected. Representative explained that the Council rely on the Teesside Pension Fund to audit this and this is used by the Actuary to prepare the asset valuation. Due to the back stop date of 28th February 2025 they had not had the opportunity to complete this audit and this had proved challenging. This issue was in relation to the timing of the audit being delayed. Further concerns were raised by the Committee as this issue had also occurred in previous years. The Representative confirmed that the assurance for this item had come later as in previous years due to the back stop date and that this needed to be back on track. It was confirmed that despite the delay in this, the overall outcome of the audit opinion would not change from what has been presented to the Committee at this meeting.

Members asked for further information in relation to the risks identified, in particular how they arose and what Members needed to be aware of. Further information was provided in terms of the management override of controls and the estimation of valuation of land, buildings and investment property and pensions.

Members queried the historic accounting for external care costs. The Director of IT, Finance and Digital confirmed this will be addressed in the current year.

The Forvis/ Mazars representative continued with their presentation of the report and highlighted the summary of main findings and the recommendations identified. Although not treated as significant weaknesses they had highlighted the areas that management needed to focus on including the need to take action regarding the pressures of children services and social care payments. Members queried if the

issue of social care costs pressures were unique to this council, and it was confirmed that this was a concern nationally and not unique to this authority. It was confirmed that there were no time scales on addressing the Value for Money recommendations but that they would be considered in 2024/25.

Recommended

(i) For the Committee to note the Audit Completion Report.

77. The 2023/24 Financial Report (including the 2023/24 Statement of Accounts) – *Director of Finance, IT and Digital*

The Director of Finance, IT and Digital presented the Financial Report including the statement of accounts to the Committee for approval. Reference was also made to the pension adjustment. It was requested that if any matters were to arise between now and the 28th February 2025, that delegated authority be given to the Director to resign the accounts.

Recommended

i) The report was noted.
ii) The Financial Report was approved, as referenced in 5.1.
iii) It was noted and agreed that should a material error be identified in the outstanding issues, that results in amendments to the Financial Report, these amendments are actioned and delegated authority be given to the Director of Finance, IT and Digital in consultation with the Chair of the Audit and Governance Committee to approve the updated Statement of Accounts 2023/24.

72. Regulation of Investigatory Power Act 2000 (RIPA) – Quarter 4 Update – *Director of Legal Governance and Human Resources*.

The Statutory Scrutiny Manager reported that Hartlepool Borough Council had powers under the Regulation of Investigatory Powers Act 2000 (RIPA) to conduct authorised covert surveillance and was required to provide Members with a quarterly update as to the use of those powers. Members were informed that in the quarter to the date of this meeting, there had been no RIPA Authorisations authorised.

Recommended

i) That the report be noted.

The meeting concluded at 5.40pm.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

1 April 2025

Report of: Head of Audit and Governance

Subject: LIMITED, NO ASSURANCE AUDIT UPDATE

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.
- of resilient and resourceful communities with opportunities for all.
- that is sustainable, clean, safe and green. - that has an inclusive and growing economy
- that has an inclusive and growing economy.
- with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

2. PURPOSE OF REPORT

2.1 Following a request form the Chair of the Audit and Governance Committee, the report allows Members the opportunity to question Assistant Directors on progress made implementing actions agreed in their areas of responsibility, in relation to limited and no assurance audits previously reported to the Committee.

3. BACKGROUND

3.1 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 implementing actions agreed to mitigate risks as part of limited and no assurance Internal Audit reports. 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. 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 Global Internal Audit Standards (GIAS).

3.2 For Members information, Table 1 below defines what the levels of assurance Internal Audit places on the audits they complete and what they mean in practice:

Table 1

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

4. LIMITED AND NO ASSURANCE AUDITS

4.1 Table 2 below summarises those audits that were assessed as Limited and No Assurance and issues identified.

Table 2

Audit/ Assistant Director	**Assurance Level**	**Issues Identified**
Gladstone Leisure Management System. Gemma Ptak.	Limited Assurance	-Because of the complexity of the Block Bookings process it was not possible to fully complete the testing to verify that all invoices due had been issued, that all invoices issued were to the correct person, for the correct amount. This is a material risk to Leisure Services as the block booking income stream is a significant portion of budget. - Bookings taken via Gladstone are paper forms or emails that must then be input into Gladstone rather than the booker being able to log bookings to be accepted. - Block booker accounts in Gladstone are in the name of the individual and there is no current link to the booking organisation or the person who needs to receive an invoice (or the supplier's number/name in Integra). -On producing the reports from Gladstone listing the bookings that need invoicing for that month, there is a large amount of time being spent identifying the supplier in Integra and collating the bookings from each organisation prior to raising the invoices in Integra, this is inefficient. -A large volume of information needs to be input into the

		invoice (dates booked, name of booker and cost per session) in Integra as it cannot be uploaded directly from Gladstone, this is time consuming and inefficient and disproportionately affects the officers at Brierton as that site has a very large volume of bookings and therefore invoices to manage. -No reconciliation between the invoices expected to be raised (Gladstone reports) and those raised (Integra) and to do so would not be a quick or easy process.
Borough/ Town Hall. Gemma Ptak	No Assurance	-An inability to account for bar income effectively due to errors on till readings. -ongoing financial performance of the venue because of historic budget setting assumptions resulting in significant budget deficit, although the auditor acknowledges that action is being taken to ensure future budgets address budget overspend. -delays in banking income received. -inadequate asset management arrangements for bar stock.
Health and Safety. Sylvia Pinkney	No Assurance	-Health & Safety not currently part of the corporate induction process, meaning that new staff may be unaware of their roles and responsibilities and so unable to comply with the policy as required. -There is currently no method of identifying and recording which posts require H&S training to ensure that the right staff have had the right training and are therefore able to comply with the requirements of the policy. -There is an inconsistent approach to Departmental H&S committee meetings. There is no evidence of discussion of H&S risk and/or risk assessments to ensure compliance with the policy and effective risk management. -There is an inconsistent approach to risk assessments being completed in departments. This could lead to H&S risks being unidentified, unassessed and unmitigated by effective controls, resulting in potential harm to staff and/or customer/service users. -Non-compliance with the policy is not currently reported to ELT.
Insurance. Paul Dixon	No Assurance	-No up-to-date insurance strategy or more regular review of full insurance cover with broker. -No recent review of departmental recharge calculations. -No process for identifying new areas of insurance cover, new or changes to assets and disposal. -Process for monitoring of claims. -Reporting lines to ensure the relevant managers, senior officers and/or Members have the required information to enable decision making. -Evaluate if Figtree application is fit for purpose and if not

		arrange for the development or purchase of suitable alternative information storage.
Proceeds of Crime Act. Paul Dixon	Limited Assurance	-Regular updates/reviews of the money laundering and terrorist financing policy and money laundering and terrorist financing risk assessment were not undertaken. -Identification of relevant staff who require training, and providing training both around the law covering money laundering and terrorist financing and around in house procedures for notifying the Money Laundering Reporting Officer (MLRO) of suspicious transactions had not been undertaken. -Out of date procedures for receiving notifications about potential money laundering transactions, for analysing those notifications and recording which if any have been reported to NCA.
Levelling Up Fund Grant. Bev Bearne.	Limited Assurance	- current arrangements need to be more robust and additional measures are needed to ensure compliance with the Grant Assurance Framework.
Drug and Alcohol Services Contract. Craig Blundred	Limited Assurance	-Contract monitoring. -Performance measurement.

4.2 More detail regarding each audit and the risks identified and action plans agreed are provided in **Appendix A**.

5. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	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.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.
LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY POVERTY CONSIDERATIONS	No relevant issues.
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.

STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.
CONSULTATION	No consultation required.

6. RECOMMENDATIONS

6.1 It is recommended that Members review progress made by Assistant Directors in relation to the actions agreed regarding limited and no assurance internal audit reports.

7. REASON FOR RECOMMENDATIONS

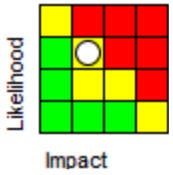
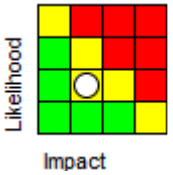
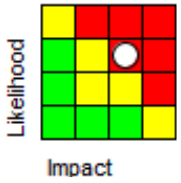
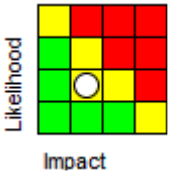
7.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it satisfies itself that those actions agreed by Internal Audit are implemented in a timely manner.

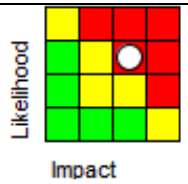
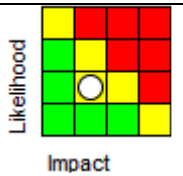
8. BACKGROUND PAPERS

8.1 - Internal Audit Reports
- Global Internal Audit Standards (GIAS).

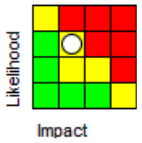
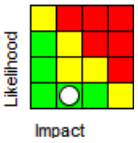
9. CONTACT OFFICER

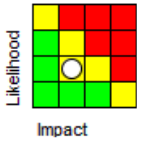
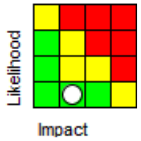
9.1 Noel Adamson
Head of Audit and Governance
Civic Centre
Victoria Road
Hartlepool
TS24 8AY
Tel: 01429 523173
Email: noel.adamson@hartlepool.gov.uk

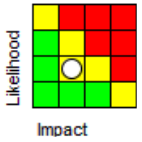
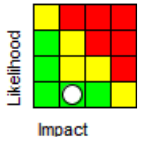
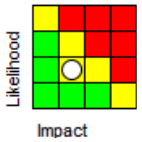
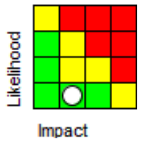
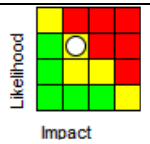
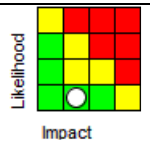
Audit	**Objective**		**Assurance Level**
Gladstone Leisure Management System	Ensure IT application controls in place		**Limited**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
There are no documented procedures and/or they are not available to the relevant staff; and/or the staff using each module have not been trained in the procedures, leading to staff not following expected procedure, resulting in the information in the Leisure Management System being incorrect or not up to date. This may have a knock-on risk effect on other areas of the organisation with whom information is shared which could ultimately result in fines, sanctions and /or reputational and financial damage to the organisation.		A list of procedures we need staff to follow will be drawn up The list will be prioritised to reflect which procedures need to be developed first We will develop the procedures for each task as per our prioritised list and roll them out to staff with some training (see action for Issue 2). The procedures will be in a format that can be made available to as many staff as possible for easy reference while they may be undertaking the task.	
There are no documented procedures and/or they are not available to the relevant staff; and/or the staff using each module have not been trained in the procedures, leading to staff not following expected procedure, resulting in the information in the Leisure Management System being incorrect or not up to date. This may have a knock-on risk effect on other areas of the organisation with whom information is shared which could ultimately result in fines, sanctions and /or reputational and financial damage to the organisation.		As each procedure note is developed (see action for Issue 1) we will provide a brief training session for the staff who complete that task to advise of the procedure and what the risks are if it is not followed to help understanding. These training sessions may be in a variety of forms, whichever is most suitable for the procedure and the staff involved.	
New bookings from clubs/organisations are incorrectly set up and/or relevant documents have not been provided, leading to facilities not being available as requested, prices quoted		A workshop session is planned to achieve the following: -Identify all the current issues in the block booking and invoicing tasks and how they impact -Make suggestions for fixes to the issues (these should	

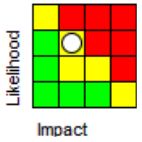
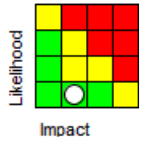
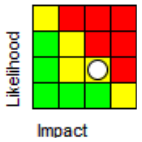
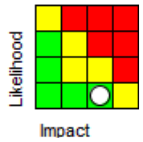
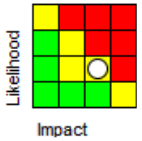
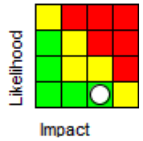
being inaccurate, insurance and other requirements not being in place, resulting in damage to the Council's reputation, loss of income and/or fines or other sanctions if an event occurs and no insurance is in place. Invoices have not been raised for any/all relevant bookings or the invoices raised are incorrect, leading to customers not being charged or being incorrectly charged, resulting in loss of income and reputational damage.		be separated into immediate fixes, short to medium term fixes and long-term fixes) -Identify any potential barriers (or possible impacts to other processes) to implementing the fixes and possible solutions -Identifying any other HBC officers or Gladstone who need to be involved in the development of each of the fixes -Involving Internal Audit in reviewing the fixes so they can verify that the risk exposure should be effectively mitigated by the controls in place -Agreeing the fixes chosen to implement to correct the issues -Drawing up an action plan to implement the immediate fixes, the short to medium terms fixes and the long-term fixes and allocating responsible officers and deadlines for action -Adding in potential test or pilot time for some of the fixes as applicable The action plan would be monitored at 1-21's and other relevant meetings.	

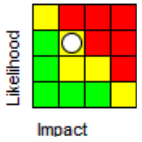
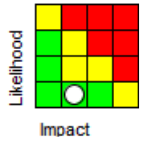
Audit	**Objective**	**Assurance Level**
Borough Hall	Controls are in place to mitigate risks in the following areas: Bar Income, Lettings income, Income Security, Banking of income, Compliance with Contract Procedure Rules, Procurement of goods / services.	**No Assurance**

Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024 in order to review/monitor existing processes and procedures and ensure training and implementation of these to ensure consistent approach by staff for completion of tasks. Service Development Coordinator to analyse z-readings	

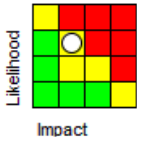
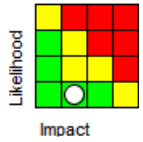
		against till readings and bar income reports to understand any discrepancies which will be further investigated. (January 2024) Training to be arranged with Cleveland Retail Systems in regards to the tills in order to maximise use of functionalities, this will enable staff to record sales correctly and avoid unnecessary errors. Also, this will allow the Duty Officer to obtain further information as appropriate. (February 2024) Recruitment of casual staff in key roles and thorough training to be included as part of induction, this will support with staff shortages and ensure only trained members of staff with prior knowledge and experience of systems are allocated work. (July 2024) Renew card machines so they can connect with the tills, provide appropriate staff with supervisor codes and integrate with the Corporate finance systems so monies are automatically coded to the correct budget codes. (July 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024. Implement new procedure already used and proven to be effective in Active Hartlepool Service to report and analyse discrepancies, with relevant training to be carried out with appropriate staff. (February 2024). Wastage report to be devised and carried out alongside banking so any trends can be explored. (February 2024). Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	

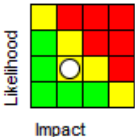
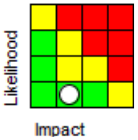
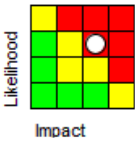
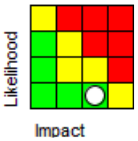
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024 in order to review/monitor banking processes and procedures. Service Development Coordinator to review banking procedure, amend as appropriate and ensure implementation/training of procedure to all staff. As part of this it will ensure the float is always taken out first. (January 2024). Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Review outstanding invoice - to be raised immediately. NB Action complete - event held on 03/10/23 was an internal transfer, therefore no invoice and income is showing in budget. Internal transfers will be noted on booking confirmations to ensure process of payment is clear for monitoring. Procedure to be implemented in order for invoices to be carried within 14 days following booking/events. (January 2024) Booking terms and conditions to be reviewed and communications plan to be developed for any changes that may need to be communicated with existing bookings. (February 2024) Deposits to be taken in advance of events as per booking terms and conditions and a clear process identified on how this will be managed and monitored. (February 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Float reduced to £1,800 and excess taken to the Cash Office 09/01/2024, current float to be reviewed and potentially reduced further.	

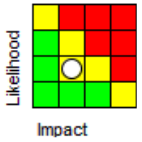
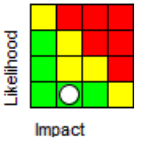
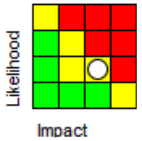
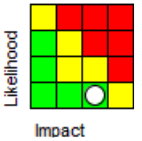
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024 in order to review/monitor banking processes and procedures and ensure implementation and training on this. Cash banking procedure is now aligned to weekly collections at the Headland Sports Centre so that banking is managed more effectively. Staff training to be arranged with Corporate Finance in relation to recording card income. (February 2024) Monthly reports to be generated and monies journalled to correct budget codes. (March 2024) Renew card machines so they can connect with the tills, provide appropriate staff with supervisor codes and integrate with the Corporate finance systems so monies are automatically coded to the correct budget codes. (July 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	
Goods / services are purchased without appropriate segregation of duties and authorisation, leading to the possibility that purchases may be made for personal use or in breach of HBC Financial Procedures, resulting in financial loss to the Authority		Analysis to be carried out in order to identify which suppliers don't currently forward invoices directly to Supplier Invoices. Procedures to be shared as appropriate with all suppliers to ensure Accounts Payable receive all invoices directly. Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	
Goods / services are purchased without appropriate segregation of duties and authorisation, leading to the possibility that purchases may be made for personal use or in breach of HBC Financial Procedures, resulting in financial loss to the Authority		Market research, analysis and testing was carried out in 2023 for the provision of alcohol/bar stock, however sector interest in supplying drinks was limited due to the relatively low volume and value of sales, reflected in figures for 2022/23. To meet and discuss with procurement team to consider if there is a different approach that can be taken. (February 2024)	

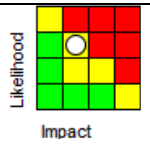
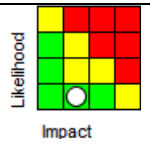
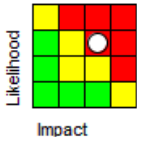
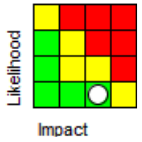
Regular independent checks of stock are not undertaken and significant differences investigated, leading to the possibility that assets may be lost and / or misappropriated leading to financial loss for the service.		Tills to be programmed in order to manage stock appropriately (February 2024) Monthly stock checks to be scheduled, recorded appropriately and accessible. (March 2024) Annual stock checks to be carried out both internally and externally. (March 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly.	

Audit	**Objective**	**Assurance Level**
Town Hall Theatre	Controls are in place to mitigate risks in the following areas: Bar Income, Lettings income, Income Security, Banking of income, Compliance with Contract Procedure Rules, Procurement of goods / services.	**No Assurance**

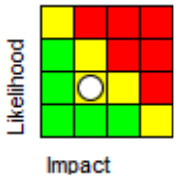
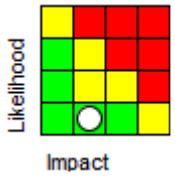
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024 in order to review/monitor existing processes and procedures and ensure training and implementation of these to ensure consistent approach by staff for completion of tasks. Service Development Coordinator to analyse z-readings against till readings and bar income reports to understand any discrepancies which will be further investigated. (January 2024) Training to be arranged with Cleveland Retail Systems to optimise till functionality. This will enable staff to record sales correctly and avoid unnecessary errors. Also, this will allow the Duty Officer to obtain further information as appropriate. (February 2024) Recruitment of casual staff in key roles and thorough training to be included as part of induction, this will	

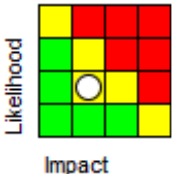
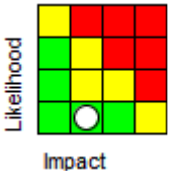
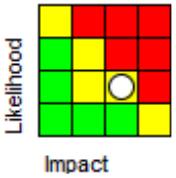
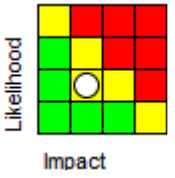
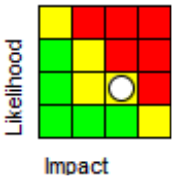
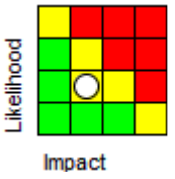
		support with staff shortages and ensure only trained members of staff with prior knowledge and experience of systems are allocated work. (July 2024) Renew card machines so they can connect with the tills, provide appropriate staff with supervisor codes and integrate with the Corporate Finance systems so monies are automatically coded to the correct budget codes. (July 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024. Implement new procedure already used and proven to be effective in Active Hartlepool Service to report and analyse discrepancies with relevant training to be carried out with all appropriate staff. (February 2024) Wastage report to be devised and carried out alongside banking so any trends can be explored. (February 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Explore financial integration with PatronBase to ensure that monies are automatically transferred to the correct project codes, as opposed to a generic holding code. (February 2024) Training for identified members of staff to be arranged with PatronBase to better understand the full functionalities of the Box Office system, so shows are set-up correctly and coded to the specific budget code. (March 2024) Monthly reports to be generated and monies journalled from the holding code to correct budget codes prior to financial integration where possible. (March 2024)	

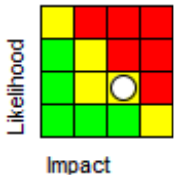
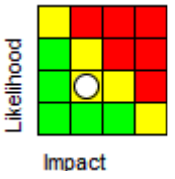
		Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	
All income is not collected, recorded, stored securely and banked promptly and intact, leading to the possibility for monies being lost / stolen resulting in to loss of income to the service.		Allocation of Service Development Coordinator time to work with operational staff (inclusive of Duty Officers) as of W/C 15/01/2024 in order to review/monitor banking processes and procedures. Banking procedure to be created with Cash Office to ensure banking can be carried out promptly following events, with flexibility outside of standard opening hours. (January 2024) Explore financial integration with PatronBase. (February 2024) Staff training to be arranged with Corporate Finance in relation to recording card income. (February 2024) Monthly reports to be generated and monies journalled to correct budget codes. (March 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	
Goods / services are purchased without appropriate segregation of duties and authorisation, leading to the possibility that purchases may be made for personal use or in breach of HBC Financial Procedures, resulting in financial loss to the Authority.		Market research, analysis and testing was carried out in 2023 for the provision of alcohol/bar stock, however sector interest in supplying drinks was limited due to the relatively low volume and value of sales, reflected in figures for 2022/23. Individual contracts are negotiated with promoters on an ongoing basis, all of which account for expenditure. To meet and discuss with procurement team to consider if there is a different approach that can be taken. (February 2024)	
Regular independent checks of stock are not undertaken and significant differences investigated, leading to the possibility that assets may be lost and / or misappropriated leading to financial loss for the service.		Tills to be programmed in order to manage stock appropriately. (February 2024) Monthly stock checks to be scheduled, recorded appropriately and made accessible for scrutiny. (March 2024)	

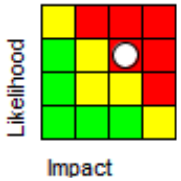
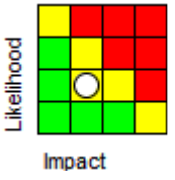
		Annual stock checks to be carried out both internally and externally. (March 2024) Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	
Effective arrangements are not in place to monitor / manage the performance of the service, resulting in Service standards not being in line with desired levels leading to financial loss arising from events and activities		Revise and extend existing system in use, to ensure all programme costs are quantified, inclusive of bar sales when assessing and managing performance for events. Performance management to be carried out for all events and accurate formula to be devised for bar profit. Ongoing review and monitoring of all actions through staff supervisions, task and finish groups, team meetings and updates to be shared with Preventative and Community Based Services Management Team monthly meetings.	

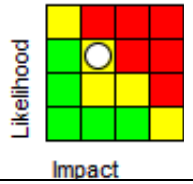
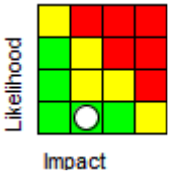
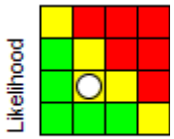
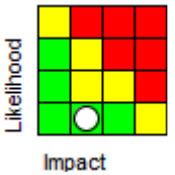
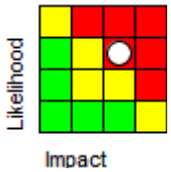
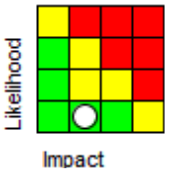
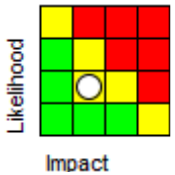
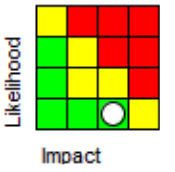
Audit	**Objective**	**Assurance Level**
Health and Safety	Ensure adequate controls are in operation to mitigate risks in the following areas: Policies and procedures; Training; Risk Assessments; and Monitoring and Reporting.	**No Assurance**

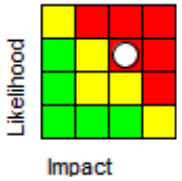
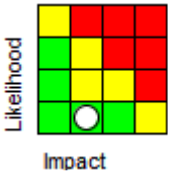
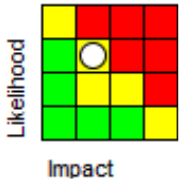
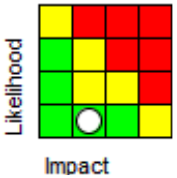
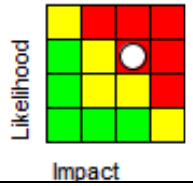
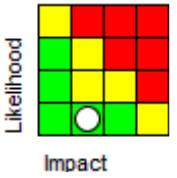
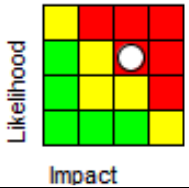
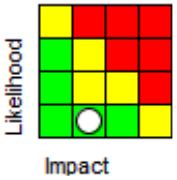
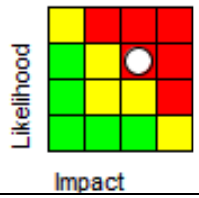
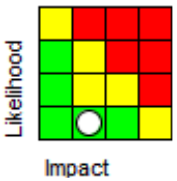
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Authority does not have an effective H&S Framework in place which sets out responsibilities or complies with Health & Safety legislative requirements resulting in significant financial penalties and reputational damage.		The current 2024 Policy has been reviewed and revised will be sent to the MD to be signed. Once signed it will be rolled out to staff and put on the intranet. The new policy has also been added onto the corporate Health and Safety Meeting scheduled for the 25th April. Moving forward a recommendation will be put in place and the policy will have a long stop formal review date or will be reviewed and revised following any organisational management changes that will affect the policy. Each year the Health, Safety and Risk	

		Manager will do a version control check and if no significant changes are required it will be published with the version control information.	
The Authority does not have an effective H&S Framework in place which sets out responsibilities or complies with Health & Safety legislative requirements resulting in significant financial penalties and reputational damage.		The draft Terms of Reference for the Corporate H&S Committee Meeting will be added on to the agenda for the next scheduled Corporate Health and Safety meeting on the 25th April. An agreement will be sought on the TOR and will be added onto the minutes. The TOR and minutes documenting the agreement will be added to the Intranet and added to a folder in the H&S drive.	
Lack of suitable training for staff appropriate to the level of requirements to manage health & safety leading to staff not being aware of their responsibilities resulting in non-compliance with policy or legislative requirements.		Manager training has been provided to date in 2 formats – face to face via the workforce development programme and an e-learning ROSPA approved Health and Safety for Managers tutor led training on the Skillgate platform. Explore the provision of H&S accredited courses. If funding is available it is proposed that budget is allocated to allow accredited management courses, such as IOSH managing safely to be added onto the Workforce Development Programme. H&S will recommend and work with HR and managers to ensure that H&S qualifications, experience and training is identified on the person specification for the post. Work with HR to include H&S on the induction process	
Health & Safety risk assessments are not undertaken by departments or reviewed on a regular basis leading to ineffective management of potential hazards resulting in non-compliance with the organisational Health & Safety Policy, Health & Safety legislation/regulations and/or potential accident, injury or loss of life.		Raise the profile of health & safety across the Authority. A report will be taken to ELT in April 2024 recommending a number of changes to Health & Safety arrangements including □ Requiring that at least once per quarter Health & Safety is a standard agenda item on all DMT and departmental SMT meetings. □ That either the AD (Regulatory Services) or Health, Safety & Risk Manager attend the quarterly DMT meetings to discuss health & Safety including audits carried out in that department and progress on actions. □ The Health, Safety & Risk Manager will also attend departmental SMT meetings as required.	

		• Update reports on Health & Safety to be taken to Finance & Policy Committee. • Changes to Health & Safety Committee arrangements (to be agreed by unions) • If there is a no assurance audit The Health, Safety & Risk Manager and AD (Regulatory Services) will meet with the relevant AD and Strategic Manager to discuss and agree the action plan. A report will then be presented to ELT. The H&S team is also going to update an info pack to include with each audit report that sets out the process and responsibility for completing actions including carrying out risk assessments and consulting with workers on line managers on the findings of the report.	
Ineffective monitoring and reporting throughout the Authority of potential hazards leading to accidents, incidents, injury or loss of life resulting in non-compliance with legislation.		Explore the use of Computer system to assist in tracking progress with audit actions.	

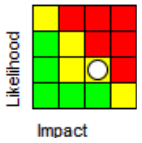
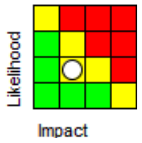
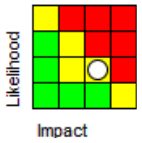
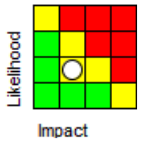
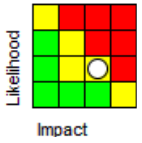
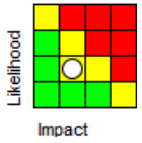
Audit	**Objective**		**Assurance Level**
Insurances	Ensure adequate Insurance Strategy; Risk Management; Use of Resources; Insurance Policies; Claims Processing; Claims Monitoring; Benchmarking and GDPR controls are in operation.		**No Assurance**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The council does not have an Insurance Strategy that considers the insurance needs of the council, leading to a lack of awareness of the overall level of risk resulting in inadequate insurance cover.		An annual review of insurance coverage specifics is already carried out with departments i.e. premises in ownership, employees numbers, numbers/types of vehicles, etc. In addition to this an annual check will be carried out with Assistant Directors moving forward, to understand if there are any new areas of insurance cover required, likely changes during the year,	

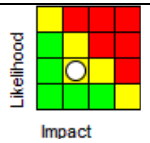
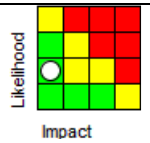
		significant (£2m+) capital projects and any areas no longer required.	
Failure to comply with HBC Information Governance Policies and Procedures leading to non-compliance with the Data Protection Act resulting in a fine from the ICO.		Review and action data cleanse in line with retention policies on all insurance related systems and documentation stores.	
Operating system access controls may enable application access controls to be bypassed leading to unauthorised access to personal / sensitive information that may result in the data being used fraudulently or maliciously. No or ineffective controls in place around access to the system parameters could lead to unauthorised/incorrect changes being made to system parameters which could result in incorrect payments/services/data.		A) Procure new insurance management system. B) Expand access on Figtree system. Admin support currently being arranged to support insurance operation during long-term sickness of insurance manager.	
The council has not used a broker or completed a thorough assessment of insurance requirements leading to insufficient level/cover of insurance resulting in insufficient transfer of financial risks associated with the Council's activities.		Annual check will be carried out with Assistant Directors moving forward, to understand if there are any new areas of insurance cover required, likely changes during the year, significant (£2m+) capital projects and any areas no longer required. In addition a review of the Risk Registers developed as part of the Corporate Risk Management Framework would also be carried out annually to identify if any risk areas need further consideration.	
Ineffective arrangements for recharging departmental budgets may lead to incorrect costings and the costs of provision of insurance cover may not be recovered from third parties resulting in financial loss.		Full review of charging mechanism to be carried out by central finance time to inform 2025/2026 budget setting process.	

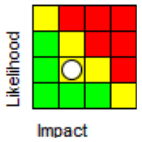
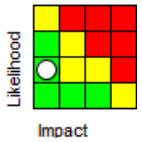
The council does not have a Risk Management Framework or Toolkit which is used by the Insurance Department to determine new areas or gaps in insurance cover, leading to inaccurate insurance cover and lack of risk awareness of the Council's requirements within the council, resulting in adverse risk culture.		Annual check will be carried out with Assistant Directors moving forward, to understand if there are any new areas of insurance cover required, likely changes during the year, significant (£2m+) capital projects and any areas no longer required. In addition a review of the Risk Registers developed as part of the Corporate Risk Management Framework would also be carried out annually to identify if any risk areas need further consideration.	
Formal arrangements for processing claims may not be in place leading to insufficient evidence required to 'defend' against fraudulent/malicious claims resulting in claims not settled in most economic, efficient and effective manner.		Expand access on Figtree system. Admin support currently being arranged to support insurance operation during long-term sickness of insurance manager. New support will allow system records to be brought up to date.	
Inadequate reporting and monitoring of the number and costs of claims which could lead to inappropriate action taken to reduce future potential claims resulting in financial loss and reputational damage.		Claims summary information to be report on a quarterly basis in to Directorate Management Teams (or other appropriate forum – TBC).	
There is no or insufficient review of the Self Insurance Fund to ensure its value is proportionate and reasonable to cover potential excesses, leading to either insufficient/too much money being held to cover costs, resulting in adverse impact on budget position.		In-year forecasting to be introduced for 2024/25. Timely providing of relevant information to finance team to assess budget position on a quarterly basis.	
There is no or insufficient review of the Self Insurance Fund to ensure its value is proportionate and reasonable to cover potential excesses, leading to either insufficient/too much money being held to cover costs, resulting in adverse impact on budget position.		Insurance provider, Marsh, engaged to support an actuarial assessment of the insurance fund level.	

Appendix A

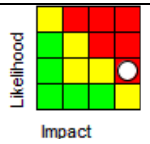
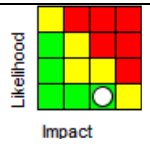
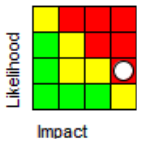
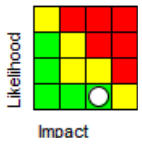
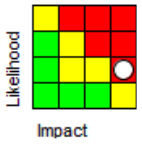
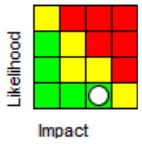
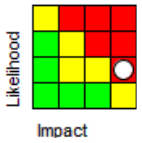
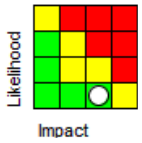
Audit	Objective	Assurance Level
Levelling Up Fund Governance Arrangements	Grant is managed in line with terms and conditions.	**Limited**

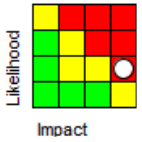
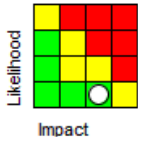
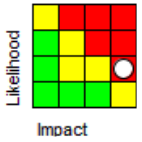
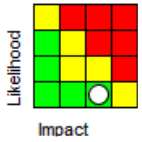
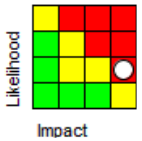
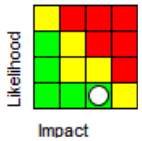
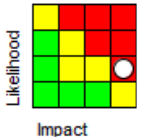
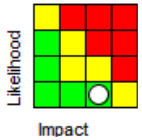
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Inability to provide the required level of assurance due to ineffective governance arrangements being in place resulting in the need for the implementation of remedial actions leading to the potential suspension of payment and non-compliance with the relevant grant agreement.		Both LUF and Town Deal projects being directly delivered by the Strategic Development Team will ensure individual project risk registers align with the Council's Corporate Overview and Scrutiny policy/procedure (where available) and Risk Management.	
Inability to provide the required level of assurance due to ineffective counter fraud arrangements being in place resulting in the need for the implementation of remedial actions leading to the potential suspension of payment and non-compliance with the relevant grant agreement.		The Strategic Development Team will ensure the Corporate Anti-Fraud Corruption Policy is applied to all LUF and Town Deal projects being delivered by HBC. Conflict of Interest Registers and Gifts are put in place for LUF. Gifts & Hospitality Registers will be put in place aligning with HBC's corporate policies and procedures. In line with Framework requirements a Fraud Risk Register will be developed and implemented.	
Inability to provide the required level of assurance due to ineffective counter fraud arrangements being in place resulting in the need for the implementation of remedial actions leading to the potential suspension of payment and non-compliance with the relevant grant agreement.		It is recognised that HBC do not currently have a corporate Subsidy Control policy or supporting documents. This has been raised with the Executive Director of Development, Neighbourhoods and Regulatory Services and will be taken to ELT for the appropriate department to take forward development of necessary policy and documentation to allow the Strategic Development Team to comply with DLUHC Assurance Framework and the action highlighted.	

Income may not be promptly received by HBC as Accountably Body or allocated accurately to projects leading to possible financial difficulties that may impact on the ability to deliver projects.		This issue has been discussed with the finance team and processes are now in place to ensure that all financial transactions are correct and valid.	

Audit	**Objective**		**Assurance Level**
Levelling Up Fund Monitoring and Evaluation	Grant is managed in line with terms and conditions.		**Limited**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The quarterly return is not submitted in accordance with DHULC timescales and does not contain all relevant information due to non-adherence to grant requirements resulting in delays in receiving payment or reduction of payment and/or the Authority being subject to a deep dive inspection.		Evidence of future checks will be saved in relevant project folders alongside M&E returns.	

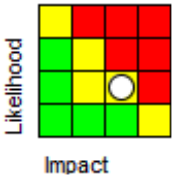
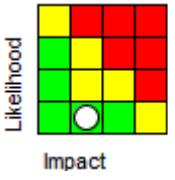
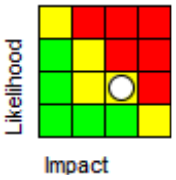
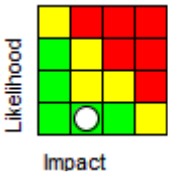
Audit	**Objective**		**Assurance Level**
Proceeds of Crime Act	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Policy and Procedure; Compliance with regulatory requirements (Governance, Risk Management, Record Keeping, Training)		**Limited**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Proceeds of Crime/Anti Money Laundering and Terrorist Financing Policy does not exist, is out of date, and/or is not sufficiently publicised leading to a lack of awareness of systems and		The Assistant Director (Corporate and Financial Services) has been designated as the responsible officer for reviewing/updating the policy and for performing regular checks for changes in relevant	

controls in place and an inability to comply with them which could result in imprisonment (2-14 years), fines (unlimited) or both.		legislation, regulation and guidance that could impact on the policy. The Assistant Director (Corporate and Financial Services) will: - review and update the policy, - develop and document a procedure for rolling out the policy to ensure organisation wide awareness of the policy, and - develop, document and implement a process for checking organisation wide compliance with the policy. Date for Implementation 31/12/23.	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The action noted above is that the policy will be updated, this will include: - updating the MLRO and their contact details. - a documented procedure for relevant staff to follow to notify the MLRO of suspicious transactions, - a documented procedure for the MLRO to follow to analyse each notification received to identify if any need SAR filing or reporting to NCA (including how to record the information and who has access) Date for Implementation 31/12/23.	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The new MLRO will request contact details and any logins required to file SARs. Date for Implementation 31/12/23.	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The Director of Finance, IT and Digital Services will carry out a risk assessment in line with the money laundering and terrorist financing regulations, timetable this in for regular review as per the guidance and report where necessary/appropriate to Senior Managers and/or Members. Date for Implementation 31/12/23.	

Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The Assistant Director (Corporate and Financial Services) will identify which (if any) services need to comply with regulation 40. The update of the policy as agreed in the action relating to Issue 1 will include: - a documented procedure for staff to follow to ensure sufficient supporting records are retained where applicable, for the required period before being disposed of securely. Date for Implementation 31/12/23	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The action agreed related to Issue 1 is to update the policy. Once this policy update has been completed, the Assistant Director (Corporate and Financial Services) will ensure all staff are made aware of the policy. Date for Implementation 31/12/23	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		The Assistant Director (Corporate and Financial Services) will identify a list of relevant staff/posts where more detailed training of the law and the organisational procedures. Date for Implementation 31/12/23	
Non-compliance with local Anti-Money Laundering and Terrorist Financing policies and procedures could lead to non-compliance with legislation, regulation and guidance which could result in imprisonment (2-14 years), fines (unlimited) or both.		Once a list of relevant staff/posts requiring more detailed training has been completed, a training package will be procured or developed which will include, as per the guidance: - awareness of the law relating to money laundering and terrorist financing, - the GDPR and Data Protection requirements, - how to recognise transactions with a money laundering or terrorist flag, - how to report it and to whom as per the organisation policy. Date for Implementation 31/12/23	

Appendix A

Audit	Objective	Assurance Level
Drug and Alcohol Services Contract	Contract delivered and monitored in line with terms and conditions.	**No Assurance**

Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
The monitoring of the contract is not undertaken or reported timely and accurately to the LA leading to under delivery of drug and alcohol treatment provision resulting in non-compliance with legislation and possible financial loss.		A contract amendment was agreed that monthly performance reports were actually quarterly which was an oversight when the contract was issued 4 years ago. Amendment to be reported in the next meeting. Foundations partners and Clinical lead present performance data quarterly to the START Performance Management meeting. These meetings will now be minuted by the Assistant Directors PA. Contract review meetings between HBC & Foundations are intended to be informal – no official minutes will be taken.	
Data is added incorrectly within the software system or not checked for accuracy leading to incorrect data reported resulting in the failure to supply contract requirements.		All data has now migrated over to SystmOne which enables data reports to be produced by HBC Data analyst once they receive the NDTMS data return. This then allows the reports to be produced. The reports are stored securely and can be referenced against when required. HBC have a dedicated SystmOne development team in place to support any SystmOne related issues for START.	

AUDIT AND GOVERNANCE COMMITTEE

1st April 2025

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT PLAN 2024/25 UPDATE

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.
- of resilient and resourceful communities with opportunities for all.
- that is sustainable, clean, safe and green. - that has an inclusive and growing economy
- that has an inclusive and growing economy.
- with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

2. PURPOSE OF REPORT

2.1 To inform Members of the progress made to date completing the internal audit plan for 2024/25

3. BACKGROUND

3.1 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 at this meeting of the Committee, and after review, will form part of the statement of accounts of the Council.

4. PROPOSALS

4.1 That members consider the issues within the report in relation to their role in respect of the Councils governance arrangements. 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.

4.2 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 corporately. 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.

4.3 Table 1 of the report 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 1

Audit	**Assurance Level**
ResourceLink/MyView IT application	Satisfactory
Levelling Up Fund Grant Quarterly Returns	Satisfactory
Levelling Up Fund Grant Annual Statement of Usage	Satisfactory
Officers Expenses	Satisfactory
Debtors	Satisfactory
Cemeteries and Crematorium	Satisfactory
Creditors	Satisfactory
Firmstep IT Application	Satisfactory
Budgetary Control	Satisfactory
Salaries	Satisfactory

4.4 For Members information, Table 2 below defines what the levels of assurance Internal Audit places on the audits they complete and what they mean in practice:

Table 2

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

4.5 Table 3 below details the audits that were ongoing at the time of compiling the report.

Table 3

Audit	**Objectives**
Housing Aid and Homelessness.	Ensure landlord services are provided in line with statutory requirement sand best practice.
National Fraud Initiative (NFI)	Manage NFI process.
Schools Capital	Ensure adequate procedures are in place to meet statutory duties.
IT Governance	Ensure IT application controls in place
Employee Protection Register	Ensure adequate procedures are in place to meet statutory duties.
Safeguarding ChildHub Front Door Referral System	Ensure adequate procedures are in place to meet statutory duties.
ICS Liquidlogic IT application	Ensure IT application controls in place
Direct Payments	Ensure adequate procedures are in place to meet statutory duties.

5. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	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.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.

LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY POVERTY CONSIDERATIONS	No relevant issues.
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.
STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.
CONSULTATION	No consultation required.

6. RECOMMENDATIONS

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

7. REASON FOR RECOMMENDATIONS

7.1 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.

8. BACKGROUND PAPERS

8.1 Internal Audit Reports.

9. CONTACT OFFICER

9.1 Noel Adamson
Head of Audit and Governance
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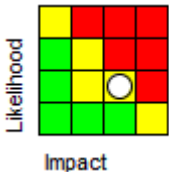
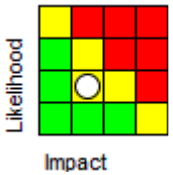
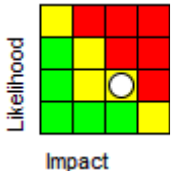
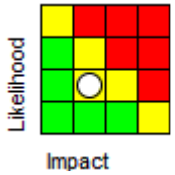
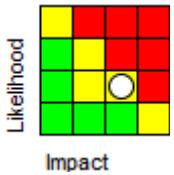
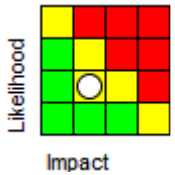
Email: noel.adamson@hartlepool.gov.uk

Appendix A

Audit	Objective			Assurance Level
ResourceLink/MyView IT application	Ensure IT application controls in place			**Satisfactory**
Risk Identified		**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Corporate Retention Policy is not complied with leading to data being retained which no longer should be, data could be available to users which is incorrect or which breaches compliance with GDPR/Data Protection legislation, all of which could result in reputational damage and fines/sanctions if there is a data breach.			Information retention arrangements to be reviewed and implemented to ensure only required information is retained.	

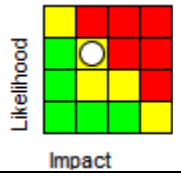
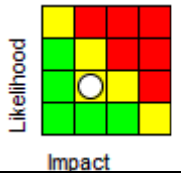
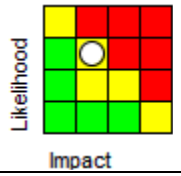
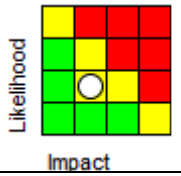
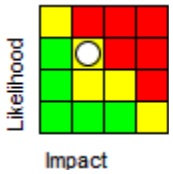
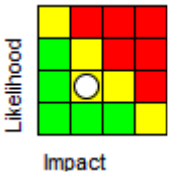
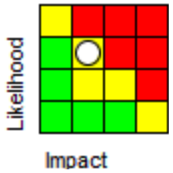
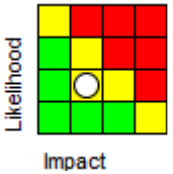
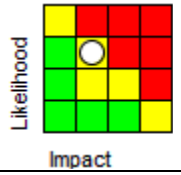
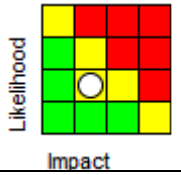
Audit	Objective			Assurance Level
Levelling Up Fund Grant Quarterly Returns	Grant is managed in line with terms and conditions.			**Satisfactory**
Risk Identified		**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
No unmitigated risk identified.				

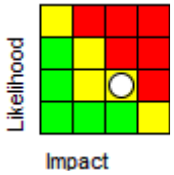
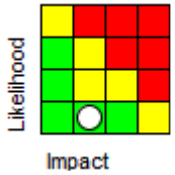
Audit	Objective	Assurance Level
Levelling Up Fund Grant Annual Statement of Usage	Grant is managed in line with terms and conditions.	**Satisfactory**

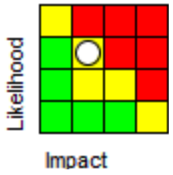
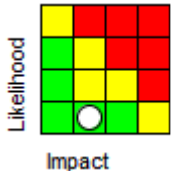
Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented
Inability to provide the required level of assurance due to ineffective counter fraud arrangements being in place resulting in the need for the implementation of remedial actions leading to the potential suspension of payment and non-compliance with the relevant grant agreement.		The Strategic Development Team will ensure the Corporate Anti-Fraud Corruption Policy is applied to all LUF and Town Deal projects being delivered by HBC. Conflict of Interest Registers and Gifts are put in place for LUF. Gifts & Hospitality Registers will be put in place aligning with HBC's corporate policies and procedures.	
Inability to provide the required level of assurance due to ineffective subsidy control arrangements being in place resulting in the need for the implementation of remedial actions leading to the potential suspension of payment and non-compliance with the relevant grant agreement.		It is recognised that HBC do not currently have a corporate Subsidy Control policy or supporting documents. This has been raised with the Executive Director of Development, Neighbourhoods and Regulatory Services and will be taken to ELT for the appropriate department to take forward development of necessary policy and documentation to allow the Strategic Development Team to comply with DLUHC Assurance Framework and the action highlighted.	

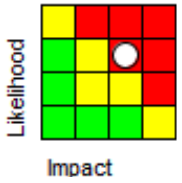
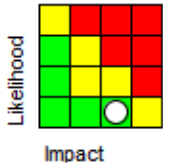
Audit	Objective	Assurance Level
Officers Expenses	To assess and provide assurance on the controls in place with regard to policies & procedures, system data, mileage claims, expense claims, data processing, insurance and GDPR/Data Protection.	**Satisfactory**

Risk Identified	Risk Level prior to action implemented	Action Agreed	Risk Level after action implemented

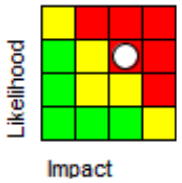
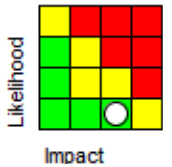
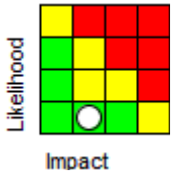
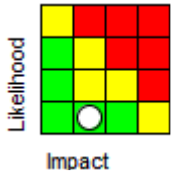
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		All claims to be based on completion within 3 months of the date the expense was incurred. To arrange with HR for a change to the wording within Single Status Agreement for this to be included.	
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Updated guidance to be circulated with regards to compliance with regulations and procedures. To target ELT to coordinate procedural review to develop good practice.	
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Single Status Agreement issue to ensure that procedures are in place to ensure that protective equipment purchased meets regulations standards. Where purchased by individual officers, procedures confirm the circumstances in which reimbursement would occur or contribution towards costs would be made.	
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Corporate car parking review to be completed in 2025 to review arrangements across Council including Social Care reimbursement.	
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of expenses resulting in financial loss.		Declaration stating that employee expense claims must be incurred in connection with official duties to be updated on MyView.	

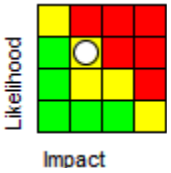
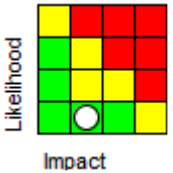
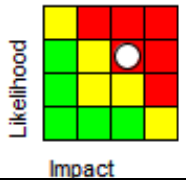
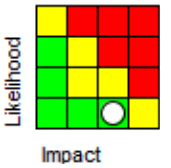
Audit	Objective		Assurance Level
Debtors	Assess and provide assurance on the controls in place to mitigate risks in the following areas: Policies and procedures, Data security, Customer account creation and amendment, Invoicing, Credit notes, Payments, Recovery of debt, Write offs, Scale of charges and GDPR.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Customer account information is incorrect leading to debt being raised to the wrong person/wrong address resulting in income not being received or delays in receiving income.		Senior Recovery Officer to work with System Support to assess debts that have been inactive without a balance outstanding for 2 years with a view to redacting bank details, email addresses & telephone numbers and deactivating the said accounts. Accounts that have been inactive for 6 year plus current year to be reviewed and where appropriate accounts deleted/archived. Exceptions for accounts written off for private sector housing may apply.	

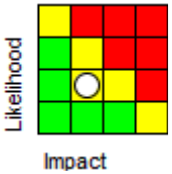
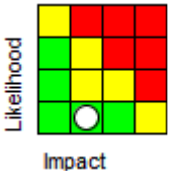
Audit	Objective		Assurance Level
Cemetries and Crematorium	Ensure that all legislative requirements are complied with. Review booking forms to ensure that all income due has been received, review Budgetary Control, Procurement and Site Maintenance / Health and Safety.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Goods / services are purchased without appropriate segregation of duties and authorisation, leading to the possibility that purchases may be made for personal use or in breach of HBC Financial Procedures, resulting in financial loss to the Authority.		Bereavement Services Team Leader to record all orders and indicate where an order has been placed at point of purchase, and if not, the reason behind this, in order to provide a clear evidence base for the systems used. Bereavement Services Team Leader to brief all staff regarding the process for placing orders and recording these in a central shared document.	

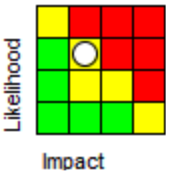
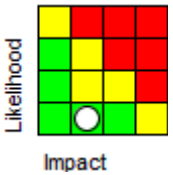
Regular inspection and maintenance of cemeteries is not undertaken and / or documented leading to areas being unsafe and causing potential accidents resulting in potential financial claims against the Council and reputational damage		Bereavement Services Team Leader to develop plan to prioritise surveys and a timescale for completion, then implement this by reviewing staff workload and agreeing proposals to progress surveys with individual team members and subsequently monitor progress during 1:1s.	

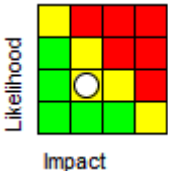
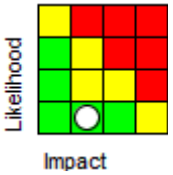
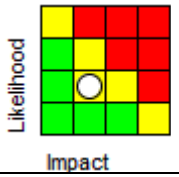
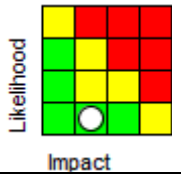
Audit	**Objective**	**Assurance Level**
Creditors	Provide assurance that risk is being managed at an acceptable level by reviewing a sample of transactions focussing on the following areas: Supplier accounts, Orders, Receipt of goods, Performance Management, Transparency Code requirements and GDPR.	**Satisfactory**

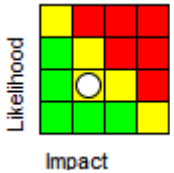
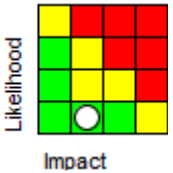
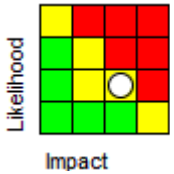
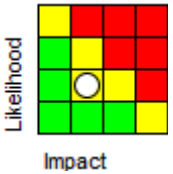
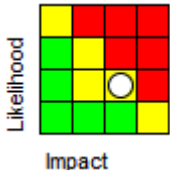
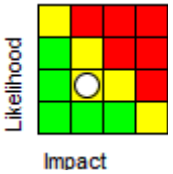
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Appropriate checks are not made to ensure new and amended supplier details are valid, correct and not duplicated, leading to incorrect / fraudulent payments being made which the organisation may be unable to recover resulting in financial loss to the Council.		All requests for new suppliers are considered within the remit of IR35 rules, based on the information supplied. However, information is not provided or reviewed if the operational arrangement with a supplier changes. Departments are expected to be aware of the requirements to disclose if “off-payroll” arrangements are introduced. This information would not be clear from the wording on invoices. To arrange for a reminder to be issued to departments of their responsibilities within this Act.	
Appropriate checks are not made to ensure new and amended supplier details are valid, correct and not duplicated, leading to incorrect / fraudulent payments being made which the organisation may be unable to recover resulting in financial loss to the Council.		A daily report identifies any potential duplicate suppliers. Also, adjustments have made for the 5 suppliers identified in the audit. However, an exercise is being organised with Fiscal Technologies to review all payments made in the last 3 years to establish whether any duplicate payments remain, either within a supplier account or across other accounts.	

Goods received details are not input correctly or checked to orders promptly when received, leading to goods not being returned for refund or replacement or no record of receiving goods resulting in payment of invoices for incorrect amount.		Integra procedure documents to be reviewed following upgrade to Centros. This area to be included in the review of good practice.	
If the Council does not publish data in accordance with the Public Contracts Regulations Act 2015 it may breach legislative requirements.		Action completed	

Audit	**Objective**		**Assurance Level**
Firmstep IT Application	Ensure IT application controls in place		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Access Policy requirements are not complied with which could lead to inappropriate/unauthorised access to the application and to personal / sensitive information which could result in fraudulent or malicious misuse of the information and the potential for fines or sanctions or reputational damage as a result.		All HBC Share users will be required complete a new user agreement. This task is to be performed on an annual basis and will strengthen the current information governance arrangements. This will be carried out annually prior to 31 March.	

Audit	Objective		Assurance Level
Budgetary Control	Ensure adequate procedures are in place to meet statutory duties.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
The Capital Strategy is not included in the Budget & Policy Framework (which also includes the Council Plan and MTFS) approved by Members, leading to Members being unaware of how capital schemes are being financed and how the capital schemes relate to delivering the Council Plan objectives.		Budgets within Integra to be reviewed and any missing budgets to be loaded	

Audit	Objective		Assurance Level
Salaries	Ensure adequate procedures are in place to meet statutory duties.		**Satisfactory**
Risk Identified	**Risk Level prior to action implemented**	**Action Agreed**	**Risk Level after action implemented**
Salary deductions are not promptly and accurately recorded in the payroll system due to processing errors leading to incorrect deductions to staff salary resulting in inaccurate payment of salaries.		Report to be produced by Payroll Manager explaining reconciliation differences and action taken to correct	
Payment of claim-based pay may not be accurate, complete and authorised due to input processing errors leading to inaccurate payment of salaries and financial loss.		Payroll Manager to review whether outstanding timesheet is available. Also to engage with department to ensure compliance with procedures for authorisation. Shared Services Manager to issue compliance document to ELT.	

Inaccurate payroll parameter data input into the payroll system leading to incorrect payments being made resulting in potential errors in salary payments.		Payroll Manager to review process and provide required evidence	
Staff do not comply with HBC Information Governance Policies and Procedures leading to non-compliance with the Data Protection Act resulting in a fine from the ICO.		Whilst data sharing arrangements are included in SLA agreements with academies, Unison and Healthwatch it was acknowledged by the Shared Services Manager that these need to be updated to fully reflect data sharing arrangements to ensure they fully comply with Data Protection Policy requirements	
Inaccurate or insufficient data published resulting in non-compliance with the Local Government Transparency Code of Practice 2015 and possible reputational impact.		Shared Services Manager to engage with Finance and HR regarding publication requirements for 2023/24 Financial Statement and Transparency Code	

AUDIT AND GOVERNANCE COMMITTEE

1 April 2025

Report of: Head of Audit and Governance

Subject: EXTERNAL QUALITY ASSURANCE UPDATE

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1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.
- of resilient and resourceful communities with opportunities for all.
- that is sustainable, clean, safe and green. - that has an inclusive and growing economy
- that has an inclusive and growing economy.
- with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

2. PURPOSE OF REPORT

2.1 To update Members on the results of the External Quality Assurance (EQA) carried out by CIPFA on Internal Audit Service compliance with professional standards.

3. BACKGROUND

3.1 Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS). All public sector internal audit services are required to measure how well they are conforming to the standards. The standards state that an external reviewer must undertake a full assessment or validate the Internal Audit Service's own self-assessment at least once in a five-year period. To comply with this requirement Internal Audit engaged CIPFA to validate the services own self-assessment.

3.2 To undertake the task, CIPFA carried out a review of the evidence provided by Internal Audit; reviewed of a sample of completed internal audits;

undertook a survey that was sent to and completed by a range of stakeholders; and interviewed key stakeholders. The interviews focussed on determining the strengths and weaknesses of Internal Audit and assessed the Service against the four broad themes of Purpose and Positioning; Structure and Resources; Audit Execution; and Impact.

4. RESULTS OF CIPFA REVIEW

4.1 In carrying out its review CIPFA stated that:

"It is our opinion that the self-assessment for the Internal Audit Service is accurate, and we therefore conclude that they GENERALLY CONFORM to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note".

4.2 This is the highest level of conformance that can be achieved and is a positive outcome, reflecting the high standards that Internal Audit adhere to when carrying out their duties. CIPFA have concluded that the relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, comply with the requirements of the individual Standard, the element of the Code of Ethics, and the Local Government Application Note in all material respects. Table 1 below highlights the areas reviewed. The full review document is attached as **Appendix A** for members information.

4.3 Table 1 – Conformance with Standards

Standard / Area Assessed	**Level of Conformance**
Mission Statement	**Generally Conforms**
Core principles	**Generally Conforms**
Code of ethics	**Generally Conforms**
Attribute standard 1000 – Purpose, Authority and Responsibility	**Generally Conforms**
Attribute standard 1100 – Independence and Objectivity	**Generally Conforms**
Attribute standard 1200 – Proficiency and Due Professional Care	**Generally Conforms**
Attribute standard 1300 – Quality Assurance and Improvement Programmes	**Generally Conforms**
Performance standard 2000 – Managing the Internal Audit Activity	**Generally Conforms**
Performance standard 2100 – Nature of Work	**Generally Conforms**
Performance standard 2200 – Engagement Planning	**Generally Conforms**
Performance standard 2300 – Performing the Engagement	**Generally Conforms**
Performance standard 2400 – Communicating Results	**Generally Conforms**
Performance standard 2500 – Monitoring Progress	**Generally Conforms**
Performance standard 2600 – Communicating the Acceptance of Risk	**Generally Conforms**

4.4 As part of its review of the Service's self-assessment, CIPFA identify and report on issues they consider could be improved in line with best practice. Whilst these areas don't impact on our overall compliance with the standards, they are issues that need to be considered to ensure best practice is carried out in all areas of operation. Table 2 below, identifies these areas and outlines our response and timeline for implementation.

Table 2 – Best Practice Improvements

Issues for management action	**Priority**	**Action/Timescale**
There is an audit charter in place for each authority, and it is understood that these are reviewed on an annual basis. We reviewed these documents and found them to contain the elements that the PSIAS expects to be included in an audit charter, except for the term "senior management" not being defined; this is a specific requirement of the PSIAS. Additionally, and with reference not just to the PSIAS but to the CIPFA LGAN 2019 it is considered that explanations would benefit from more specifics. As an example, PSIAS and the Application note require "setting out relevant arrangements within the organisation's anti-fraud and anti-corruption policies" but no arrangements are set regarding whistleblowing or money laundering. We appreciate that the new Global Internal Audit Standards (GIAS) will be mandatory from 1st April 2025 and suggest that updating of the Audit Charter is combined at the same time as building in the additional requirements of GIAS.	**Medium**	Update/include definitions in Internal Audit Charter, for Audit and Governance Committee approval 01.04.25
Neither Hartlepool Borough Council's or the Cleveland Fire Authority's Audit and Governance Committees have performed their annual review of self-assessment of the effectiveness of the Audit and Governance Committee, as required by the CIPFA guidance on audit committees. This is a mandated requirement and will also assist with the rotation of Audit and Governance Committee members and enhance the underpinning of the Annual Governance Statement and Annual Internal Audit Opinion.	**Medium**	Agree and facilitate Audit and Governance Committee self-assessment for 25/26.
We understand that due to a requirement for a third of HBC Councillor's to stand for election each year that this can lead to regular rotation on and off the Audit and Governance Committee. Cleveland Fire Authority's Audit and Governance Committee has a similar make up with representatives from each of the four constituent Council's and is understood to have a new Chair. We recognise that training is provided by both Internal Audit and the Finance team but suggest that enhanced training is focused where there are	**Medium**	Agree and facilitate Audit and Governance Committee training for 25/26.

Issues for management action	Priority	Action/Timescale
Audit and Governance Committee representatives with new responsibilities and as a refresher for the more experienced members.		
We have been advised that the Council encourages growing talent from within and that consideration is being given to bringing in trainees to build up the service. Consideration could be given to trainees following the IIA apprentice programme and the CAE could probably draw on the apprenticeship levy to fund the places although there is of course a requirement to supervise them which is a draw on management resources. There may be suitable candidates already in the council whose jobs are at risk who could take up a trainee post and change careers. The HAG is aware that there is a dire shortage of experienced and/or qualified internal auditors across the country and particularly in the North East should posts need filling at short notice. We were also made aware that an alternative may be to pool resourcing with other local Council's Internal Audit Service's. With this in mind, it would be prudent to develop a mid/long term resourcing and succession plan as part of the service's wider strategy which will be required under Global Internal Audit Standards.	**Medium**	In conjunction with ongoing work around workforce planning and resilience, ensure Internal Audit Charter communicates Internal Audit approach in this area. Internal Audit Charter approval by Audit and Governance Committee 01.04.25.
The Internal Audit Service operates under PSIAS with its last external quality assessment (EQA) reporting in August 2018. PSIAS mandates that there is an EQA at least every five years; it is now six years and four months since the previous one. It appears there was a misunderstand regarding the previous EQA that it referred to 2019. Delay to the five-year review brings risks of lack of external oversight and potential delayed insights and opportunities. We suggest that the Audit and Governance Committee has a clear timetable of reports that they should expect to see with dates; including the future EQA.	**Low**	Set out timetable for reports and future EQA to Audit and Governance Committee in Internal Audit Charter, for approval 01.04.25.
The Head of Audit and Governance has identified that there is scope to enhance the QAIP process by documenting a more formal approach to the process.	**Low**	Formally document Quality and Improvement Programme for inclusion in 25/26 Head of Audit Opinion

Issues for management action	Priority	Action/Timescale
		Report.
The Service's use of data analytics can be enhanced further by making use of external sources of data for benchmarking purposes. Suitable sources of external sources of data are the local authority data held in the CIPFA statistics and 'Nearest Neighbour Model' applications, which the Councils should already have access to, and the benchmarking data held by the Local Government Association in their LG Inform application.	**Advisory**	Continue review of Data Analytic tools and use of benchmarking as part of 25/26 Internal Audit Development Plan.
There is always scope for more IT audit training and qualifications due to the speed at which IT is moving and therefore suggest this is also included in the medium long term resourcing strategy	**Advisory**	Continue the review/development of IT audit skills as part of 25/26 Internal Audit Development Plan, as reflected in individual auditor training plans.
There may be some areas of management who are not engaged with the process and are not treating Internal Audit as a critical friend. There may be some advantage in these areas to training sessions around what Internal Audit does and does not do.	**Advisory**	Agree and facilitate Audit awareness training for 25/26.
Any recommendations made by Internal Audit are there to improve matters and the Executive Leadership Team, once they agree the Internal Audit findings has to own them. At that point they are not Internal Audit recommendations but are agreed management actions. It is the Executive Leadership Team's responsibility to ensure they are implemented promptly and this needs to be made clear at senior management meetings. The HAG recognises this issue and is revising the follow up process to include reporting to the Executive Leadership team where appropriate.	**Advisory**	Update Internal Audit Charter to reflect revised follow up procedure. Internal Audit Charter approval by Audit and Governance Committee 01.04.25.
The Chair of the Audit and Governance committee needs to hold management to account where there has been a lack of input /response on recommendations. If managers fail to implement the actions they need to turn up at the Audit and Governance Committee and explain their lack of action. It is possible this could be a key objective to be included in manager's annual appraisals. Whilst it may be welcomed more easily via clarity amongst the senior management team this option is worth considering.	**Advisory**	Update Internal Audit Charter to reflect revised follow up procedure. Internal Audit Charter approval by Audit and Governance Committee 01.04.25.
The Internal Audit Service needs to ensure they are regularly demonstrating to the Executive Leadership Teams that they are adding value to their operations - benchmarking, sharing issues	**Advisory**	Update Internal Audit Charter to reflect revised reporting procedures to both

Issues for management action	Priority	Action/Timescale
picked up at network meetings, horizon scanning, more insight and generally being proactive and dynamic - staying ahead of the curve. Whilst we believe the Service already does this, they need to demonstrate that they understand the client's business in depth across all of the senior management team.		ELT and Statutory Officers. Internal Audit Charter approval by Audit and Governance Committee 01.04.25.
There may be benefit to adding a sentence onto draft planning documents, draft reports and follow up emails to state that there is an escalation process in place for non-responses to raise awareness of the process where action to recommendations is not taken.	**Advisory**	Update Internal Audit Charter to reflect revised follow up procedure. Internal Audit Charter approval by Audit and Governance Committee 01.04.25.
Some of the performance measures reported to the Audit and Governance Committees are 'traditional measures' of service inputs and could be modernised. An informed approach would be to provide the Audit Committees with performance data relating to 'outcomes achieved' by the Internal Audit Service, for example audits delivered compared to those audits in the original audit plan; audits that overran the budgeted days; and the time taken to issue the final report following the final meeting, to provide just a few possible examples.	**Advisory**	Update Internal Audit Charter to reflect revised Performance Indicators. Internal Audit Charter approval by Audit and Governance Committee 01.04.25. Continue the review/ development of Teammate, Power BI and Excel as part of 25/26 Internal Audit Development Plan, as reflected in individual auditor training plans.

5. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	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.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.
LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY	No relevant issues.

POVERTY CONSIDERATIONS	
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.
STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.
CONSULTATION	No consultation required.

6. RECOMMENDATIONS

6.1 It is recommended that Members note the following:

- The external review of Internal Audit Services carried out by CIPFA, concluded that the service GENERALLY CONFORM to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.
- The timetable of actions proposed to comply with best practice recommendations made by CIPFA as part of the review.

7. REASON FOR RECOMMENDATIONS

7.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it is satisfied that the Internal Audit carries out its duties in compliance with professional standards.

8. BACKGROUND PAPERS

8.1 -CIPFA External Quality Assurance Report, Conformance to the Public Sector Internal Audit Standards.
-UK Public Sector Internal Audit Standards (PSIAS).

9. CONTACT OFFICER

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

Appendix A

External Quality Assessment of Conformance to the Public Sector Internal Audit Standards

Hartlepool Borough Council's Internal Audit Service

Final Report

Lead Associate: Sean Titley, ACA, CISA

Oversight & Review: Ray Gard, FCCA, CFIIA, DMS

Quality Assessment: Diana Melville, FCPFA

17 December 2024

Hartlepool Borough Council's Internal Audit Service

1. Introduction

1.1 Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS), which have been in place since 1st April 2013 (revised 2016 and 2017). All public sector internal audit services are required to measure how well they are conforming to the standards. This can be achieved through undertaking periodic self-assessments, external quality assessments (EQA), or a combination of both methods. However, the standards state that an external reviewer must undertake a full assessment or validate the Internal Audit Service's own self-assessment at least once in a five-year period.

2. Background

2.1 The Internal Audit Service provides its services to Hartlepool Borough Council, the second smallest unitary authority in the country, and the Cleveland Fire Authority. The Chief Audit Executive is the Council's Head of Audit and Governance (HAG). Below the HAG post is one FTE Principal Auditor post (until recently there were two); 1 FTE Senior Auditor post and 2 FTE Auditor posts. The team have been working together at the Council for many years with the least experienced having been there for 15 years. The HAG is aware that this limits opportunities for career progression and that there has been little scope for trainees to join the Internal Audit Service. We have been advised that the Council encourages growing talent from within and that consideration is being given to bringing in trainees to build up the service. The HAG is aware that there is a dire shortage of experienced and/or qualified internal auditors across the country and particularly in the North East should posts need filling at short notice. We were also made aware that an alternative option may be to pool resources with other local council's internal audit services. With this in mind, it would be prudent to develop a mid/long term resourcing strategy for the Service; this should form part of the Internal Audit Strategy which will be required under Global Internal Audit Standards. We have included this as a medium priority in section 10 of the report.

In addition to the in-house team, the Service has a small budget for the use of some external partners for specialist provision e.g. IT Audit, if required.

2.2 The HAG is an experienced internal audit professional who is a CCAB accountant, holding the CIPFA qualification. The Principal Auditor that is in post is also an experienced internal audit professional with relevant qualifications and a member of the Chartered Institute of Internal Auditors.

2.3 The Internal Audit Service operates under PSIAS with its last external quality assessment (EQA) reporting in August 2018. PSIAS mandates that there is an EQA at least every five years; it is now six years and four months since the previous one. It appears there was a misunderstanding, by the HAG, regarding the previous EQA that it referred to 2019. Delay to the five-year review brings risks of a lack of external oversight and potential delayed insights and opportunities. We have raised an advisory action in Section 10 of the report to suggest that the Audit Committee has a clear timetable of reports that they should expect to see with dates; including the future EQA of the Service.

2.4 Hartlepool Borough Council's Audit and Governance Committee meets regularly and includes Councillors and Independent members. We understand that due to a requirement for a third of Councillors to stand for election each year that this can lead to regular rotation on and off the Audit and Governance Committee. Cleveland Fire Authority's Audit and Governance Committee has a similar make up with representatives from each of the four constituent Councils and is understood to have a new Chair. We recognise that training is provided by both Internal Audit and the Finance team but have raised an advisory action in Section 10 of the report to suggest that further training is focused where there are Audit and Governance Committee representatives with new responsibilities.

Further to this finding, we also noted that neither Audit and Governance Committee has performed their annual review of self-assessment of their effectiveness as mandated by the CIPFA guidance to Audit and Governance Committees. We have raised an advisory action in Section 10 of the report to suggest that this is done promptly and then managed to ensure that the effectiveness reviews are done annually. We believe this will assist with the rotation of Audit and Governance Committee members as well as help underpin the Annual Governance Statement and the Annual Internal Audit Opinion. From April 2025 there will be

new internal audit standards for the function, which include the oversight and governance of internal audit.

2.5 The Internal Audit Service has an audit manual that provides the auditors with a comprehensive guide to all aspects of performing an internal audit or consultancy assignment. The Service uses standard templates for all terms of reference, engagement working papers, testing schedules, and audit reports, all of which are contained in their Teammate audit management system. Supervision of the engagements takes place at every stage of the process and is recorded in Teammate.

2.6 There is a quality assurance process in place that includes internal and external quality assessments of the Service, reviews of live engagements, a post-audit client feedback survey, and final clearance of all completed reports is carried out by the HAG, all of which feed into the Internal Audit Service's Quality Assurance and Improvement Programme (QAIP).

3. Validation Process

3.1 This validation of the Internal Audit Service's self-assessment comprised a combination of a review of the evidence provided by Internal Audit; a review of a sample of completed internal audits; a survey that was sent to and completed by a range of stakeholders; and interviews with key stakeholders, using MS Teams. The interviews focussed on determining the strengths and weaknesses of Internal Audit and assessed the Service against the four broad themes of Purpose and Positioning; Structure and Resources; Audit Execution; and Impact.

3.2 The Internal Audit Service provided a comprehensive range of documents that they used as evidence to support their self-assessment, and these were available for examination prior to and during this validation review. These documents included the:

- self-assessment against the standards;
- quality assurance and improvement plan (QAIP);
- evidence file to support the self-assessment;
- the audit charters;
- the annual reports and opinions
- the audit plans and strategies;
- audit procedures manual;
- a range of documents and records relating to the team members;
- progress and other reports to the respective Audit Committees.

All the above documents were examined during this EQA.

3.3 The main phase of the validation process was carried out during the week commencing 2 December 2024, with limited further work undertaken during the following week. This phase of the EQA involved a review of a sample of audit files and interviews with a sample of key stakeholders from Hartlepool Borough Council and the Cleveland Fire Authority. Overall, the feedback from the interviewees was very positive with clients valuing the professional, knowledgeable, transparent and objective way the Internal Audit Service delivered their services.

3.4 The assessor reviewed examples of completed audits with different outcomes in their opinion to confirm his understanding of the audit process used, and to determine how Internal Audit has applied the PSIAS and LGAN in practice.

4. Opinion

It is our opinion that the self-assessment for the Internal Audit Service is accurate, and we therefore conclude that they GENERALLY CONFORM to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.

4.1 The table below shows the Internal Audit Service's level of conformance to the individual standards assessed during this external quality assessment:

Standard / Area Assessed	Level of Conformance
Mission Statement	**Generally Conforms**
Core principles	**Generally Conforms**
Code of ethics	**Generally Conforms**
Attribute standard 1000 – Purpose, Authority and Responsibility	**Generally Conforms**
Attribute standard 1100 – Independence and Objectivity	**Generally Conforms**
Attribute standard 1200 – Proficiency and Due Professional Care	**Generally Conforms**
Attribute standard 1300 – Quality Assurance and Improvement Programmes	**Generally Conforms**
Performance standard 2000 – Managing the Internal Audit Activity	**Generally Conforms**
Performance standard 2100 – Nature of Work	**Generally Conforms**
Performance standard 2200 – Engagement Planning	**Generally Conforms**
Performance standard 2300 – Performing the Engagement	**Generally Conforms**
Performance standard 2400 – Communicating Results	**Generally Conforms**
Performance standard 2500 – Monitoring Progress	**Generally Conforms**
Performance standard 2600 – Communicating the Acceptance of Risk	**Generally Conforms**

5. Areas of full conformance with the Public Sector Internal Audit Standards

5.1 **Mission Statement and Definition of Internal Audit**

The mission statement and definition of internal audit from the PSIAS are included in the audit charter.

5.2 **Core Principles for the Professional Practice of Internal Auditing**

The Core Principles, taken as a whole, articulate an Internal Audit function's effectiveness, and provide a basis for considering the organisation's level of conformance with the Attribute and Performance standards of the PSIAS.

The indication from this EQA is that the Core Principles are, on the whole, embedded in Internal Audit's procedures and working methodologies. The Internal Audit Service are a competent, experienced, and professional function that generally conforms to all ten elements of the Core Principles. We received a great deal of positive feedback from all key stakeholders who contributed to this review in the area of Core Principles, particular strengths highlighted included:

- objectivity and independence;
- integrity with regard to being prepared to raise difficult issues and report them;
- strong communication skills particularly one to one; although there was a suggestion that internal audit could be more visible, which brings out the risks around remote working; endemic in the post Covid audit profession;
- audit skills and professionalism;
- proactive involvement in the early stages of project development and managing risk
- proactive, meeting organisational objectives and achieving value for money; although there were some indications that more could be done; and
- as a corollary of the above point that a lot is achieved by a relatively small Internal Audit Service.

The Internal Audit Service is valued, respected and delivering flexibly to plan and budget with limited resources.

5.3 **Code of Ethics**

The purpose of the Institute of Internal Auditors' Code of Ethics is to promote an ethical culture in the profession of internal auditing, and is necessary and appropriate for the profession, founded as it is on the trust placed in its objective assurance about risk management, control, and governance. The Code of Ethics provides guidance to internal auditors and in essence, it sets out the rules of conduct that describe behavioural norms expected of internal auditors and are intended to guide their ethical conduct. The Code of Ethics applies to both individuals and the entities that provide internal auditing services.

The clear indication from this EQA is that the Internal Audit Service conforms to the Code of Ethics, and this is embedded in their procedures, and their audit methodologies. The code of ethics is part of their overarching culture and underpins the way the Internal Audit Service operates.

5.4 **Attribute Standard 1000 – Purpose, Authority and Responsibility**

The purpose, authority and responsibility of the Internal Audit activity must be formally defined in an internal audit charter, consistent with the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards, and the Definition of Internal Auditing). The internal audit charter must be reviewed regularly and presented to senior management and the audit panel for approval.

There is an audit charter in place for both authorities, and it is understood that these are reviewed on an annual basis. We reviewed these documents and found them to contain all

the elements that the PSIAS expects to be included in an audit charter except for the term "senior management" not being defined, which is a specific requirement of the Standards. Additionally, and with reference not just to the PSIAS but also to the CIPFA application note 2019, some of the areas should be set out in more depth. As an example, PSIAS and the LGAN require "setting out relevant arrangements within the organisation's anti-fraud and anti-corruption policies" but no arrangements are set regarding whistleblowing or money laundering. We have included this as an advisory action in section 10.

Whilst it is important that these issues are reviewed and addressed, we are satisfied that the Internal Audit Service conforms to attribute standard 1000 and the LGAN.

5.5 **Attribute Standard 1100 – Independence and Objectivity**

Standard 1100 states that the Internal Audit activity must be independent, and internal auditors must be objective in performing their work.

The need for independence and objectivity is an integral part of any internal audit service's culture. The HAG reports in his own name directly to the Senior Management Teams at each authority, and to the Audit and Governance Committee at Hartlepool Borough Council and the Cleveland Fire Authority. All employees declare any potential impairment to their independence or objectivity on recruitment to the Service and subsequently provide annual declaration of interests

We have reviewed the Internal Audit Service's procedures and their standard documentation; their quality assurance and improvement plan; and a small sample of completed audits. We have also reviewed their reporting lines and their positioning within both authorities. In addition to internal audit, the HAG is involved in the implementation of counter fraud, risk management, and he investigations of fraud and irregularity. All these functions are subjected to periodic review and assessment from external partners with their findings being reported directly to the HAG's line manager.

With a small internal audit team who have worked together in the same organisation for many years there are risks around lack of rotation, innovation, dynamism and closeness of personal relationships. Having gone into some depth in meetings, comfort was taken from the actions the HAG has taken to ensure that there is appropriate rotation of staff for specific audits, a robust training plan and a strong ethical culture which goes beyond simply returning declarations of independence. This is further backed up by the many findings and recommendations, including those of a significant nature, that the audit team bring to the respective Audit and Governance Committees.

We are satisfied that the Internal Audit Service conforms with attribute standard 1100 and the LGAN.

5.6 **Attribute Standard 1200 – Proficiency and Due Professional Care**

Attribute standard 1200 requires the Internal Audit Services' engagements are performed with proficiency and due professional care, having regard to the skills and qualifications of the staff, and how they apply their knowledge in practice.

As mentioned above, the HAG is an experienced internal audit professional who is a CIPFA qualified accountant. The Principal Auditor that is in post is also an experienced internal audit professional with relevant qualifications and is a member of the Chartered Institute of Internal Auditors. The internal audit team have sufficient knowledge of the operation of high-level IT controls, and they incorporate these in their testing for the audits they undertake. HBC's internal audit service carry out a full programme of IT audit each year. This includes expected IT controls, detailed application audits and service delivery of the ICT provider. HBC's internal audit service review the service providers (NEC) detailed and complex ICT reports for assurance, this is built into their risk assessment and if they need to bring in specialist IT audit due to the risk being assessed as sufficiently high they will, for which they have a separate budget.

Coverage of IT governance and the more technical side of IT audits were discussed in some detail with the Internal Audit team and others. This area is a potential risk in a small, long-standing team; however the Internal Audit approach is valid. We understand that Office 365 has just been introduced across the organisation and that is a move to use PowerBI and

related dashboards which the Internal Audit Service will help to develop. There is always scope for more IT audit training and qualifications due to the speed at which IT is moving and we have included this, with the medium long term resourcing strategy, as an advisory action in section 10 of the report. This may be built into future resource thinking but there is nothing here that contradicts meeting the requirements of this standard.

The Standards require internal audit services to consider the use of data analytics when performing their audit reviews. The Service has the latest version of the IDEA data analytics software and makes use of this application. The HAG has recognised in the QAIP that there is further need for a data analytics strategy. We suggest that alongside IDEA and client data there are further opportunities to broaden the use of data analytics by making use of external sources of data for benchmarking purposes, such as the local authority data held in the CIPFA statistics and 'Nearest Neighbour Model' applications, which both authorities should already have access to, and the data held by the Local Government Association in their LG Inform application. The Principal Auditor is currently investigating how LG Inform may be best used. These are useful sources of data for benchmarking, particularly when auditors are undertaking research and preparing the terms of reference for audits as benchmarking can highlight areas where there may be scope to add value to the Council's operations, or at least challenge the current thinking. We have included this as an advisory action for management to consider in section 10 of this report.

Standard 1200 expects internal auditors to maintain and enhance their knowledge and this is usually achieved through undertaking relevant training, reading technical publications, networking with relevant professional groups and research for audits. Individual training plans are discussed with the team members, and all professionally qualified staff are required to maintain their CPD records according to the requirements of their respective institutions.

Notwithstanding the above observations, it is evident from this review that the Internal Audit Service's employees are experienced and perform their duties with due professional care. We are therefore satisfied that the Internal Audit Service complies with attribute standard 1200 and the LGAN.

5.7 **Attribute Standard 1300 – Quality Assurance and Improvement Programmes**

This standard requires the Head of Audit to develop and maintain a quality assurance and improvement programme that covers all aspects of the Internal Audit activity.

The Internal Audit Service has developed a quality assurance process which feeds into their quality assurance and improvement programme and ensures engagements are performed to a high standard. Supervision of audit engagements is carried out at all stages of the audit and is recorded throughout the audit process in the Teammate management system. There are, however, opportunities to strengthen the QAIP process. Whilst there is a systematic process to submitting the QAIP to the Audit and Governance Committee and senior management, this process hasn't been formalised and documented in the Audit Manual. We have included this observation, along with an advisory action, in section 10 of this report.

We have examined the supporting evidence provided by the Internal Audit Service during this EQA and subsequently provided to us, and notwithstanding the observation mentioned above, we feel that the Internal Audit Service generally conforms to attribute standard 1300 and the LGAN.

5.8 **Performance Standard 2000 – Managing the Internal Audit Activity**

The remit of this standard is wide and requires the Chief Audit Executive to manage the Internal Audit activity effectively to ensure it adds value to its clients. Value is added to a client and its stakeholders when Internal Audit considers their strategies, objectives, and risks; strives to offer ways to enhance their governance, risk management, and control processes; and objectively provides relevant assurance to them. To achieve this, the Chief Audit Executive must produce an audit plan and communicate this and the Service's resource requirements, including the impact of resource limitations, to senior management and the Governance and Ethics Committee for their review and approval. The Chief Audit Executive must ensure that Internal Audit's resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.

The standard also requires the Chief Audit Executive to establish policies and procedures to guide the Internal Audit activity, and to share information, co-ordinate activities and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimise duplication of efforts.

Last, but by no means least, the standard requires the Chief Audit Executive to report periodically to senior management and the Governance Committee on Internal Audit's activities, purpose, authority, responsibility, and performance relative to its plan, and on its conformance with the Code of Ethics and the Standards. Reporting must also include significant risk and control issues, including fraud risks, governance issues and other matters that require the attention of senior management and/or the audit committee.

The Internal Audit Service has an internal audit manual in place that covers all aspects of the Internal Audit Service. Their planning processes take into consideration the respective Authorities' risk management and governance frameworks; objectives and priorities; other relevant and reliable sources of assurance that are available; the key issues identified by managers during the annual planning meetings; the Internal Audit Service's own risk and audit needs assessments; and any emerging risks identified through horizon scanning and networking with other organisations and regional audit groups.

For Hartlepool Borough Council and the Cleveland Fire Authority, the Service produces risk-based audit plans that are designed to provide relevant assurance on their governance, risk management and control frameworks. The audit plans are reviewed and approved by the Senior Management Teams and the Audit and Governance Committees.

Staffing resources within the Internal Audit Service are tight, however the team has a history of delivering to plan with a minimum of reports deferred each year, although at the time of doing the review a majority of audits were still to be completed although there is a plan to ensure that audits are completed with the year to underpin the annual Internal Audit opinions. The HAG has strong support from his Principal Auditor to provide management and supervision capacity and there is a view that, at least in the short-term, capacity could be brought in were the team to be depleted further for any reason.

Details of the completed audits, together with updates on the progress being made on delivering the audit plans and the performance of the Internal Audit Service, are reported to the respective Senior Management Teams and the Audit and Governance Committees on a regular basis. The performance data reported to the respective Audit and Governance Committees includes the number of planned audit days compared to the actual audit days delivered by the Internal Audit Service, with the planned days being adjusted when the audit plan has been adjusted i.e. for audits that have been cancelled, removed from the plan, or postponed, together with the timeliness of completed audit reports, and customer satisfaction with the respective audits.

Some of these performance indicators are 'traditional measures' of service inputs. Global Internal Audit Standards will require that performance objectives for Internal Audit Service are agreed. Consideration should be given to providing the Audit and Governance Committee with performance data relating to 'outcomes achieved' by the Internal Audit Service, for example audits delivered compared to those audits in the original audit plan; audits that overran the budget days; and the time taken to issue the final report following the final meeting, to provide just a few possible examples.

An annual report and opinion at the end of the year for each Authority and presented to the respective Senior Management Teams and Audit and Governance Committees. This explicitly covers risk management, governance and control frameworks at the Council.

We feel that notwithstanding the observations mentioned above, the Internal Audit Service generally conforms to standard 2000 and the LGAN.

5.9 **Performance Standard 2100 – Nature of Work**

Standard 2100 covers the way the Internal Audit activity evaluates and contributes to the improvement of the organisation's risk management and governance framework and internal control processes, using a systematic, disciplined and risk-based approach.

This is the approach adopted by the Internal Audit Service and is embedded in their working methodologies. During this EQA, we reviewed a small sample of completed audits and examined them to see if they conformed to standard 2100, the LGAN and Internal Audit's own methodologies. We found that all the sample audits examined during the EQA complied with all three.

The indication from this EQA is that the Internal Audit Service conforms to performance standard 2100 and the LGAN.

5.10 **Performance Standard 2200 – Engagement Planning**

Performance standard 2200 requires Internal Auditors to develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. The plan must consider the organisation's strategies, objectives, and risks relevant to the engagement.

As mentioned above, the Internal Audit Service has an audit manual and supervision processes in place, that include engagement planning and meets the requirements of the PSIAS. From the sample of audits that we examined during the EQA, we found that they all conformed to standard 2200, the LGAN, and the Internal Audit Service's own audit procedures, and we therefore conclude that Internal Audit conforms to performance standard 2200 and the LGAN.

5.11 **Performance Standard 2300 – Performing the Engagement**

Performance standard 2300 seeks to confirm that Internal Auditors analyse, evaluate and document sufficient, reliable, relevant, and useful information to support the engagement results and conclusions, and that all engagements are properly supervised.

The Internal Audit Service has an audit manual, supervision arrangements, and quality assurance processes in place that meet the requirements of the standards. We reviewed the evidence provided in support of the Internal Audit Service's self-assessment, together with a sample of audits to see if they conformed to the standards, and Internal Audit Service's own working methodologies. We found that all the evidence we examined conformed to the standards and their own procedures and methodologies. We therefore conclude that the Internal Audit Service conforms to performance standard 2300 and the LGAN.

5.12 **Performance Standard 2400 – Communicating Results**

This standard requires Internal Auditors to communicate the results of engagements to clients and sets out what should be included in each audit report, as well as the annual report and opinion. When an overall opinion is issued, it must take into account the strategies, objectives and risks of the clients and the expectations of their senior management, the audit committee and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant, and useful information. Where an internal audit function is deemed to conform to the PSIAS, reports should indicate this by including the phrase "conducted in conformance with the International Standards for the Professional Practice of Internal Auditing".

The Internal Audit Service's procedures and supervision processes cover the communication of results of individual audits and meet the requirements of the PSIAS. During the EQA we reviewed the evidence provided in support of the Service's self-assessment and the audit reports issued for a sample of audits to establish if they conformed to the standards. We found that all the evidence we examined conformed to the standards and the Internal Audit Service's own procedures and methodologies.

We also reviewed the progress and annual reports presented to the respective Audit and Governance Committees and found that, on the whole, these also conformed to the standards and the Service's own internal procedures, although we have made observations regarding performance indicators provided to the respective Audit and Governance Committees under performance standard 2000 above.

Notwithstanding the observations under performance standard 2000, we conclude that the Internal Audit Service conforms to performance standard 2400 and the LGAN.

5.13 **Performance Standard 2500 – Monitoring Progress**

There is a follow-up process in place, the objective of which is to monitor the client's progress towards the implementation of agreed actions. The results of the follow-up reviews are reported to the respective Audit and Governance Committees. Whilst we consider that the Internal Audit Service are generally meeting the requirements of this standard, the number of recommendations actioned/completed by senior management for the Council and Cleveland Fire Authority are 65% in 23/24 and to date 33% in 24/25 which indicates there could be improvement. The HAG is aware of this, following up on non-responses and escalating when required. The HAG is keen to improve performance to the highest level possible; to assist we offer some further suggestions below which we also include as advisory actions in Section 10:

- First, there may be some areas of management who are not engaged with the process and are not treating Internal Audit as a critical friend. There may be some advantage in these areas to training sessions around what Internal Audit does and does not do.
- Second, any recommendations are there to improve matters and the Executive Leadership Team, once they agree the Internal Audit findings has to own them. At that point they are not Internal Audit recommendations but are agreed management actions. It is the Executive Leadership Team's responsibility to ensure they are implemented promptly and this needs to be made clear at senior management meetings. The HAG recognises this issue and is revising the follow up process to include reporting to the Executive Leadership team where appropriate.
- Third, the Chair of the Audit and Governance committee needs to hold management to account where there has been a lack of input /response. If managers fail to implement the actions they need to turn up at the Audit and Governance Committee and explain their lack of action. It is possible this could be a key objective to be included in manager's annual appraisals. Whilst it may be welcomed more easily via clarity amongst the senior management team this option is worth considering.
- Fourthly, there is an escalation process in place for non-response to recommendations. There may be benefit to adding onto draft planning documents, draft reports and follow up emails to state that there is an escalation process in place for non-responses.
- Finally, the Service needs to ensure they are regularly demonstrating to the Executive Leadership Teams that they are adding value to their operations - benchmarking, sharing issues picked up at network meetings, horizon scanning, more insight and generally being proactive and dynamic - staying ahead of the curve. Whilst we believe the Service already does this, they need to demonstrate that they understand the client's business in depth across all of the senior management team.

In the scope of this short validation review we cannot be certain why some members of senior management are not responding to recommendations more promptly and there is also no assessment provided by Internal Audit, that we have seen, of the priority / risk of which recommendations have been actioned and which have not. However, this is mitigated by an assessment of priority/risk of the recommendation in each audit report (explaining the impact and likelihood at pre and post action stage). Monitoring progress is highlighted in the new Global Internal Audit Standards (15.2). The Internal Audit Service will need to continue their good practice and be proactive to gain the support of senior management and the Audit Committee to evidence conformance going forward.

Notwithstanding these comments from this EQA we consider that the Internal Audit Service conforms to performance standard 2500 and the LGAN.

5.14 **Performance Standard 2600 – Communicating the Acceptance of Risk**

Standard 2600 considers the arrangements which should apply if the HAG has concluded that managers have accepted a level of risk that may be unacceptable to the organisation. Situations of this kind are expected to be rare, consequently, we did not see any examples of this during this review. From this EQA, it is evident that the Internal Audit Service conforms to performance standard 2600 and the LGAN.

6. Areas of partial conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

6.1 There are no areas of partial conformance with the Public Sector Internal Audit Standards or the CIPFA Local Government Application Note.

7. Areas of non-conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

7.1 There are no areas of non-conformance with the Public Sector Internal Audit Standards or the CIPFA Local Government Application Note.

8. Survey results

8.1 Overall, the results of the survey of key stakeholders were positive with respondents valuing the services provided by them with most respondents agreeing or partially agreeing with the survey statements. The detailed findings from the survey have been shared with the Head of Audit and Assurance to enable them to explore the responses in more depth. A summary of the survey results is included in this report at Appendix A.

9. Global Internal Audit Standards

New Global Internal Audit Standards (GIAS), modified by the GIAS UK Application Note (published December 2024) replacing the current Public Sector Internal Audit Standards (PSIAS), are effective from 1st April 2025 for the UK public sector.

Broadly speaking, it is expected that an Internal Audit Service that is compliant with the PSIAS would be compliant with the GIAS. There are however changes of emphasis around purpose, ethics, professionalism and some documentation requirements. In particular there is greater emphasis being place on the governance of the internal audit function and the role of audit committees in this process. The CIPFA Code of Practice on the Governance of Internal Audit will be published in January.

It is expected that all internal audit functions will have a transition plan to show what they need to do to ensure conformance to the GIAS and by when, and to share this with their respective audit committees. They should pay particular attention to those areas highlighted for their transition plans.

10. Issues for management action

10.1 From our review of the Service's self-assessment we have identified several issues that the Internal Audit Service and the Council need to address or consider, and these are all set out in the table below:

Issues for management action	**Priority**
There is an audit charter in place for each authority, and it is understood that these are reviewed on an annual basis. We reviewed these documents and found them to contain the elements that the PSIAS expects to be included in an audit charter, except for the term "senior management" not being defined; this is a specific requirement of the PSIAS. Additionally, and with reference not just to the PSIAS but to the CIPFA LGAN 2019 it is considered that explanations would benefit from more specifics. As an example PSIAS and the Application note require "setting out relevant arrangements within the organisation's anti-fraud and anti-corruption policies" but no arrangements are set regarding whistleblowing or money laundering. We appreciate that the new Global Internal Audit Standards (GIAS)	**Medium**

Issues for management action	Priority
will be mandatory from 1st April 2025 and suggest that updating of the Audit Charter is combined at the same time as building in the additional requirements of GIAS.	
Neither Hartlepool Borough Council's or the Cleveland Fire Authority's Audit and Governance Committees have performed their annual review of self-assessment of the effectiveness of the Audit and Governance Committee, as required by the CIPFA guidance on audit committees. This is a mandated requirement and will also assist with the rotation of Audit and Governance Committee members and enhance the underpinning of the Annual Governance Statement and Annual Internal Audit Opinion.	**Medium**
We understand that due to a requirement for a third of HBC Councillor's to stand for election each year that this can lead to regular rotation on and off the Audit and Governance Committee. Cleveland Fire Authority's Audit and Governance Committee has a similar make up with representatives from each of the four constituent Council's and is understood to have a new Chair. We recognise that training is provided by both Internal Audit and the Finance team but suggest that enhanced training is focused where there are Audit and Governance Committee representatives with new responsibilities and as a refresher for the more experienced members.	**Medium**
We have been advised that the Council encourages growing talent from within and that consideration is being given to bringing in trainees to build up the service. Consideration could be given to trainees following the IIA apprentice programme and the CAE could probably draw on the apprenticeship levy to fund the places although there is of course a requirement to supervise them which is a draw on management resources. There may be suitable candidates already in the council whose jobs are at risk who could take up a trainee post and change careers. The HAG is aware that there is a dire shortage of experienced and/or qualified internal auditors across the country and particularly in the North East should posts need filling at short notice. We were also made aware that an alternative may be to pool resourcing with other local Council's Internal Audit Service's. With this in mind, it would be prudent to develop a mid/long term resourcing and succession plan as part of the service's wider strategy which will be required under Global Internal Audit Standards.	**Medium**
The Internal Audit Service operates under PSIAS with its last external quality assessment (EQA) reporting in August 2018. PSIAS mandates that there is an EQA at least every five years; it is now six years and four months since the previous one. It appears there was a misunderstand regarding the previous EQA that it referred to 2019. Delay to the five-year review brings risks of lack of external oversight and potential delayed insights and opportunities. We suggest that the Audit and Governance Committee has a clear timetable of reports that they should expect to see with dates; including the future EQA.	**Low**
The Head of Audit and Governance has identified that there is scope to enhance the QAIP process by documenting a more formal approach to the process.	**Low**

Issues for management action	Priority
The Service's use of data analytics can be enhanced further by making use of external sources of data for benchmarking purposes. Suitable sources of external sources of data are the local authority data held in the CIPFA statistics and 'Nearest Neighbour Model' applications, which the Councils should already have access to, and the benchmarking data held by the Local Government Association in their LG Inform application.	**Advisory**
There is always scope for more IT audit training and qualifications due to the speed at which IT is moving and therefore suggest this is also included in the medium long term resourcing strategy	**Advisory**
There may be some areas of management who are not engaged with the process and are not treating Internal Audit as a critical friend. There may be some advantage in these areas to training sessions around what Internal Audit does and does not do.	**Advisory**
Any recommendations made by Internal Audit are there to improve matters and the Executive Leadership Team, once they agree the Internal Audit findings has to own them. At that point they are not Internal Audit recommendations but are agreed management actions. It is the Executive Leadership Team's responsibility to ensure they are implemented promptly and this needs to be made clear at senior management meetings. The HAG recognises this issue and is revising the follow up process to include reporting to the Executive Leadership team where appropriate.	**Advisory**
The Chair of the Audit and Governance committee needs to hold management to account where there has been a lack of input /response on recommendations. If managers fail to implement the actions they need to turn up at the Audit and Governance Committee and explain their lack of action. It is possible this could be a key objective to be included in manager's annual appraisals. Whilst it may be welcomed more easily via clarity amongst the senior management team this option is worth considering.	**Advisory**
The Internal Audit Service needs to ensure they are regularly demonstrating to the Executive Leadership Teams that they are adding value to their operations - benchmarking, sharing issues picked up at network meetings, horizon scanning, more insight and generally being proactive and dynamic - staying ahead of the curve. Whilst we believe the Service already does this, they need to demonstrate that they understand the client's business in depth across all of the senior management team.	**Advisory**
There may be benefit to adding a sentence onto draft planning documents, draft reports and follow up emails to state that there is an escalation process in place for non-responses to raise awareness of the process where action to recommendations is not taken.	**Advisory**
Some of the performance measures reported to the Audit and Governance Committees are 'traditional measures' of service inputs and could be modernised. An informed approach would be to provide the Audit Committees with performance data relating to 'outcomes achieved' by the Internal Audit Service, for example audits delivered compared to those audits in the original audit plan; audits that overran the budgeted days; and the time taken to issue the final report	**Advisory**

Issues for management action	Priority
following the final meeting, to provide just a few possible examples.	

The co-operation of the Head of Audit and Governance and the Principal Auditor in providing the information requested for the EQA and the spirit and efficiency in which this was done is greatly appreciated. Our thanks also go to the Chair of the Hartlepool Borough Council's Audit and Governance Committee and the key stakeholders that made themselves available for interview during the EQA.

Sean Titley, ACA, CISA

17 December 2024

11. Definitions

Level of Conformity	Description
Generally Conforms	The Internal Audit Service complies with the standards with only minor deviations. The relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the individual Standard, the element of the Code of Ethics, and the Local Government Application Note in all material respects. This means that there is general conformance to a majority of the individual Standards, elements of the Code of Ethics, or the Local Government Application note, and at least partial conformance to the others.
Partially Conforms	The Internal Audit Service is endeavouring to deliver an effective service however, they are falling short of achieving some of their objectives and/or generally conforming to a majority of the individual Standards, elements of the Code of Ethics, or the Local Government Application note and at least partial conformance to the others. There will usually be significant opportunities to improve the delivery of effective internal audit, and enhance conformance to the Standards, elements of the Code of Ethics, and/or the Local Government Application Note. The Internal Audit Service may be aware of some of these opportunities and the areas they need to develop. Some identified deficiencies may be beyond the control of Internal Audit and may result in actions for Senior Management or the Board of the organisation to address.
Does Not Conform	The Internal Audit Service is not aware of; not making efforts to comply with; or is failing to achieve many/all of the individual Standards, elements of the Code of Ethics, or the Local Government Application Note. These deficiencies will usually have a significant adverse impact on Internal Audit's effectiveness and its potential to add value and are likely to represent significant opportunities for improvement to Internal Audit. Some identified deficiencies may be beyond the control of Internal Audit and may result in recommendations to Senior Management or the Board of the organisation.

Action Priorities	Criteria
High priority	The Internal Audit Service needs to rectify a significant issue of non-conformance with the standards. Remedial action to resolve the issue should be taken urgently.
Medium priority	The Internal Audit Service needs to rectify a moderate issue of conformance with the standards. Remedial action to resolve the issue should be taken, ideally within a reasonable time scale, for example six months.
Low priority	The Internal Audit Service should consider rectifying a minor issue of conformance with the standards. Remedial action to resolve the issue should be considered but the issue is not urgent.

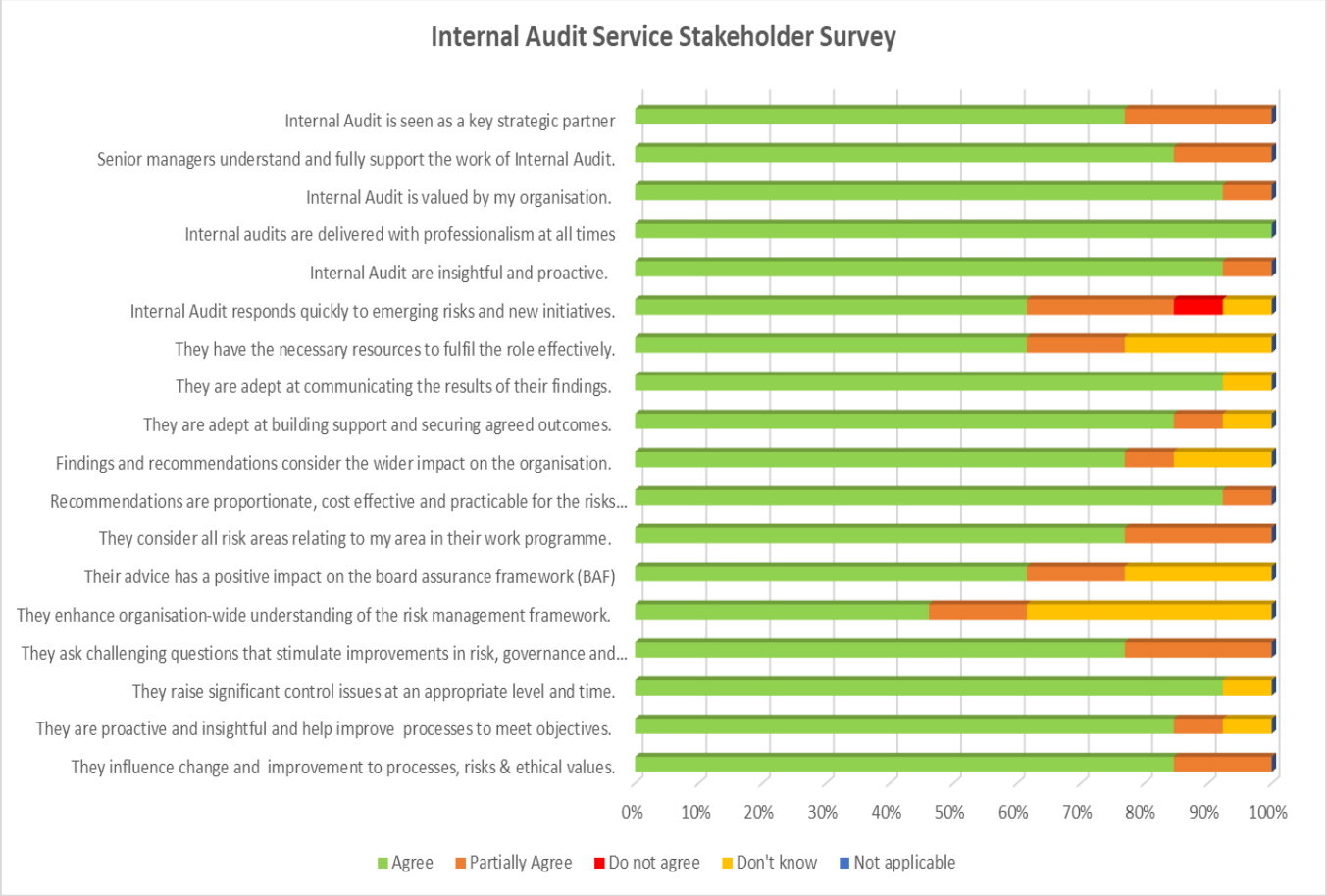
Advisory	These are issues identified during the course of the EQA that do not adversely impact the service's conformance with the standards. Typically, they include areas of enhancement to existing operations and the adoption of best practice.

12. Disclaimer

This report has been prepared by CIPFA at the request of the Hartlepool Borough Council Internal Audit Service, and the terms for the preparation and scope of the report have been agreed with them. The matters raised are only those that came to our attention during our work. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, we have only been able to base findings on the information and documentation provided to us. Consequently, no complete guarantee can be given that this report is necessarily a comprehensive statement of all the issues that exist with their conformance to the Public Sector Internal Audit Standards that exist, or of all the improvements that may be required.

The report was prepared solely for the use and benefit of the Hartlepool Borough Council Internal Audit Service, including the Officers and elected Members of the Council, and the Internal Audit Service's client's, and to the fullest extent permitted by law, CIPFA accepts no responsibility and disclaims all liability to any other third party who purports to use or rely, for any reason whatsoever on the report, its contents, conclusions, any extract, and/or reinterpretation of its contents. Accordingly, any reliance placed on the report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification by any third party is entirely at their own risk.

Appendix A


Internal Audit Service Stakeholder Survey
Internal Audit is seen as a key strategic partner
Senior managers understand and fully support the work of Internal Audit.
Internal Audit is valued by my organisation.
Internal audits are delivered with professionalism at all times
Internal Audit are insightful and proactive.
Internal Audit responds quickly to emerging risks and new initiatives.
They have the necessary resources to fulfil the role effectively.
They are adept at communicating the results of their findings.
They are adept at building support and securing agreed outcomes.
Findings and recommendations consider the wider impact on the organisation.
Recommendations are proportionate, cost effective and practicable for the risks...
They consider all risk areas relating to my area in their work programme.
Their advice has a positive impact on the board assurance framework (BAF)
They enhance organisation-wide understanding of the risk management framework.
They ask challenging questions that stimulate improvements in risk, governance and...
They raise significant control issues at an appropriate level and time.
They are proactive and insightful and help improve processes to meet objectives.
They influence change and improvement to processes, risks & ethical values.
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Agree
Partially Agree
Do not agree
Don't know
Not applicable

EXTERNAL QUALITY ASSURANCE UP

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AUDIT AND GOVERNANCE COMMITTEE

1 April 2025

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT CHARTER, STRATEGY AND PLAN 2025/26

1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people are enabled to live healthy, independent and prosperous lives.
- where those who are vulnerable will be safe and protected from harm.
- of resilient and resourceful communities with opportunities for all.
- that is sustainable, clean, safe and green. - that has an inclusive and growing economy
- that has an inclusive and growing economy.
- with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

2. PURPOSE OF REPORT

2.1 To inform Members of the direction of internal audit activity. To seek approval of the Internal Audit Charter **(Appendix A)**, and the Internal Audit Strategy and annual operational Internal Audit Plan 2025/2026 **(Appendix B)**.

3. INTERNAL AUDIT CHARTER AND STRATEGY

3.1 In order to ensure compliance with Global Internal Audit Standards (GIAS) Internal Audit must regularly update it procedures and strategies. The Internal Audit Charter outlines the mission, purpose and authority Internal Audit must perform its duties in compliance with.

3.2 The mission of Internal Audit is to strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight. enhance and protect organisational value by providing risk-based and objective assurance, advice and insight to our clients. The charter sets out how this is achieved by providing an independent, objective assurance and consulting activity.

3.3 The strategic objectives of Internal Audit are:

Objective 1	to sustain a high-quality internal audit service which is responsive, flexible and consistent with best professional practice within the constraints of the budget available
Objective 2	to maintain an experienced and knowledgeable Internal Audit Team, who are independent and objective, with professional courage
Objective 3	to keep digital, technological and AI opportunities under review and to utilise them as effectively and efficiently as possible
Objective 4	to focus on areas that matter to our stakeholders, adding value, providing valuable advice, insights and foresights

4. INTERNAL AUDIT ANNUAL PLAN

4.1 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 GIAS. At Hartlepool, the authority for ensuring this responsibility is met has been delegated to the Director of Finance IT and Digital.

4.2 To accord with GIAS 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.

4.3 Given available audit resources, all aspects of the Council's systems and arrangements cannot be audited in one year. In recognition of this an Annual 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

4.4 The Annual 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 all Assistant Directors and Executive Leadership Team (ELT), of their current operational issues.

5. INTERNAL AUDIT RESOURCES 2025/2026

5.1 Internal Audit currently has five FTE within the section. Staffing levels are comparable to other authorities of our size, but this will be kept under review to ensure there is enough capacity to complete audit coverage. When considering operational costs of providing the service and income generated, the net budget for the provision of Internal Audit is £263,391.

5.2 A total of 74 planned areas of audit coverage will form the basis of the mainstream Internal Audit work for 2025/26. 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.

5.3 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.

5.4 For 2025/26, we are contracted to provide 100 days of audit work to the Cleveland Fire Authority.

6. DELIVERING THE AUDIT

6.1 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.

- Monitor management implementing the agreed actions plans, and reporting any non-implementations to Senior Management.

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

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

7. INTEGRATION

7.1 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. Meetings are held with Mazars to ensure overall audit resources are most effectively focussed.

7.2 Internal Audit will also seek to gain assurance from the work of the Internal Audit Section of the Councils I.T. provider NEC, where possible.

8. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	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.
FINANCIAL CONSIDERATIONS	No relevant issues.
SUBSIDY CONTROL	No relevant issues.
LEGAL CONSIDERATIONS	No relevant issues.
CHILD AND FAMILY POVERTY CONSIDERATIONS	No relevant issues.
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues.

STAFF CONSIDERATIONS	No relevant issues.
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues.
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues.
CONSULTATION	No consultation required.

9. RECOMMENDATIONS

9.1 It is recommended that Members:

- Review and approve Internal Audits Charter and Strategy.
- Review and approve the 2024/25 Internal Audit Plan and note the Internal Audit budget for 2024/25 of £263,391.

10. REASON FOR RECOMMENDATIONS

10.1 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.

11. BACKGROUND PAPERS

11.1 - Accounts and Audit Regulations 2015
- Global Internal Audit Standards (GIAS).

12. CONTACT OFFICER

12.1 Noel Adamson
Head of Audit and Governance
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Victoria Road
Hartlepool
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Email: noel.adamson@hartlepool.gov.uk

APPENDIX A

HARTLEPOOL
BOROUGH COUNCIL

INTERNAL AUDIT CHARTER

The Councils Vision for the future of Hartlepool in 2030

Hartlepool will be…

… a place where people live healthier, safe and independent lives.	**… a place that is connected, sustainable, clean and green.**	**… a place that is welcoming with an inclusive and growing economy providing opportunities for all.**
People	**Place**	**Potential**

… a place with a Council that is ambitious, fit for purpose and reflects the diversity of its community.

Organisation

Our mission

Our mission is to strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight.
We will achieve the mission statement through our overall delivery arrangements. This charter sets out how this is done.

Internal Audit Mandate

Authority

The council is required by law to have an internal audit of its governance, risk and control processes. Under the Accounts and Audit Regulations 2015 the audit must consider:

- Global Internal Audit Standards (GIAS)
- Chartered Institute of Public Finance (CIPFA) Code of Practice for the Governance of Internal Audit in UK Local Government
- any mandatory guidance

The standards:

- set the basic principles for carrying out internal audit in the public sector
- provide criteria against which quality and performance can be evaluated

CIPFA Code of Practice for the Governance of Internal Audit in UK Local Government is available on the CIPFA website. The code sets out the proper practice for internal audit in local government.

For the purposes of compliance with GIAS, in this Charter the "Board" is defined as the Audit and Governance Committee. "Senior Management" is defined as the Executive Leadership Team (ELT).

We derive our authority from:

- the standards
- this charter
- the council's constitution, specifically the financial procedure rules

The head of internal audit and governance (HIAG) is the chief audit executive. The HIAG and internal audit staff are authorised to:

- have unrestricted access to all the council's:
    - records
    - property
    - personnel
    - management
    - elected members
    - partnership services
    - services under contract with external organisations
- Receive information and explanations as a result of audit work.
- Obtain the assistance of council staff in relevant engagements. This includes other specialised services from within or outside the council.

We have no authority or management responsibility for any of our engagement subjects.

We (and our auditors) will not make any management decisions or engage in any activity which could reasonably be construed to compromise our independence.

Auditors are free from operational system involvement or influence.

Role

Support the delivery of the authority's People, Place, Potential and Organisation vision by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal control processes.
Serving the public interest by championing and advising on good practice in Governance, risk management, and internal control processes.

We provide:

- An independent, objective assurance and consulting activity. It is designed to:
  - add value and improve the council's operations
  - help the council to meet its objectives
  - brings a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes
- The audit and governance committee with information necessary for it to fulfil its own responsibilities and duties.
- Support to management to fulfil its own risk, control and compliance responsibilities.

Responsibility

The head of internal audit and governance (HIAG) is responsible for all aspects of internal audit activity, including:

- strategy
- planning
- performance
- quality
- reporting

The HIAG will:

Strategy

- Develop and maintain an internal audit strategy.
- Review the internal audit strategy annually with management and audit and governance committee.

Planning

- Develop and maintain a risk based internal audit plan aligned with the council's corporate objectives.
- Engage with management and consider the council's:
  - strategic and operational objectives.
  - related risks in the development of the internal audit plan.
- Review the internal audit plan periodically with management. The review will reflect changes in the risk environment. These changes must be approved when significant.
- Present the internal audit plan, including updates, to the audit and governance committee for periodic review and approval.
- In conjunction with ongoing work around workforce planning and resilience, ensure Internal Audit service is suitably staffed.

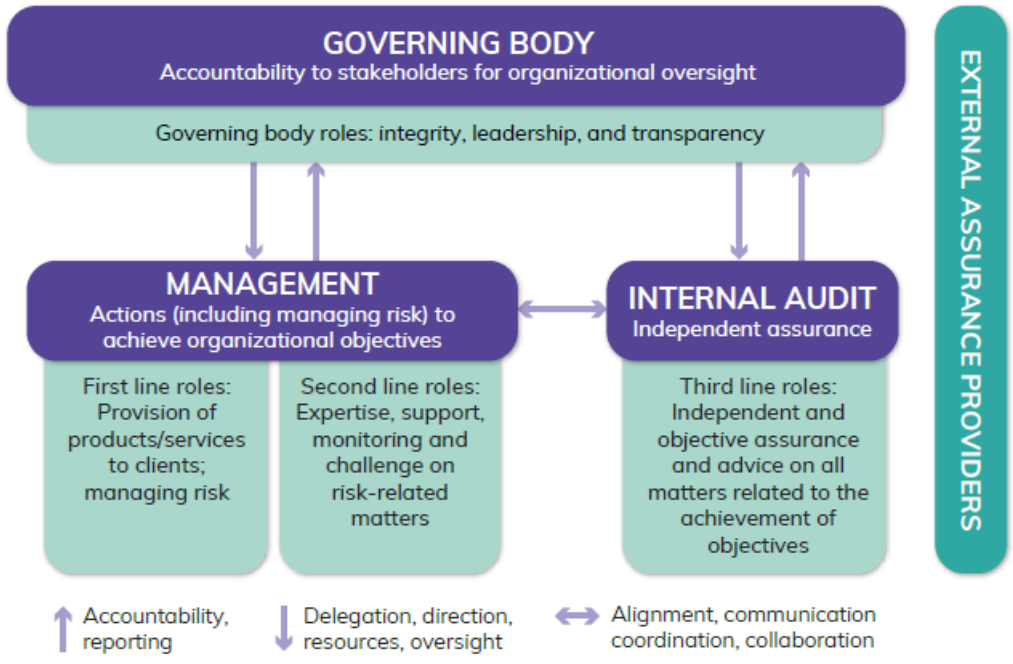
- Agree an internal audit budget sufficient to fulfil the requirements of:
  - this charter,
  - the internal audit strategy,
  - the internal audit plan.
- The internal audit budget is reported annually to the finance and purposes committee and full council. This is for approval as part of the council's overall budget. The head of internal audit and governance will draw any resourcing issues that potentially impact on the effectiveness of the internal audit function to the attention of:
  - the managing director
  - section 151 officer
  - the audit and governance committee
- Coordinate with and (where relevant) provide oversight of other control, monitoring and assurance functions, including risk management and external audit.
- Consider the scope of work of the external auditors (and other assurance providers) for the purpose of providing optimal audit coverage to the organisation.

The HIAG should be consulted about:

- Significant proposed changes to the internal control system
- Implementation of new systems

Advice can then be provided on the standards of controls to be applied. This need not prejudice the audit objectivity when reviewing systems later.

In developing the internal audit plan, we also take account of the council's assurance framework. We use the three lines of assurance model in compliance with CIPFA "Developing an effective assurance framework in a local authority guidance". These are detailed in the diagram below and are obtained through our combined assurance work.



We achieve these through:

- Speaking to senior and operational managers who have the day-to-day responsibility for managing and controlling their service activities
- Working with corporate functions and using other third-party inspections to provide information on:
    - performance
    - successful delivery
    - organisational learning
- Using the outcome of internal audit work to provide independent insight and assurance opinions
- Considering other information and business intelligence that feed into and has potential to impact on assurance

Performance

- Implement and deliver the risk based internal audit plan
- Maintain professional resources with sufficient knowledge, skills and experience to meet the requirements of:
    - this charter
    - the internal audit strategy
    - the internal audit plan
- Allocate and manage resources to accomplish internal audit engagement objectives
- Establish and maintain appropriate internal auditing procedures incorporating best practice approaches and techniques
- Monitor delivery of the internal audit plan using appropriate performance indicators
- Hold regular senior management and statutory officer (golden triangle) liaison meetings

Quality

- Establish a quality assurance framework to:
    - provide a system for monitoring and evaluating our effectiveness and conformance with the standards
    - ensure continuous improvement within the internal audit service
    - ensure compliance with professional standards, code of ethics and council codes of conduct
    - meet client expectations and demonstrate our importance to the business
    - facilitate the head of internal audit and governance's statement on conformance with the international standards for the professional practice of internal auditing
- Undertake an annual assessment of the service and its compliance with the standards. Every five years the assessment is undertaken externally by a suitably qualified, independent assessor, next due 2029
- Obtain regular feedback on the quality and impact of our work (added value)

The GIAS consist of the basic requirements for the professional practice of internal auditing and for evaluating the effectiveness of performance. The five domains and fifteen standards set out what we must do to be considered effective. There are 5 domains and 15 principles, with Standards under each principle. The first 2 domains are the foundations, and the remaining 3 domains are focused on key areas of Internal Audit delivery:

Reporting

The following table illustrates who and where Internal Audit reports and documents are reported to:

Report/Reporting to	Audit Project Client	Assistant Director	Directors/ELT	Audit & Governance Committee	External Audit
IA Charter			✓	✓	
IA Strategy			✓	✓	
IA Annual Plan			✓	✓	
IA Strategy and Annual Plan Update			✓	✓	
IA Strategy and Annual Plan Outturn			✓	✓	
IA Annual Opinion & Effectiveness of Internal Control			✓	✓	
Draft/Final Planning Document	✓	✓			

Draft/Final Report	✓	✓			✓
Follow Up Report	✓	✓	✓	✓	

Follow Up Reporting

To ensure all actions are implemented within agreed timescales, the following process is in place:

- Business Contacts and the relevant Assistant Director reminded 5 working days before actions are due for implementation, and again 5 working days after the implementation due date:
- No response to either of these reminders, escalate to Director:
- No response from Director (or AD/BC) within 5 working days report to ELT and Audit and Governance Committee.

Scope

The scope of internal audit activities includes all council activities including services which are:

- provided in partnership
- under contract with external organisations

There are no restrictions.

Activities which have specific internal audit engagements are identified in the internal audit plan.

Assurance engagements involve the objective assessment of evidence. This provides an independent opinion or conclusions regarding the effect control of risk.
The nature and scope of the assurance engagement are determined by internal audit.

Consulting engagements are advisory in nature. They are generally performed at the specific request of management.

The nature and scope of consulting engagements are subject to agreement with management. They should assist management in meeting the objectives of the organisation without undermining the key principles of independence and objectivity. Internal audit should not assume management responsibility.

The HIAG will assist with the:

- implementation of the council's counter fraud policy and strategy
- investigation of fraud and irregularities in line with policy, strategy, and the constitution
- implementation of whistleblowing arrangements including reporting and investigation
- implementation of money laundering arrangements including reporting and investigation

The HIAG must be notified of all suspected or detected fraud, corruption or impropriety.

Consultancy engagements should only be performed where resources and skills exist. They should focus on governance, risk and control – supporting the head of internal audit's annual opinion. They should not replace assurance engagements.

The HIAG cannot give total assurance that control weaknesses or irregularities do not exist. Managers are fully responsible for the quality of internal control within their area of accountability.

Managers should ensure that appropriate and adequate arrangements exist for:

- risk management
- control systems
- accounting records
- financial processes
- governance (the control environment)

Managers should not depend on internal audit activity to identify weaknesses or control failures.

Independence

To provide for internal audit's independence, the HIAG reports directly to the:

- audit and governance committee (the board)
- executive leadership team
- section 151 officer

We support the discharge of statutory responsibilities, and those responsibilities set out in the constitution for the:

- section 151 officer
- monitoring officer
- head of paid service

The HIAG:

- has free and full access to the chair of the audit and governance committee
- is employed by Hartlepool Borough Council

The appointment, removal and performance of the HIAG will be in accordance with established procedures, with the involvement of the Chair of the Audit and Governance Committee.

We have an impartial, unbiased attitude and will avoid conflicts of interest.

If our independence or objectivity is impaired, details of the impairment should be disclosed to either:

- the section 151 officer
- the chair of the audit and governance committee
- or both dependent upon the nature of the impairment

We are not authorised to:

- perform any operational duties for the organisation
- initiate or approve accounting transactions external to the internal audit service
- direct the activities of any council employee not employed by the internal auditing service (unless they have been assigned to the service or to assist the internal auditor)

Constructive working relationships make it more likely that our work will be accepted and acted upon.

The internal auditor does not allow our objectivity or impartiality to be impaired.

Governance

Audit and governance committee

The audit and governance committee is a key component of the council's governance framework. They underpin good governance and financial standards by providing an independent and high-level focus on:

- the audit
- assurance
- reporting arrangements

The committee provides independent assurance to the council members of the adequacy of the:

- risk management framework
- internal control environment
- integrity of the financial reporting and annual governance processes

It oversees internal audit and external audit. This helps to ensure efficient and effective assurance arrangements are in place.

For the purposes of the GIAS the audit committee performs the role of the 'board'.

The audit and governance committee complies with CIPFA best practice standards through their terms of reference and work programme. An annual review of self-assessment of the effectiveness of the Audit and Governance Committee, as required by the CIPFA guidance on audit committees will be facilitated.

The audit and governance committee will:

- approve the internal audit charter
- approve the risk-based internal audit plan and strategy

- receive reports from the head of internal audit and governance on internal audit activity's performance relative to its plan and other matters

Standards of internal audit practice

- We work in accordance with the International Professional Practices' Framework (IPPF) of the Chartered Institute of Internal Auditors and Global Internal Audit Standards.

We are further guided by interpretation provided by the:

- Chartered Institute of Public Finance (CIPFA) Code of Practice for the Governance of Internal Audit in UK Local Government
- CIPFA publication on the "role of the head of internal audit"
- CIPFA "Developing an effective assurance framework in a local authority guidance"

External work and charter validity

External work

The internal audit section provides internal audit services to public sector external clients.

The nature and extent of work for external clients is kept under review to ensure:

- it does not impinge on the audit work carried out for the council
- there is no conflict of interest or impairment of independence arising from this work

Approval and validity of this charter

This charter shall be reviewed and resubmitted annually. It will be also reviewed should there be any changes to:

- internal audit arrangements
- public sector internal audit standards

Approval will be sought from:

- senior management
- the audit and governance committee as the board of the organisation and council.

Appendix B

HARTLEPOOL BOROUGH COUNCIL

INTERNAL AUDIT STRATEGY

Internal Audit

AUDIT STRATEGY

1 Purpose of Internal Audit

1.1 To support the delivery of the authority's People, Place, Potential and Organisation vision by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal control processes.

1.2 Serving the public interest by championing and advising on good practice in Governance, risk management, and internal control processes.

2 Vision of Internal Audit

2.1 Use technology and training to empower the team to achieve their full potential in delivering an annual plan of added value, risk-based assurance assignments in compliance with Global Internal Audit Standards (GIAS), contributing to the governance and control environment that will enable the Council to meet its People, Place, Potential and Organisation vision.

3 Mission of Internal Audit

3.1 To strengthen the Councils ability to meet its People, Place, Potential and Organisation vision. We will achieve this by creating, protecting, and sustaining value by providing the Audit and Governance Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

4 Strategic Internal Audit Objectives

4.1 The Internal Audit environment is evolving rapidly, and the Internal Audit Team will need to be aware of these changes and have the skills to consider them in relation to the activities planned, and the skills to adapt those plans where necessary to continue to provide valued assurance in the most efficient and effective ways.

4.2 Our strategic objectives are:

Objective 1	to sustain a high-quality internal audit service which is responsive, flexible and consistent with best professional practice within the constraints of the budget available
Objective 2	to maintain an experienced and knowledgeable Internal Audit Team, who are independent and objective, with professional courage
Objective 3	to keep digital, technological and AI opportunities under review and to utilise them as effectively and efficiently as possible
Objective 4	to focus on areas that matter to our stakeholders, adding value, providing valuable advice, insights and foresights

4.3 We will do this by:

- delivering a range of assurance assignments each annual plan year, which focus on the Council's core governance processes, strategic priorities, corporate risks and key financial systems. We will perform these assignments in line with GIAS as set out in our suite of Internal Audit documents
- identifying areas for improvement in the Council's risk management, internal control, governance and service delivery arrangements to make a positive contribution to the overall management and operation of the authority. We will do this by examining and reporting on the adequacy and effectiveness of the control environment for each audit in the Annual Plan.
- continually improving the knowledge base and skills of the Internal Audit Team across relevant areas to support the Council's objectives. We will achieve this through our Training Plan
- reviewing and updating the Internal Audit suite of documents to ensure that all process and procedures comply as far as possible with the GIAS. We will do this through our Development Plan.
- engaging with our stakeholders to ensure that we are meeting their expectations. We will do this through our Development Plan.
- promoting the Internal Audit Team as a valuable resource who can be engaged in relevant emerging issues, projects and programmes at an early stage to provide advice and guidance to prevent control weaknesses from arising. We will do this through our Development Plan.

The table below identifies how Internal Audit policy documents fit together in complying with GIAS and where policy documents are reported to and approved.

4.4 The Head of Internal Audit and Governance is accountable for the delivery of this Internal Audit Strategy. Progress reports on the delivery of the Annual Plan, (attached as Appendix A), and the relevant parts of the Development and Training Plans (attached as Appendix B), for that year will be presented to both ELT and the Audit and Governance Committee.

4.5 A suite of performance indicators will be developed and reported to both ELT and the Audit and Governance Committee. These indicators will measure progress against goals recorded in the sections Development Plan.

25/26 Internal Audit Plan

Department	Director/Assistant Director	Auditable Area
Adult & Community Based	John Lovatt	Emergency Duty Team Contract and Developments – Credit Card, Out of Hours Placements
Adult & Community Based	John Lovatt	Deferred Payments
Adult & Community Based	John Lovatt	Domestic Abuse Act – Implementation
Adult & Community Based	John Lovatt	Better Care Fund
Adult & Community Based	John Lovatt	Individual Placement Agreements
Adult & Community Based	John Lovatt	Stockton Borough Council Assurance Work
Adult & Community Based	John Lovatt	Controcc Application
Adult & Community Based	John Lovatt	CareFirst Application
Adult & Community Based	Gemma Ptak	Gladstone Leisure Management System
Adult & Community Based	Gemma Ptak	Art Gallery/Museum Stock Including NHLF Grant
Adult & Community Based	Gemma Ptak	Borough Hall/Town Hall Income
Adult & Community Based	Gemma Ptak	Summerhill Including Cycle Track/School Provision
Adult & Community Based	Gemma Ptak	Connect to Work Grant
Adult & Community Based	Gemma Ptak	Adult Education – Core Learning Skills Grant
Adult & Community Based	Gemma Ptak	Shared Prosperity Fund Grant
Adult & Community Based	Gemma Ptak	Highlight Move Support
Children's & Joint Commissioning	Amanda Whitehead	Kingsley Primary
Children's & Joint Commissioning	Amanda Whitehead	Clavering Primary
Children's & Joint Commissioning	Amanda Whitehead	Dedicated Schools Grant – High Needs Block
Children's & Joint Commissioning	Laura Gough	ICS Application
Children's & Joint Commissioning	Laura Gough	Children's Homes
Children's & Joint Commissioning	Laura Gough	Youth Offending Services File Management
Neighbourhood & Regulatory	Bev Bearne	Levelling Up Fund
Neighbourhood & Regulatory	Bev Bearne	Risk Management
Neighbourhood & Regulatory	Bev Bearne	Procurement
Neighbourhood & Regulatory	Bev Bearne	Housing Management
Neighbourhood & Regulatory	Kieran Bostock	Gas Safety Management
Neighbourhood & Regulatory	Kieran Bostock	Stores
Neighbourhood & Regulatory	Kieran Bostock	Waste Recycling Centre
Neighbourhood & Regulatory	Kieran Bostock	National Driver Offender Retraining Scheme (NDORS)
Neighbourhood & Regulatory	Kieran Bostock	Concessionary Travel
Neighbourhood & Regulatory	Kieran Bostock	Fuel Management
Neighbourhood & Regulatory	Kieran Bostock	Trade/Commercial Waste Inc Bulk, Garden Waste
Neighbourhood & Regulatory	Kieran Bostock	Planning/Building Control Income
Neighbourhood & Regulatory	Kieran Bostock	Highways Grant
Neighbourhood & Regulatory	Kieran Bostock	Highways Pothole Grant
Neighbourhood & Regulatory	Kieran Bostock	Highways Traffic Signal Grant
Neighbourhood & Regulatory	Sylvia Pinkney	Warm Homes Grant
Neighbourhood & Regulatory	Sylvia Pinkney	Business Continuity/Disaster Recovery
Neighbourhood & Regulatory	Sylvia Pinkney	Licensing
Neighbourhood & Regulatory	Sylvia Pinkney	Car Parking Income
Neighbourhood & Regulatory	Sylvia Pinkney	Health and Safety
Public Health	Craig Blundred	Tobacco Control/Smoking Cessation
Public Health	Craig Blundred	Drug and Alcohol Contact
Public Health	Craig Blundred	Homelessness Audit Revisit

Public Health	Craig Blundred	Refugee Asylum Seekers Grant
Public Health	Craig Blundred	Health Checks Provided by GPs
Finance IT and Digital	James Magog	Transformation Project
Finance IT and Digital	Laura Griffiths	Computer Audit
Finance IT and Digital	Laura Griffiths	Iworld Application
Finance IT and Digital	Laura Griffiths	Firmstep Application
Finance IT and Digital	Laura Griffiths	Enterprise Application
Finance IT and Digital	Laura Griffiths	Housing Benefits
Finance IT and Digital	Laura Griffiths	Council Tax
Finance IT and Digital	Laura Griffiths	Local Council Tax Support Scheme
Finance IT and Digital	Laura Griffiths	National Non-Domestic Rates (NNDR)
Finance IT and Digital	Paul Dixon	National Fraud Initiative (NFI)
Finance IT and Digital	Paul Dixon	Budgetary Control
Finance IT and Digital	Paul Dixon	Cash/Bank
Finance IT and Digital	Paul Dixon	Creditors
Finance IT and Digital	Paul Dixon	Debtors
Finance IT and Digital	Paul Dixon	Insurances
Finance IT and Digital	Paul Dixon	Loans & Investments
Finance IT and Digital	Paul Dixon	Main Accounting System
Finance IT and Digital	Paul Dixon	Officers Expenses
Finance IT and Digital	Paul Dixon	Salaries and Wages
Finance IT and Digital	Paul Dixon	VAT
Finance IT and Digital	Paul Dixon	Integra Application
Finance IT and Digital	Paul Dixon	Resource Link/My View Application
Finance IT and Digital	Paul Dixon	Fraud Awareness
Legal Governance and HR	Hayley Martin	Members Allowances/Travel/Subsistence
Legal Governance and HR	Hayley Martin	Sickness Monitoring
Legal Governance and HR	Hayley Martin	Equality and Diversity Statutory Compliance
Legal Governance and HR	Hayley Martin	Policies - Gifts and Hospitalities/register of interests

Internal Audit Development Plan

High Priority

TEAMMATE+ RELEASES	**ACTION**	**STRATEGIC OBJECTIVE**
Maintain an effective process for recording, managing and reporting internal audit work.	Implement Document Request function. Roll out new follow up process. Update Reports	1, 3
TRAINING	**ACTION**	
Formally document Quality and Improvement Programme	For inclusion in 25/26 Head of Audit Opinion Report.	1, 2
TRAINING	**ACTION**	
Provide a robust training plan for Internal Audit staff	Teammate admin training, NFI admin training.	1, 2
TRAINING	**ACTION**	
Agree and facilitate Audit and Governance Committee self-assessment	Agree with Management and Audit and Governance Committee for 25/26.	1, 2
TRAINING	**ACTION**	
Agree and facilitate Audit and Governance Committee training for 25/26.	Agree with Management and Audit and Governance Committee for 25/26.	1, 2
TRAINING	**ACTION**	
Continue the review/ development of Teammate, Power BI and Excel.	Continue individual CIPFA Power BI and Excel training as reflected in individual auditor training plans.	1, 2
REPORTING	**ACTION**	
Improve reporting to clients.	Roll out of root cause to reports	1, 4
REPORTING	**ACTION**	
Set out timetable for reports and future EQA to Audit and Governance Committee	Internal Audit Charter, for approval 01.04.25 by Audit and Governance Committee.	1
REPORTING	**ACTION**	
Update Internal Audit Charter to reflect revised follow up procedure.	Internal Audit Charter approval by Audit and Governance Committee 01.04.25.	1
REPORTING	**ACTION**	
Update Internal Audit Charter to reflect revised reporting procedures to both ELT and Statutory Officers.	Internal Audit Charter approval by Audit and Governance Committee 01.04.25.	1
REPORTING	**ACTION**	
Update Internal Audit Charter to reflect revised Performance Indicators.	Internal Audit Charter approval by Audit and Governance Committee 01.04.25	1
REPORTING	**ACTION**	
Update Audit Committee reporting requirements.	1 List what audit committee needs and develop insights reports to produce the information.	3, 4

	2 PI's and list of data capture, then develop insights reports and/or dashboard charts to provide these in reports. 3 List of deadlines for calendar so can ensure updates done in time before reports due.	
REPORTING	**ACTION**	
Improve reporting to AD's and Directors.	½ Yearly update report to AD's to include follow up status. Review use of dashboard to explore if ADs could easily use to review progress of their audits. Development of PowerBI dashboards for ELT. Annual report to Directors/ELT.	1, 4
REPORTING	**ACTION**	
Update/include definitions in Internal Audit Charter.	Audit and Governance Committee approval 01.04.25	1
QUESTIONNAIRES/FEEDBACK	**ACTION**	
Assess if we are obtaining feedback from all relevant stakeholders, including feedback from auditors.	Develop as part of QAIP. Decide on program of themes for questionnaires at the end of audits and link to IA strategy. Decide if additional questionnaires to go to AD's and/or Directors, or ELT, or Audit Committee to ask specific questions.	1, 2, 4
PERFORMANCE INDICATORS	**ACTION**	
Develop a suite of PI's that will measure progress/achievement of goals.	Develop as part of QAIP. Decide on a suite of PI's that will measure each year to enable comparison and show progress or not. Decide on PI's that will only measure 1 year or only to support the progress in one area until its completion aligning with IA strategy. Develop dashboards and insights reports to action this.	1, 2, 4
FOLLOW UP PROCEDURE	**ACTION**	
Review follow up process.	Roll out new follow up process	1, 4
RISK ASSESSMENT	**ACTION**	
Promote Risk Management and controls throughout the audit process.	Add departmental risks and controls and assignments to dimension entities so pulls into RA for assessment. Add in evidence to support RA scores such as analysis (whole team could have responsibilities for this), add in legislation or other regulation, guidance, policies, info to help – this should also then feed into the projects if selected for plan (more support for the scope and planning?). To make sure above is accurate may	4

	need to add in another scoring mechanism to account for inclusion in strategic risk register and other things.	
TM+ RELEASES	**ACTION**	
Maintain an effective process for recording, managing and reporting internal audit work.	Document request process needs to be reviewed/tested considering M365 platform and how that operates.	1, 3

Medium Priority

WORKFORCE PLANNING	**ACTION**	**STRATEGIC OBJECTIVE**
In conjunction with ongoing work around workforce planning and resilience, ensure Internal Audit Charter communicates Internal Audit approach in this area.	Internal Audit Charter approval by Audit and Governance Committee 01.04.25.	1, 3
STORES	**ACTION**	
Develop procedure to deal with the admin of Stores.	Include annual routine in IA calendar.	3
INSIGHTS	**ACTION**	
Develop Insights procedure.	Check access levels. Restructure reports and folders.	1, 3
DASHBOARDS	**ACTION**	
Develop dashboards for auditors and clients.	Explore what we can collect, where it can go and how it can be included in the dashboard, (might need to review some procedures regarding what collected and added where). Decide if rolling out dashboards to others e.g. AD's or Directors.	1, 3
DATA ANALYTICS STRATEGY	**ACTION**	
Develop a data analytics strategy for the audit team. Continue review of Data Analytic tools and use of benchmarking as part of 25/26 Internal Audit Development Plan.	Develop a strategy showing where we want to get to and how we will get there, including improving the use of IT data analytics within the audit process. Include assessment of data available, work being undertaken within the authority already, training of staff, keeping up to date with IT developments within the authority	1, 3

Low Priority

TRAINING	**ACTION**	**STRATEGIC OBJECTIVE**
Develop training plan for clients, managers and AD's. Agree and facilitate Audit awareness training for 25/26.	Deliver training in areas clients will be involved in such as the audit process, risk and control, etc. Produce own reports from systems for testing	2

	purposes.	
CONSULTANCY PROCEDURE	**ACTION**	
Develop procedure to identify process for undertaking potential consultancy exercises.	Develop procedure outlining our expectations and limitations	1
REPORTING TO STAKEHOLDERS	**ACTION**	
Reporting to areas such as Finance, Risk, IGG, H&S and other categories.	Does this also need to be taken into account at end of plan year? Should these areas receive a note of risks and o/s actions that are categorised as 'in their remit' so they can see if any change on policy needed?	1, 4
BRANDING OF IA DOCUMENTS	**ACTION**	
Review branding/logo.	Use tick logo.	1
INTRANET	**ACTION**	
Review documents/information on intranet.	Update the pages with correct information. Consider whether we could present any of the information in a different way e.g. Teams video recording. Introduce the team, photos?	1

AUDIT AND GOVERNANCE COMMITTEE

1 April 2025

Subject: SAFER HARTLEPOOL PARTNERSHIP ACTION PLAN 2024/25

Report of: Assistant Director (Regulatory Services)

Decision Type: For Information

1. COUNCIL PLAN PRIORITY

Hartlepool will be a place:
- where people will be safe and protected from harm

2. PURPOSE OF REPORT

2.1 To provide an overview of Safer Hartlepool Partnership performance linked to the priorities outlined in the Community Safety Plan 2024/27.

3. BACKGROUND

3.1 The Community Safety Plan for 2024/27 has a strategic objective to "make Hartlepool a safe, prosperous and enjoyable place to live, work and visit". Members agreed that the priority areas of focus to achieve this objective should be Anti-Social Behaviour, Drugs and Alcohol, Domestic Violence and Serious Violence.

3.2 Partners contribute to a Safer Hartlepool Partnership Action Plan by providing an outline of the work they are carrying out covering each priority with the Community Safety Plan. The action plan is a living document and allow partners to include new initiatives to fully reflect the work being carried out.

3.3 The reporting arrangements are that the Safer Hartlepool Partnership Action Plan is reported to the Partnership for consideration & comments.

4. PROPOSAL

4.1 The Safer Hartlepool Partnership Action Plan is attached in **Appendix 1** of the report it outlines activities carried out by partners across the priorities of the 2024/2027 plan.

4.2 Some partners produce action plans to accompany strategies such as Domestic Abuse and Drugs & Alcohol Details, links to these are included in the action plan to ensure that it fully reflects the work being carried out by all partners.

5. OTHER CONSIDERATIONS/IMPLICATIONS

RISK IMPLICATIONS	No relevant issues
FINANCIAL CONSIDERATIONS	No relevant issues
LEGAL CONSIDERATIONS	No relevant issues
CHILD AND FAMILY POVERTY	No relevant issues
EQUALITY AND DIVERSITY CONSIDERATIONS	No relevant issues
STAFF CONSIDERATIONS	No relevant issues
ASSET MANAGEMENT CONSIDERATIONS	No relevant issues
ENVIRONMENT, SUSTAINABILITY AND CLIMATE CHANGE CONSIDERATIONS	No relevant issues
CONSULTATION	No relevant issues

6. RECOMMENDATIONS

6.1 Members are asked to consider and comment on the SHP Action Plan 2024/2025

7. REASONS FOR RECOMMENDATIONS

7.1 The Audit and Governance Committee has within its responsibility to act as the Council's Crime and Disorder Committee and in doing so scrutinize the performance management of the Safer Hartlepool Partnership.

8. BACKGROUND PAPERS

8.1 The following background papers were used in the preparation of this report:-

Safer Hartlepool Partnership – Community Safety Plan 2024/27

9. CONTACT OFFICER

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Appendix 1 – 6.1
blue = June 204 comments **red** = February/March 2025 comments

Priority	Objective / Outcome	Who	Actions/Progress/Comments
Anti-Social Behaviour	Ensure victims understand how to report ASB.	SHP members and partner organisations	**28/02/2025 - Cleveland Police update** Cleveland Online Policing App (COPA) provides residents of Cleveland a digital platform to Cleveland Police and the Police and Crime Commissioner. The app allows them to feed in information about policing and community safety issues easily and quickly. It also lets them ask questions and give feedback. A new 'Neighbourhoods Alert' App is due to go live imminently, which will provide a digital platform for communicating between police and residents – more details to follow upon launch. Traditional methods of the 999, 101 and police front desk remain available. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Publicity has occurred during 2024-25 regarding the work of Hartlepool Community Safety Team including work in the town centre and enforcement activity that has been undertaken.
	Ensure victims are aware of the ASB case review process – "Community Trigger" and how to initiate it	SHP members and partner organisations	**28/06/24 – Nicholas Stone, Community Safety Team Leader** Publicity to occurring regarding the work of Hartlepool Community Safety Team. Information regarding the team is available on HBC website.

			Information regarding the Community Trigger is available on HBC website. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** The Community Safety Team webpages on the Council website have been updated in anticipation of a new Council website in 2025. Information regarding the Community Trigger remains available on HBC website. (Nicholas Stone)
	Provide a more visible police and council officer 'on street' presence	Police and Local Authority	ASB hot spot funding uniformed patrols carried out in Headland & Harbour and Victoria wards. **28/02/2025 - Cleveland Police update** A new shift pattern was introduced in January 2025 for Hartlepool Neighbourhood Policing Teams, this has reduced the original three teams to two, meaning more police officers and Community Support Officers are on duty at any one time. All officers have dedicated wards to increase public confidence, engagement and officer accountability. Operation Artemis: In July 2025, Cleveland Police will be leading a large-scale day of action, involving several partner agencies, charities, local organisations – this will be aimed at two key areas, Anti-Social behaviour and Open Water Misadventure.

			04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager Safer Streets 5 project funding provided Community Cohesion Officer and Environmental Project Officer roles in Victoria Ward from April 2024 to March 2025. Town Centre patrols in place by Kingdom. **04/03/2025 – Sylvia Pinkney (AD Regulatory Services)** ASB hot spot funding has provided additional uniformed patrols in • Victoria ward between October 2023 and September 2024. • Foggy Furze ward between September 2024 and March 2025 • Headland & Harbour ward between October 2023 and March 2025 UKSPF funding has provided additional uniformed patrols in the town centre and marina areas of the town between April 2024 to March 2025.
	Make full use of the ASB tools and powers related to the partnership activity to tackle ASB	Local Authority, Police and partner organisations; Thirteen Group	Community Safety Accreditation scheme in ASB hot spot areas giving Civil Enforcement Officers additional powers

	Reduce deliberate fires	Local Authority, Police, Fire Brigade and partner organisations	**03/03/25 - Sean Smith (Hartlepool District Manager)** Fire Brigade District manager, Sean Smith has now agreed to chair this group. (Sean Smith). Would recommend that all individuals who are known to be involved in deliberate fire setting are referred to Fire Brigade 'Fire Education Intervention' team for 1 to 1 education. Would recommend this group is attended by Fire Brigade Road and Water safety co-ordinator. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Multi agency deliberate fires group – Chaired and hosted by FB with representation from partner agencies
	Reduce the nuisance caused by illegal / off road bikes/vehicles	Local Authority, Police, Fire Brigade and partner organisations	**28/02/2025 - Cleveland Police update** A reinvigorated Operation Endurance is in train, which will be aimed at a Multi-Agency approach to enforcement, problem solving and preventative activity regarding off-road bikes and ASB. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Multi agency off road vehicle group – Chaired and hosted by HBC with representation from partner agencies

	Tackle environmental crime in all its forms	Local Authority, Police, Fire Brigade and partner organisations	**04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Multi agency fly tipping group. – Chaired and hosted by HBC with representation from partner agencies
	TOWN CENTRE RAMP / ASB - ACTION PLAN Explore greater use of Public Space protection Orders (PSPO)	HBC & Police Explore how far / to who the orders can be devolved. HBC & Police Explore the introduction of a PSPO across the wider Town Centre and Marine.	**04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** A review of the Anti-social Behaviour, Crime and Policing Act 2014 legislation and associated Home Office guidance for the Act shows that it would be possible to implement a PSPO for the town centre area. **04/03/2025 – Sylvia Pinkney (AD Regulatory Services)** Work is starting to gather evidence to support a PSPO and identify the area which it will relate to.
	Create a 'Support Hub / Safe Space'	HBC Explore potential locations for the creation of the support Hub / Safe Space HBC Identify who could be co-located in the Hub / Safe Space (options including Wharton Trust, START / Drugs Services and Homeless Team)	**28/02/25 – Abigail Reay (Public Health)** A meeting was held with Start, Sylvia Pinkney, Neil Harrison and Phil Hepburn. It was agreed that a 'support hub/safe space' may not be the best option to tackle ASB at the ramp after discussions were held with wider partners. It was discussed that a place-based approach using assertive outreach should be explored. This will include a team of staff working together to provide support to these individuals. A further meeting has been arranged to put plans into action.

	Maximise the use of available interventions Create a 'Retail Crime Forum' to ensure that the voices of retailers are hear and promote greater reporting of crime	HBC & CFB Explore types of support that could be provided, including Fire Brigade offer. HBC & Police i) General promotion of use of available interventions: - Community Protection Warnings - Community protection Notices - Fixed Penalty Notices - Dispersal Orders - AS13s Police Support Middleton Grange Shopping centre to bettered use the AS13s HBC PCC & MP Letter to Businesses to include York Road businesses to: Explore benefits and business support of the creation of a retail Crime Forum.	**28/02/2025 - Cleveland Police update** A bespoke problem-solving plan has been commissioned, aimed at reducing retail crime in key locations/business within Hartlepool. This will include focus on both Theft of goods and violence towards employees and involve many stakeholders within the Community Safety Partnership. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Several meetings have occurred between Community Safety, Cleveland Police and MGSC during 2024 to discuss joint working and tackling problems in the town centre. A further meeting has been arranged on 13th March 2025. Cleveland Police have offered to attend any Retail Crime Forum established by MGSC. The Community Safey Team has issued 21 Community Protection Warnings, and 4 Community Protection Notices under Operation Grantham which has targeted aggressive persons in the town centre. Anti-social Behaviour Officers and ward PCSOs have on a number of occasions undertook walkabouts around the town centre during 2024 to speak to local businesses about any problems, and to provide advice on how to report any problems. Officers have also updated businesses on the actions being taken by Community Safety and provided them with posters with

			names/photos of perpetrators who have been issued with CPWs/CPNs so that any breaches of these can be reported. Cleveland Police undertook 3 dispersal orders around the town centre in 2024. Should MGSC security pursue Community Safety Accreditation with Cleveland Police then this issue could be discussed.
	Actively pursue additional funding opportunities	PCC, HBC Explore options for increased / continued access to: - UK Shared prosperity Funding (UKSPF) (including the ongoing provision of additional Warden Patrols). CURV funding	**04/03/2025 – Sylvia Pinkney (AD Regulatory Services)** Meetings have been held Police to discuss initiatives and joint working Further meetings are planed
	Expand the use of Community Safety Accreditation Scheme powers.	PCC Expand the delegation of Community Safety Accreditation Scheme powers to Middleton Grange Shopping Centre	**04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Should MGSC wish to pursue Community Safety Accreditation they should contact Cleveland Polices Licensing Support Unit for advice and guidance on the Accreditation process.
	Use of Licensing Powers	Police Review Licensing powers available.	

		Police Licensing teams to better control the sale of alcohol to intoxicated individuals.	
	CCTV in Hartlepool	HBC Improve communication and awareness of CCTV in Hartlepool and how it is monitored	**04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** The Council is currently undertaking a refurbishment of town centre CCTV cameras. Once this has been completed by end March 2025 publicity will occur regarding the CCTV service.
	Other Comments		**28/02/2025** - **Cleveland Police update** **Operation Artemis – January 2025:** Officers in Hartlepool carried out activity with Hartlepool Council Community Wardens to tackle antisocial behaviour, aggressive begging and alcohol related violence. They also engaged with local shop staff around the threat of violence to shopworkers. Two people were found to have drugs and dealt with, three antisocial behaviour orders were issued and a shop was reported to Trading Standards. Further activity continued into the evening, with checks on and around licensed premises. Sixty people were stop searched by officers, with seven of those dealt with for possession of drugs. Two were arrested on suspicion of possession with intent to supply drugs and one person arrested for an outstanding stalking offence.

			A drugs dog was taken around licensed premises, which led to a large quantity of drugs discarded which was then recovered by officers.
Domestic Violence and Abuse*	Local delivery of the Domestic Abuse Local Strategic Partnership action plan 2022-2025	SHP members and partner organisations Local Domestic Abuse Partnership Board / All	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** Needs assessment, strategy and action plan are in place with oversight provided by the statutory Domestic Abuse Local Strategic Partnership. Needs assessment completed 2021 and currently being refreshed. Strategy was published 2022 and will be updated 2025. Action plans completed for years 1 and 2 and year 3 is in progress. **28/02/2025 – Cleveland Police update** Domestic Abuse policy and appropriate strategies are in place, with a strategic governance framework. Referral mechanisms pertaining to the sharing of information with key services are well implemented.
	Workforce are equipped to ask the right questions and to support victims of Domestic Abuse	Strategic MARAC Group / Local Domestic Abuse Partnership Board	Training/ promotion of Domestic Abuse campaigns; Ask for Angela, 16 Days of Action/…. **27/06/24 – Olivia Highley, Domestic Abuse Coordinator** The council has adopted and are implementing the Safe & Together model and an implementation plan is being rolled out initially targeting children's safeguarding teams and Multi-Agency partners. Training is available via HSSCP, TSAB and the council's workforce development team as well as through our

			commissioned service provider, Harbour. In addition training is being developed via Strategic MARAC. **02/03/24 – Olivia Highley, Domestic Abuse Coordinator** The implementation of Safe and Together is going well, with a further two, 4 day Core training sessions delivered to children's social care, health colleagues and Harbour. MARAC training is available via TSAB website which has been developed by Strategic MARAC. Training is available via HSSCP, TSAB and the council's workforce development team as well as through our commissioned service provider, Harbour. **28/02/2025 – Cleveland Police update** Incident reporting mechanisms are in place to ensure appropriate risk grading for domestic abuse and victim needs assessments – connecting with MARAC and additional support services.
	Ensure that the needs of victims / survivors with multiple and complex issues are given due consideration	All / HBC Domestic Abuse Coordinator / Corporate Communication Teams	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** TSAB refreshed the Team Around the Individual process which is now High Risk Adult Panel. Harbour have a dedicated assertive outreach worker for victims with complex needs. A second refuge has been opened specifically for complex needs victims and survivors. **02/03/24 – Olivia Highley, Domestic Abuse Coordinator**

			A perpetrator strategy has been developed and is currently out for consultation via OPCC
	Domestic Abuse in all its forms is recognised by the workforce and in the community	HBC Domestic Abuse Coordinator / Harbour	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** A robust communications strategy is in place educating the public as well as professionals on domestic abuse, appropriate response and how to access help and support. The council's website has been updated to reflect our offer of support services.
	Victims/survivors (adults and children) are true partners in the review and development of services	SHP members and partner organisations	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** The board has survivor representation, the needs assessment was completed and is being refreshed with support from victims and survivors. Harbour's service user panel contributes to any policies, procedures and plans to ensure we are led by lived experience.
	Learning from Domestic Homicide Reviews is disseminated, resulting in improved service delivery across the whole system	SHP members and partner organisations	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** DHR – the SHP is responsible for commissioning DHRs where a death is a result of domestic abuse. The SHP will manage any recommendations and action plans with support from the Domestic Abuse Local Strategic Partnership Board
	Other Comments		**28/02/25 – Abigail Reay (Public Health)**

			DAPO pilot to begin with START D&A service this is a one year funded pilot providing dedicated staffing resource to the pilot **28/02/2025 - Cleveland Police update** DAPO: Cleveland police are one of three forces to pilot the introduction of Domestic Abuse Prevention Orders. This goes live on 05/03/2025. DAPO is a joint policy shared between the Home Office and Ministry of Justice. The aim of the DAPO is to bring together the strongest elements of the existing protective order regime into a single comprehensive, flexible order to afford longer-term protection for victims of all domestic abuse. The DAPO will be the first order available in all court jurisdictions (criminal, family and civil) providing victims with a choice to identify the most appropriate route for them. This emphasises the importance of victims having greater choice of how to apply and allows third parties the option to apply on behalf of victims.
Drug and Alcohol Misuse	Work in partnership with the Combatting Drugs Partnership (CDP) to reduce drug supply	SHP members and partner organisations	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** Hartlepool public health are represented at the combatting drugs partnership, as well as chairing CDP subgroup 2 regarding treatment and recovery. Community D+A services (Start) are also in attendance. **28/02/25 – Abigail Reay, Public Health** The above still stands – no updates

	Local delivery of the Drug & Alcohol Strategy action plan	START and Criminal Justice Partners	**27/06/24 – Olivia Highley, Domestic Abuse Coordinator** Drug and alcohol strategy plan continues to be delivered with quarterly update meetings with partners we need to present this joint at Safer Hartlepool Partnership **28/02/25 – Abigail Reay, Public Health** Update meetings currently on hold whilst reviewed partnership. Meetings to be reinstated in the coming weeks. The D+A strategy plan continues to be worked on. **28/02/2025 – Cleveland Police update** Cleveland Police restructuring has seen the creation of a 'Prevention Command', with a dedicated team driving the use of Out of Court Disposals, diversionary schemes and early intervention.
	Review the current criminal justice pathways into substance misuse services to ensure efficacy of treatment and support	Police Trading Standards Community Safety	**28/06/24 – Abigail Reay, Public Health/START** Hartlepool's continuity of care continues to be significantly higher than the national average, suggesting continuation of robust pathways between the prisons and community drug and alcohol services. Work on going to ensure that those who are taken into custody are also given opportunities to speak to substance use professionals, including onward referrals to community services. Those that are on community orders are also referred into our dedicated CJIT Team.

			28/02/25 – Abigail Reay, Public Health There has been a dip in CoC stats across the region. Start have prioritised this work to increase CoC numbers and ensure timely and effective treatment to our prison leavers. Start are currently working closely with regional prisons. We can see from our local data, that our CoC stats have started to increase, showing progress with regard to the work Start have been doing. Aswell as being a pilot site for ISC Start are also working with Cleveland Police to look at Out of Court Disposal's this will allow an even wider reach to individuals coming through the CJ pathways to support and divert away of crime and D+A use.
	Work in partnership to disrupt the supply of illegal drugs	Police Trading Standards Community Safety	Supply chain disruption work carried out including. Premises visits, raids & premise closures orders **28/02/2025 – Cleveland Police update** Cleveland Police, along with key partners, continue to disrupt the manufacture and supply of controlled drugs. This includes effective intelligence gathering and making best use of search warrants and planned operations to target suspicious properties, seize drugs and arrest suspects. Hartlepool Neighbourhood Teams have recovered in excess of 12 million pounds worth of drugs over the last 24 months.

	Raise awareness of the harms associated with drug and alcohol misuse amongst school and college students	Neighbourhood Police Team (PC Coggin)	Presentations and targeted interventions delivered in schools and colleges across Hartlepool on key themes including County Lines and anti-social behaviour and drink spiking **28/06/24 – Abigail Reay, Public Health/START** Start CYP Team have been approaching secondary schools to expand their treatment offer, as well as offering awareness sessions. CYP team also involved in an enrichment pilot lead by YouthFocusNE within High Tunstall and English Martyrs which will include substance use drop ins. CYP Team attend colleges frequently on their market place days and events such as Freshers. **28/02/25 – Abigail Reay, Public Health** The above is complete. Start CYP team are now working into all secondary and youth clubs across the town. A priority for Start CYP team for 2025 is to increase numbers into treatment for under 18s. Start continue to provide prevention and resilience work across the town. **28/02/2025 – Cleveland Police update** School liaison and engagement continuous with presentations and events raising awareness of many high-risk areas; including drugs, use of weapons, violence against women and girls.
	Other Comments		**28/02/2025 – Cleveland Police update**

			Refresh of Naloxone training for Hartlepool police intended during 2025.
Serious Violence*	Analysis of existing and emerging hotspots of serious violence is shared and a Multi-Agency response is planned.	Cleveland Unit for the Reduction of Violence (CURV)	Partners providing data for need assessment. Partners providing data for deep dive. **27/06/24 – Rachel Readman (Trading Standards and Licensing Manager)** Three Bleed Cabinets have been installed in the NTE area. Installation took place on Wednesday 19th June. The fourth cabinet has been purchased and will be installed as soon as the pole mounting kit has arrived. **03/03/25 – Rachel Readman (Trading Standards and Licensing Manager)** **Bleed Control Cabinets** Four Bleed Cabinets have been installed in and around the Night Time Economy area. **Bleed Control Kit Cabinet Locations** 1. **Bleed Cabinet 1** Hartlepool Community Central Hub 124 York Road, Hartlepool, TS26 9DE On front wall of building, left of entrance, next to existing Defibrillator cabinet Three What Words /// loser.report.dock

			1. **Bleed Cabinet 2** Hartlepool Borough Council Civic Centre building, Victoria Road, Hartlepool, TS24 8AY At front of building, at top of steps on front entrance concourse, next to existing Defibrillator cabinet Three What Words /// handle.boot.twigs 2. **Bleed Cabinet 3** Tranquillity House (Orange Box building) Harbour View, Hartlepool, TS24 0UX Front wall of building, left of entrance, next to existing Defibrillator cabinet Three What Words /// hype.occurs.nobody 3. **Bleed Cabinet 4** Hartlepool Railway Station Station Approach, Hartlepool, TS24 7ED On Council owned public space CCTV camera column, opposite front entrance of Hartlepool Railway Station, and opposite existing Defibrillator cabinet Three What Words /// beats.vines.filer **28/02/2025 – Cleveland Police update** We have a dedicated Licencing Officer for Hartlepool within the Police who is working with the HBC officer(s). Plans are in

			place to fund further high visibility operations throughout the year tackling NTE violence and taxi licencing. We will continue to work in partnership to tackle problem premises and offenders.
	Local delivery of the CURV Response Strategy  CURV Response Strategy-Final.pdf	Cleveland Unit for the Reduction of Violence (CURV)	27/06/24 - **Rachel Readman (Trading Standards and Licensing Manager)** Premises have been chosen from the NTE area. Launch event taking place on 8th July when the radios will be distributed. Launch event will be attended by Cleveland Police, CURV, HBC Licensing, Licensing Committee representative and SHP Representative. 03/03/25 - **Rachel Readman (Trading Standards and Licensing Manager** With support from the UKSPF funding the 25 pub watch radios are going to be funded for a further year (free to the NTE premises until July 2026). The UKSPF funding has also provided us with the opportunity to hire a further ten radios bringing the NTE Pub watch network up to 35 premises. So far 38 NTE premises have taken advantage of one years free membership to Schemelink, to assist with their Pub watch. SCHEMELINK is more than just a tool - it's the backbone of hundreds of watch schemes across the UK, from Pub watch to Shopwatch and beyond. With features designed to keep members connected, informed, and secure, SCHEMELINK

			brings cutting-edge technology to the front lines of community safety and crime prevention. Via UKSPF funding free membership has been offered for the LASAI scheme to NTE premises within the eligible area. So far one premises has completed the process and been awarded five stars. Licensing Security & Vulnerability initiative has been launched to keep licensed premises safer for staff and customers. Licensing SAVI brings together all the information a premises need to meet the requirements of police and council licensing teams to promote the four Licensing Objectives. **04/03/24 – Brian Hughff, Integrated Offender Management (IOM) Team** Cleveland IOM is a partnership approach to tacking the most prolific offenders committing 'Neighbourhood Crime' offences (Robbery, Burglary and other serious acquisitive crime). The key stakeholders are The Probation Service and Cleveland Police, who work with partners to collectively address the criminogenic needs of the cohorts. With substance misuse being a key driver behind the offending of this cohort the team work closely with START, who attend monthly meetings to discuss IOM cases who are causing the most concern, re-offending or harm. IOM prioritise selection of violent offenders who have committed Robbery and Aggravated Burglary offences as part of their index offence.

			There are currently 17 offenders actively managed by the IOM Team. Over the last year the desistence rate for Hartlepool offenders has been positive (above 81.5% for the 'fixed' cohort) and there have been real sustainable outcomes for people at the end IOM management. Work is ongoing to expand IOM to include a cohort of other offenders who wouldn't usually be 'in scope', but who would benefit from the IOM approach which will see the number offenders being managed increase.
	Assist in the delivery of the CURV nighttime economy action plan.	SHP members and partner organisations	**27/06/24 - Rachel Readman (Trading Standards and Licensing Manager)** Responsible Authorities group has been established. The group has been well received and has met regularly since its incorporation. The group is chaired by HBC Licensing Manager. **03/03/25 - Rachel Readman (Trading Standards and Licensing Manager)** Responsible Authorities group continues to meet to discuss new Premises Licence Applications. Multi Agency group made up of all responsible authorities as defined by the Licensing Act 2003. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** A fourth Bleed Control Cabinet has been installed in the town centre. Locations are: (1) Central Community Hub, York Road; (2)

			Civic Centre, Victoria Road; (3) Hartlepool Railway Station; (4) Orangebox, Navigation Point. **04/03/25 – Anna Waddington, Police** All four bleed cabinets have now been installed and CURV are working to add these to NEAS's CAD system so they can be accessed through a 999 call. Licensed premises and other NTE stakeholders have been trained in the use of the cabinet equipment. Has been agreed bleed cabinets will be installed at a number of police and fire stations. 25 APEX radios have been distributed to licensed premises to support communication between venues, CCTV and police. Ask for Angela training for licensed premises is planned for this month. Hartlepool Town Pastors given funding for additional resources. Drug dog operation carried out in licensed premises. This was 'piloted' with CURV funding to be taken forward by the force in future.
	Raise awareness of the risks and potential consequences of serious violence	Neighbourhood Police Team - Supt. Martin Hopps / PC Geoff Coggin	Presentations and targeted interventions delivered in schools and colleges across Hartlepool on key themes including knife crime, personal safety and "Ask for Angela" initiative.

	amongst school and college students		
	Provide a more visible police presence to prevent and deter serious violence in identified hotspot areas and the night-time economy	Police - Supt. Martin Hopps / Ch. Inspector Pete Littlewood	Dedicated patrols in hotspot (GRIP) areas / positive action / reduction in offences and victims **27/06/24 - Rachel Readman (Trading Standards and Licensing Manager)** Hartlepool Town Pastors meeting are hosted by HBC. The meetings are attended by Licensing, Cleveland Police and CCTV. 03/03/25 - **Rachel Readman (Trading Standards and Licensing Manager)** Close working alongside the Hartlepool Town Pastors continues. **28/06/24 – Nicholas Stone, Community Safety Team Leader** Installation of 2 mobile CCTV cameras in the NTE area. **28/02/2025 – Cleveland Police update** During the year there have been multiple operations running which have tackled the reduction in Serious Violence within the LPA. Op Deterrence patrols have targeted areas highlighted from data for High Visibility Policing at key times which have been identified.

			Operation Tranquillity is an ongoing force order for Night Time Economy Policing with a commitment to increasing staffing numbers on key identified dates that violence can increase. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Pub Watch (Apex) radios have been distributed to Licenced Premises through the Hartlepool Licensee Association members. These radios are monitored by Hartlepool's CCTV Control Room.
	Other Comments		**28/02/2025 – Cleveland Police update** Officers in Hartlepool carried out activity with Hartlepool Council Community Wardens to tackle antisocial behaviour, aggressive begging and alcohol related violence. They also engaged with local shop staff around the threat of violence to shopworkers. Two people were found to have drugs and dealt with, three antisocial behaviour orders were issued, and a shop was reported to Trading Standards. Further activity continued into the evening, with checks on and around licensed premises. Sixty people were stop searched by officers, with seven of those dealt with for possession of drugs. Two were arrested on suspicion of possession with intent to supply drugs and one person arrested for an outstanding stalking offence.

			Within Op Artemis Pc Coggin attended the College of Further education and delivered sessions on One Punch, Spiking and Violence Against Women and Girls.
Re-offending	The Ministry of Justice (MOJ) 'Proven adult offending rate' for Hartlepool offenders is reduced.	Probation / Integrated Offender Management	
	Implement the Youth Justice Service Strategic Plan	YJS Management Board Chair (Jo Heaney) / HBC YJS Manager (Roni Checksfield	**28/02/2025 – Cleveland Police update** Cleveland Police continue to utilise Juvenile out of court disposal methods with projects such as the Triage scheme. These are referred to and then managed by the Youth Offending Team who work with partners to educate and divert children from re offending. This has been particularly well received in respect of youths involved in the Murray Street disorder. As described above there is a force wide focus led by the Prevention command to increase the use of Out of Court Disposals and Education to prevent re-offending and build safer communities. **03/03/25 – Phil Gleaves (Youth Offending Operational Lead)** The strategic plan has been to full council and been approved.

Prevent	Susceptible individuals are safeguarded from being radicalised by individuals and/or groups promoting extremist ideologies online or in the community	Community Safety / Police	Training: Key partners briefed on the Counter Terrorism Local Profile Local Prevent Risk Assessment is in place **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Ongoing assessment to ensure compliance with Prevent duty – including developing venue booking policy, Mandatory staff training and providing Prevent awareness for commissioned services. Developing an ongoing local operational group to ensure delivery of the wider Cleveland Action Plan
	Workforce and Community awareness of Prevent and the risks of radicalisation is increased	Community Safety / Police / Corporate Communication Team	**28/02/2025 – Cleveland Police update** Cleveland Police have Prevent officers as part of the Counter Terrorism Unit which is managed in the Northern Area by West Yorkshire Police. Referrals are submitted via the intelligence submission process. Within the LPA Tasking and Co-ordinating Group meeting the current trends concerns are discussed as an overview with then further discussion in relation to specific identified individuals.
	Victims of hate crime have increased confidence in reporting and accessing support services	Community Safety / VCAS / Third Party Reporting Centres	Develop a Prevent Communications Plan **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager**

			Hartlepool Community Safety Team operate a network of 10 Third Party Hate Crime Reporting Centres around Hartlepool. These centres are located in public and voluntary sector buildings. Centres are advertised through signage on buildings and with contact information published on the Council and OPCC websites. The Council will also be participating in the Hate Crime Awareness Week 11-18th October 2025.
Acquisitive Crime	Reduction in residential burglary offences	Police / Crime Prevention/Community Safety	Proactive patrols in key areas/ prioritise activity to locate and arrest outstanding suspects / crime prevention and target hardening measures to prevent repeat victimisation. **28/02/2025 – Cleveland Police update** This is an area monitored by the Tasking and Co-Ordinating Group with discussion around Crime trends and locations. This will then direct increased ward patrols by Neighbourhood Policing and Response Teams with Local CID tackling offenders. The Local Policing Framework has a force mission of Tackling Criminals and to this end we now have a Pro-active team in the Hartlepool Local Policing Area to support the arrest of people who are wanted. Within the LPA present figures show a 9.7% reduction in Residential Burglaries in the last 12 months. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager**

			The Safer Streets Project has handed out 287 anti-burglary packs to at risk residents in the Victoria Ward. Hartlepool Community Safety Team also operate a target hardening service for victims of crime.
	Reduction in shoplifting offences	Police / PCSOs / Community Safety	Proactive patrols in key areas / prioritise activity to locate and arrest outstanding suspects / pursue robust enforcement for repeat offenders. **28/02/2025 – Cleveland Police update** A bespoke problem-solving plan has been commissioned, aimed at reducing retail crime in key locations/business within Hartlepool. This will include focus on both Theft of goods and violence towards employees and involve many stakeholders within the Community Safety Partnership. **03/03/2025 - Rachel Readman (Trading Standards and Licensing Manager)** Through UKSPF funding over 55 Apex radios have been provided to Hartlepool Town Centre shops. The premiss have received a radio with a two years free subscription in place. The radios will be used to help ensure effective communication between shops and the sharing of information/intelligence. The radio will also be connected to several services that operate in

			the daytime economy that can provide help and support, including the Councils CCTV team and Cleveland Police.
Protect	Workforce and Community awareness of Protect duty and the risks of terrorist threats.	SHP members and partner organisations	Requirement for staff to undertake ACT Awareness eLearning and SCaN for All training package Recommended that all staff with a work Mobile phone to download the free ProtectUK App **27/06/24 - Rachel Readman (Trading Standards and Licensing Manager)** Protect training is now incorporated into the mandatory training section of the 2024/25 Workforce Development Programme for all HBC members of staff. **03/03/2025 - Rachel Readman (Trading Standards and Licensing Manager)** Updates regarding Protect are provided at all meetings with stakeholders; for example, Hartlepool Licensee Association and HUFC Safety Advisory Group. An HBC Safety Advisory Group Protect letter is now integrated within our SAG process and is provided to all internal and external event organisers to ensure that Protect measures are incorporated into the event planning. **28/02/2025 – Cleveland Police update**

			ACT package is part of our e-learning Mandatory packages and compliance has been monitored. **04/03/25 – Nicholas Stone, Community Safety Team Leader and Philip Hepburn, Community Safety Manager** Prevent training is now incorporated into the mandatory training section of the 2024/25 Workforce Development Programme for all HBC members of staff.

AUDIT AND GOVERNANCE COMMITTEE

1 April 2025

Report of: Scrutiny and Legal Support Officer

Subject: SCRUTINY INVESTIGATION - RECOMMENDATION UPDATE

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1. PURPOSE OF REPORT

1.1 To provide Members with the progress made on the delivery of the agreed scrutiny recommendations of the Audit and Governance Committee.

2. BACKGROUND INFORMATION

2.1 In accordance with the agreed procedure, this report provides Members of the Committee with details of progress made against investigations undertaken.

(i) The progress made in relation to the Child and Family Poverty investigation is attached at **Appendix A.** This provides an overview of the recommendations, and a detailed explanation of the progress made against each outstanding scrutiny recommendation agreed by the Committee.

(ii) The progress made in relation to the Accessibility of Council Services in Hartlepool investigation is attached at **Appendix B.** This provides an overview of the recommendations, and a detailed explanation of the progress made against each outstanding scrutiny recommendation agreed by the Committee.

3. RECOMMENDATIONS

3.1 That Members:-

(a) Note the progress against the agreed recommendations of the Audit and Governance, and explore further where appropriate; and

(b) Retain **Appendix A** and **Appendix B** for future reference.

Contact Officer:- **Gemma Jones** – Scrutiny & Legal Support Officer
Legal Governance and HR
Hartlepool Borough Council
Tel: 01429 284171
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Child and Family Poverty

+ please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations
* please note that for monitoring purposes a date is required rather than using phrases such as 'on-going'

RECOMMENDATION	RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
1) Exceptional services are provided in Hartlepool to mitigate the effects of poverty and these are the predominant focus of Hartlepool Council poverty activities. However, going forward, strategies and services need to move towards a more hands up/prevention/route out of poverty focused model lead to deliver more impactful change. As is being planned by the Trussell Trust Foodbank and The Joseph Rowntree Foundation.	Welfare Support has been adjusted to move from a 'hand outs' to 'hands up' model of help. The Head of Service responsible for hardship is part of the Trussell Trust working group leading on implementing their strategic change plan. Work has begun to develop a local 'anti-poverty' strategic group tasked with grounding any strategic actions based on lived experience and the need to support change.		PT PT DS/PT/ and others internal to HBC and external VCSE	**Complete** **Five year plan – to 2027** **Complete**
2) The voluntary Socio Economic Duty be potentially adopted with the assistance of a working group that will look into: - What is required to facilitate	Establish task group based on recommendation. Research other councils/ anchor organisations who have successfully implemented the		PT PT	**September 2023** **Complete**

the formal adopt the Socio Economic Duty; - What would be the benefits of its adoption; - How might it reduce poverty; and - What all of the above mean in practical and financial terms for the Council.	duty			
3) The establishment of a Hartlepool Poverty Truth Commission be progressed with the assistance from Thrive Teesside and the Poverty Truth Network. The purpose being to incorporate lived experience of socio economic disadvantage at all levels of decision making and policy development.	Meet with Poverty Truth Network to establish what is required to establish a PTC Work with Voices of Hartlepool, a small resident voice group that aims to become a PTC Identify further residents that want to be actively part of a PTC Engage with Thrive Teesside, local experts in PTC work		DS/ PT – local anti-poverty strategic group PT DS/ PT – local anti-poverty strategic group DS/ PT – local anti-poverty strategic group	**Complete** **Complete** **Complete** **In progress**
4) As and when the outcomes of ongoing national work in relation to best practice and service improvement becomes available, a further refresh of the new Child and Family Poverty Strategy be undertaken.	Based on PTC work, adoption of SED, engagement of internal HBC colleagues, external key anchor organisations and VCSE, establish the framework for an anti-poverty strategy using local proven successful action and learning from other areas that have tried something different		DS/ PT – local anti-poverty strategic group	**In progress**
5) The implementation of the recommendations contained within the report to be	As outlined in all points above		PT	6 monthly check-ins

	monitored by the Audit and Governance Committee. Alongside an update on the poverty position in Hartlepool.				
6)	National targets have been removed for the reduction of poverty, however, national indicators have been created. It would be beneficial to set a series of Hartlepool specific indicators, against which outcomes (including the activities of the Poverty Truth Commission and adoption of the Socio Economic Duty) can be measured.	Collate a local data set that indicates need – based on e.g. Free School Meals (financial), Local Council Tax Support, access to Foodbanks, take up on advice and debt services		PT and Hartlepool Financial Inclusion Partnership	**In progress**
7)	Ward based poverty data to be sent to Cllrs on an annual basis.	This would be based on national datasets (households below average income) together with FSM and LCTS data		PT	**Annually**
8)	In terms of Schools, a poverty update is to be provided at a Head Teachers Briefing, as part of which schools: - Will be reminded of the value of the 'Poverty Proofing' exercise offered by Children North East; - Be encouraged to seek guidance and advice from external source where available, such as the SHINE	PT to provide a briefing at Director's Headteachers briefing outlining Poverty Proofing the School Day opportunities and continuing discussions around the impact of the cost of school uniform to households		PT	**Complete**

Trust; and - Asked to promote the second hand uniforms scheme (Hartlepool Preloved Clothing) as a means of reducing costs for parents.				
9) In terms of decision making: - Impact assessments are a part of the 'key' decision making process and development of strategies and Child and Family Poverty Impact Assessment and Equability and Diversity Impact Assessments are to be amalgamated to simplify the process; and - Where the process for monitoring the implementation of decisions identifies a potential 'new' or 'increased' poverty impact, the Impact Assessment should be revisited to gain a full understanding of the position and any action that may be required.	Task group to be established to begin to address impact assessments, to merge them together and to establish processed to track impact		Catherine Grimwood	**In progress**
10) In terms of debt collection: - The impact of debt collection on those experiencing poverty needs to be	Task group to be established to determine how the council takes action on households for e.g. non-payment of council tax, the administration and court charges		James Magog, Penny Thompson	**In progress**

evaluated with a view to supporting the provision of focused assistance and support; and - Where debt is poverty related, options for changes to procedures for debt collection be explored in terms of the provision of additional support / assistance.	attached to this and the impact of attachment of earnings on households			
11) In terms of advice and support: - Citizens Advice and other debt counselling services to be promoted to local groups and the VCS; and - Awareness rolled out to partners/voluntary sectors on initiatives such as Baby Bank/Sensory spot.	Communications strategy will be part of the anti-poverty strategy namely – Who offers what help, how and where with a variety of options of how to access the information from traditional methods (print) to digital methods (websites and social media)		DS/ PT – local anti-poverty strategic group	Complete
12) The Council to seek from the Joseph Rowntree Foundation (JRF) an ongoing strategic commitment to work with Hartlepool Borough Council on Hartlepool's poverty issues.	MD has sent a letter to the new Chief Exec and senior leaders in JRF This is to be followed up by the strategic poverty group Ongoing meetings locally with JRF staff working on the ground		DM PT/DS PT	Commitment secured no later than December 2023 **In progress**

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Accessibility of Council Services in Hartlepool for Those with Disabilities and Long-Term Conditions

+ please detail any risk implications, financial / legal / equality & diversity / staff / asset management considerations
* please note that for monitoring purposes a date is required rather than using phrases such as 'on-going'

RECOMMENDATION	RESPONSE/PROPOSED ACTION	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
1) Exploration of some adjustments would require more significant investment and be longer term actions. Other short / medium term actions would be to:- i) Develop a communications campaign to: - Highlight the various support schemes and reasonable adjustments that are already have in place; - Promote 'One-Stop-Shop' touch points such as the Civic Centre reception and Community Hubs where people can get assistance with everything in one place.	i) Communications Plan to be developed with campaign work to begin from August 2023		i) To iv) Connor Kerr / Bev Bearne	i) *December 2024** **April 25 update – to be launched in **2025**. A brand refresh will improve branding accessibility, better use of colours, easier to read fonts etc.*

Making those who find accessing the Civic Centre aware that the same service can be accessed elsewhere; and - Promote the role of Community Hubs and Community Navigators to increase the understanding of the services they offer.				
ii) Ensure that community buildings and touch points have posters and leaflets on display for a range of disability support groups and charities.	ii) Communications Team to facilitate the distribution of posters and leaflets to community buildings			ii) December 2024* – *see above*
iii) Circulate basic guidance to staff on font size and type, use of plain English, how to book an interpreter when one is required and put this information in an easy to find location on the intranet.	iii) Guides to creating accessible content and booking interpreters are already available on the Equality and Diversity tile on the intranet for staff			iii)**Complete**
iv) Create an “accessibility” tile on the intranet homepage so it is easy to find and collate a range of useful accessibility information for staff to be able to find quickly	iv) An Equality Diversity tile is in place on the intranet homepage and links to a range of information including the above			iv) **Complete**

and easily when a disabled person makes contact.				
2) Equality of access to services for all is a fundamental right and residents with disabilities and long term conditions should not be restricted in terms of the times they can access services or the levels of privacy they can expect. To this end:-				
i) A Text Relay Service should be introduced;	i) The Text Relay service: - Is now in use via customer services for all Adult Social Care Team including Adult Safeguarding / ISPA with access to the Relay UK app. - Has been introduced in the Support Hub.		i)Laura Griffiths / Julie Howard / Leigh Keeble	i)**Complete**
ii) Given the financial restrictions faced by the local authority, the feasibility and benefits, of creation of a pod facility in the Civic Centre be explored to allow residents and officers to use online signing / translation services;	ii) There would be a cost implication to this. Civic Centre - Meeting rooms within the Civic Centre reception area can be utilised as pod facilities – wider issue is access to translation services at point of contact but this is addressed further in the plan.		ii)Laura Griffiths / Julie Howard / Leigh Keeble	ii)**Complete** .

	Community Hubs - There is a pod that that could be used in the community hubs for 1:1 and a laptop or tablet could be provided to support video interpretation. This would, however, need to be booked and a pilot of block booking a few hours a week can be trialled.			
iii) The creation of a network of BSL trained staff, to act as first point of contact for volunteers, be explored;	iii) Staff volunteers would be a first point of contact with any complex communication via qualified translators. There would be a resource implication in setting this up. Currently exploring training provision with the Council's Organisational Development team who are in contact with RNIB and RNID – it is recommended that this be mandatory training for all frontline staff. There is also the potential opportunity to offer BSL training to employees through the Workforce Development Programme and is currently being reviewed.	iii)Financial implication to be calculated before final decision on the implementation of the recommendation	iii)Gemma Ptak/ Leigh Keeble Laura Griffiths / Julie Howard	iii) 31 December 2023 - **Undeliverable** *Deaf Awareness training that can be accessed by all staff has been added to the Workforce Development Programme from 2024-25.*

	In terms of the Community Hubs staff some level of training would be useful but this would need to be used regularly to be effective.			
iv) Existing TV screens in the Civic Centre reception be used to promote accessibility services and the assistance that is available; and	iv) Easy to do with no additional resources (other than loading information. A sign language video could be produced that could be accessible via a range of mediums including web-site and Hartlepool Now. Once a clear service offer is known this can be promoted via a wide range of mediums.	Financial implication to be calculated before final decision on the implementation of the recommendation	iv)Laura Griffiths / Julie Howard	iv)31 March 2024 **Undeliverable** *Due to location of screens this is not deemed to be suitable.*
v) The Loop system currently used in council buildings be reviewed to ensure that it is still compatible with modern hearing aids.	v) Indications as part of the investigation were that new hearing aids aren't compatible with the existing system. This action has be allocated to the Building Maintenance team for review. Specialist company have been contacted and are to visit the Civic Centre to undertake compatibility tests.	Financial implication to be calculated before final decision on the implementation of the recommendation	v)Laura Griffiths / Julie Howard	v)31 March 2024 **Complete** *– A company has been out to assess Civic Centre. Stated all compatible.*
3) Provide access to a video / telephone translation service	- This was specifically requested by the BSL community so I think that this should be referenced	Financial implication to be calculated before	Laura Griffiths / Julie Howard	31 December 2023* (subject to finances)

(for BSL and other languages) in the Civic Centre, and a private room for the discussion of confidential issues. This facility to be promoted (e.g. via signs on glass partitions in a similar way to how pharmacies tell customers they can use a private consultation room).	and linked to a facility to request a BSL interpreter at the same time – the private room is no use without the Translation service. - The provision of a room in the Civic is possible and a standard laptop could be used to provide a video translation service (no other equipment needed and 'Big Word' system is already used for translations). This could also be provided in the central hub. Rooms are in fact already available on request for all residents but this was something that Deaf users really wanted The question being – why are deaf residents not aware of this – do we publicise it and are staff encouraged to use it) The introduction of a process to ensure that they are taken to a separate room for private signed / translated discussions would be achievable with a refresh of accessibility awareness training - Request for translation services and use of the text service is low (historic use of the video translation service had also been low) but it is unclear if this is	final decision on the implementation of the recommendation		**April 25 update – Sign video will be officially launched with the website refresh in **2025**.*

	because of a failure to engage or that individuals fell that their views aren't heard. - We do not have a person qualified to provide translation services. Having trained staff to be a first point of contact (basic translation / signposting services) would be useful but would have cost implications and demand is unclear. A suggested option, albeit with a financial implication being: • A refresh of awareness training • Staff with basic translation services and knowledge of how to access other systems • A pilot scheme for the provision of a trained individual to be located in the Central Hub and / or Civic (drop in sessions half a day a week), demand and success of which could be monitored. This to be publicised as an option to access translators and other options provided (such as text service or video translation, etc.) • Introduction of sign video service to be scoped / considered although usage of			

	previous solutions has been historically moderate.			
4) A review of workforce training be undertaken to explore how disability awareness and an understanding of reasonable adjustments, could be increased, within available resources. As part of this:- i) Accessibility and diversity awareness training to be rolled out as mandatory training for all HBC staff and offered as an option for Councillors as part of the induction process; and ii) Options for training be explored including the use of online packages to allow ease of access and roll out across departments, without the need for an external trainer.	There may be some courses on Skillsgate that staff can access however we don't have enough licences for all staff so there would need to be a managed process to this. Aug update - Deaf Awareness training that can be accessed by all staff has been added to the Workforce Development Programme from 2024-25. Feb 2024 update – money has been allocated to Adult learning train to 100 front line staff in 'communication tactics'. Neil Harrison to identify staff to inc. customer services etc.		Hayley Martin / Gillian Laight / Rachel Clark	**Complete**
5) The newly established Equality, Diversity and Inclusion Officer Group to be used as a mechanism to share best practice, monitor performance and identify service improvements.	A new Equality, Diversity and Inclusion Officer Group was established at the beginning of the year and this falls under their remit.		Catherine Grimwood / Bev Bearne	**Complete**
6) Improvements to the HBC website be explored to ensure that it is EDI compliant going			Connor Kerr / Bev Bearne	March 2024*

forward, including but not be limited to:- i) Read options for documents, to allow access by blind or visually impaired residents; ii) Captions / signing on social media posts / videos; and iii) When time-critical videos are posted on social media, and there is not time to set up closed captions, the video should include a text card to say that subtitles will be added. For videos which are not time-critical subtitles should be added before they are uploaded.	i) Current website to be replaced and this recommendations will be covered in the specification for the new site ii) and iii) will be completed as recommended			**April 25 update – the launch of the website refresh is scheduled for **2025** which will meet accessibility requirements* December 2023*
7) Council reports, documents and forms must be accessible (easy read / screen reader friendly) and going forward clear content guidance should to be provided, and its use promoted, including:- i) Where appropriate, instructions for the inclusion of links to allow the use of screen readers; and ii) Promotion of use of a document accessibility checker.	i) The brand guidelines refresh will include reference to accessible content. ii) MS Word has an in-built document accessibility checker.		Connor Kerr / Bev Bearne	i) March 2024* **April 25 update – to coincide with website*

	Instructions on how to use it are on the intranet on the Equality and Diversity tile			*refresh launch in **2025**.*
8) A consultation to be undertaken with partners (attendees to be confirmed) on the potential benefits, and level of support for, the creation of a needs passport / card system that could be used to ensure that officers quickly recognise and respond to any additional support needs.	Discussion in respect of developing a passport card locally with representatives from the joint Sensory Support Plan working group on 19/10/2023. Included HI-VIS UK, Hartlepool Vision Support, Hartlepool Deaf Centre. There are a number of existing schemes that can support identification of a certain condition however people should be considered as individuals in their own right. https://www.did-card.co.uk/ https://www.disabilityid.co.uk/about		Neil Harrison /John Lovatt	**Complete** Exploration of these types of cards has shown this would not be the most appropriate way of ensuring that individual needs are easily identifiable.
9) The process for creation of the Highlight on the Waterfront development is an example of good practice in terms of engagement / involvement with residents with disabilities and lifelong conditions. This good practice to be rolled out across the development of all services and strategies.	Engagement itself can be delivered but it is hard to quantify as it will be relevant to each specific service/strategy. The financial element of strategy development is dependent on the nature of consultation and the service and so difficult to quantify.	Financial implication to be calculated before final decision on the implementation of the recommendation	Directors	**Complete** While this approach has been well received, any consultation and engagement is geared towards the size and

	There is already a commitment to: - Engaging and involving people in service developments. - Developing the co-production process to involve people who have lived experience - Engaging and involving people at the earliest stages of service design and development. Recent strategy consultations have also included everything from behavioural insights work to talking to the client group so varies significantly in terms of costs			complexity of the scheme.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

2 December 2024

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor Harrison , Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Boddy, Darby and Roy
Representative of North East and North Cumbria Integrated Care Board – Katie McLeod as substitute for Karen Hawkins
Director of Public Health, Hartlepool Borough Council – Craig Blundred
Executive Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Executive Director of Adults and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representative of Healthwatch – Steve Thomas

Other Members:

Managing Director, Hartlepool Borough Council – Denise McGuckin
Representative of Tees, Esk and Wear Valley NHS Trust – Jamie Todd
Representatives of Hartlepool Voluntary and Community Sector – Carl Jorgeson
Representative of Headteachers – Sonia Black
Representative of North Tees and Hartlepool NHS Trust – Linda Hunter
Observer – Statutory Scrutiny Representative, Hartlepool Borough Council – Councillor Jorgeson

Also Present:-
Philippa Walters, Pharmacy Lead
Julie Simons, Hartlepower Community Trust
Louise George and Calvin George, Hartlepool Sport
Nicola Haggan and Amanda Britten, Alice House Hospice

Officers: Ashley Musgrave, Danielle O'Rourke, Public Health Team
Claire Robinson, Public Health Principal
Joan Stevens, Statutory Scrutiny Manager
Denise Wimpenny, Democratic Services Team

20. Apologies for Absence

Representative of Tees Esk and Wear Valley NHS Trust - Brent Kilmurray
Representative of North East and North Cumbria Integrated Care Board - – Karen Hawkins
Representatives of Healthwatch – Christopher Akers-Belcher and Margaret Wrenn
Representative of Hartlepool Voluntary and Community Sector – Christine Fewster
Representative of GP Federation – Fiona Adamson
Head Teacher Representative – Sonia Black

21. Declarations of interest by Members

None

22. Minutes of the Meeting held on 9 September 2024

Confirmed

23. Minutes of the Meeting of the Children's Strategic Partnership held on 27 September 2023

Received

24. Minutes of the Meeting of the Tees Valley Area ICP held on 9 August 2024

Received

25. Hartlepool and Stockton-On-Tees Safeguarding Children Partnership Annual Report 2023-24 (*Executive Director, Children's and Joint Commissioning Services)*

The Executive Director, Children's and Joint Commissioning Services updated the Board on the work undertaken by the Hartlepool and Stockton-On-Tees Safeguarding Children Partnership during the year 2023-24. The report summarised the key successes and achievements of the Safeguarding Children Partnership throughout 2023-24 including updates on qualitative and quantitative data, information for the reporting period and outlined the specific areas being taken forward in the coming year.

In the discussion that followed Board Members debated issues arising from the annual report. In response a query raised, clarification was provided in relation to child protection data across the two areas and the predominant reasons were also outlined. Details of consultation arrangements with young people were provided which included consultation and engagement events

and involvement activity with school councils across the secondary and primary sectors.

Decision

The contents of the HSSCP Annual Report were noted.

26. Teeswide Safeguarding Adults Board Annual Report 2023/24 (*Executive Director of Adults and Community Based Services and Independent Chair of Teeswide Safeguarding Adults Board)*

Members were referred to the Teeswide Safeguarding Adults Board (SAB) Annual Report for 2023-24 appended to the report. It was noted that it was required under the Care Act 2014 that each SAB published an annual report setting out what had been done during that year to achieve its objective and implement its strategy, the findings of any safeguarding adults reviews and what had been done to implement findings of any reviews.

Decision

The Board noted and endorsed the Teeswide Safeguarding Adults Board Annual Report 2023-24.

27. Tobacco Control Strategy (*Director of Public Health)*

Board Members were referred to the updated Tobacco Control Strategy Action Plan for Hartlepool, attached at Appendix 1, which provided an update on progress to date on actions against priorities and also updated the Board on the new Specialist Smoking Service for Hartlepool.

The Board was provided with a summary of key deliverables between April and November 2024 against the Tobacco Control Action Plan, appended to the report. The action plan set out under each theme the detail of how each priority area would be delivered, who would deliver, the timescales and outcome framework arrangements.

Board members expressed support of the strategy and debated issues arising from the report. Members welcomed the redevelopment of the stop smoking service in Hartlepool, the benefits of which were outlined. Clarification was provided in response to concerns raised regarding the increasing access and prevalence of vaping particularly in young people and the challenges around managing this issue. The Public Health Principal advised of the ongoing work and plans in place with schools in relation to changing behaviours around vaping. Representatives from the Hartlepool Community and Voluntary Sector and Hartlepool Sport commented on the benefits of sharing messages around the dangers of smoking and vaping in sports and community facilities and it was suggested that this be progressed following the meeting with a member of the public health team.

Concerns were also raised in relation to the illegal sale of tobacco products. The Managing Director referred to the successes of the Council's Environmental Health Team and ongoing work with the police in terms of tackling this issue.

Decision

The Board noted progress against the Tobacco Control Action Plan.

That messages around the dangers of smoking and vaping be shared in sports and community facilities.

28. Director of Public Health (DPH) Annual Report (*Director of Public Health*)

Elected Members were referred to the requirement for the Director of Public Health to write an Annual Report on the health status of the town, and the Local Authority duty to publish it, as specified in the Health and Social Care Act 2012. The 2024 Annual Report looked at how to address the key early years to give children the best start in life. There was strong evidence that the first 1001 days of a child's life from conception to age 2 were critical in providing the foundations needed to build a healthy life in the future. The report highlighted some of the key areas where this support was provided and provided an overview of a number of activities. Following the success of utilising an electronic format and videos in recent years, the report was again accessed via a link included in the report with a copy of the Director's report also appended to the report. The Director of Public Health presented a video to the meeting from the Annual Report.

Members welcomed the approach and debated issues arising from the Annual report including the benefits of utilising videos to present information, school readiness, the challenges for schools given the increasing numbers of children and families with complex and additional needs, concerns in relation to child poverty and the factors which had an impact on the health wellbeing and outcomes of children. In response to a query raised, the Chair was pleased to report that breastfeeding take- up in Hartlepool had increased in the last 12 months. Clarification was provided in relation to how the Board could access supporting health data including breast feeding information via the Joint Strategic Needs Assessment.

Emphasis was placed on the need for more collaborative working with the voluntary sector in terms of supporting families to ensure every child in Hartlepool was given the best start in life.

In response to a number of further queries raised, clarification was provided in relation to the budget position around the future of family hubs and the challenges around responding to the increasing number of safeguarding

referrals. A number of queries were raised in relation to interpretation of the school readiness data and a breakdown of school readiness data was requested by school following the meeting.

Decision

That the 2024 Director of Public Health annual report be approved.

That a breakdown of school readiness data by school be provided following the meeting.

29. Joint Local Health and Wellbeing Strategy 2025-2030

(*Director of Public Health)*

Type of decision

Non-key

Purpose of report

To present the Health and Wellbeing Board (HWBB) Strategy refresh for approval (Appendix 1).

Issue(s) for consideration

The Director of Public Health presented the Joint Health and Wellbeing Strategy refresh for Members' approval. The strategy, attached at Appendix 1, outlined the key priority areas for the next five years:-

- **Starting Well** – All Children and young people living in Hartlepool have the best start in life.
- **Live well** - People live and work in connected, prosperous and sustainable communities.
- **Age well** - People live healthier and more independent lives, for longer

The strategy would inform the development of a detailed action plan and outcome framework which would be monitored and reviewed through the Health and Wellbeing Board.

In the discussion that followed officers responded to issues raised arising from the report in relation to the positives around a GP early dementia diagnosis and monitoring arrangements in terms of reablement care.

Decision

That the Health and Wellbeing Board Strategy be agreed and be utilised to support the joint development of the 2025/26 action plan.

30. Pharmaceutical Needs Assessment (PNA) 2022 – Maintenance Report *(Director of Public Health)*

The report updated the Board on the process for statutory maintenance of the Pharmaceutical Needs Assessment 2022, to receive notification of applications, decisions or other notice of changes to pharmaceutical services in Hartlepool from the ICB NENC or Primary Care Support England (PCSE) since the date of the last Health and Wellbeing Board Maintenance Report (9 September 2024). In relation to the requirement to seek approval for publication of any Supplementary Statement to the PNA 2022 required as a consequence of those reported changes to pharmaceutical services, the Board was advised that no new Supplementary Statements had been issued under delegated authority since the last meeting of the Board in July 2024.

Members were advised of the process towards statutory publication of a new PNA by 30 September 2025.

In response to concerns raised regarding the high levels of poor literacy in the town, details of the proposed communication and engagement arrangements were provided which would include face to face communication co-ordinated by Healthwatch and it was noted that information would be made available in different formats in community hubs. The need for Board Members to advocate on behalf of individuals where necessary was highlighted.

Decision

The Board noted:-

1. That no supplementary statements to the Hartlepool PNA 2022 had been issued since the last report in July 2024 and no further changes to pharmaceutical services in Hartlepool had been notified.

2. Progress towards the publication of a new PNA by September 2025.

31. Voluntary and Community Sector Reports *(Director of Public Health)*

Voluntary and Community Sector representatives, who were in attendance at the meeting presented the following reports to Board Members as being of interest to the Board, copies of which had been circulated with the agenda documentation in advance of the meeting:-

- The Haven, Service and Information (Appendix A)
- Urban Sport and Urban Play Summer Activity Report (Appendix B)
- Pumpkins in the Park 2024 (Appendix C)

Following presentation of the reports, Members commended the work of the groups and welcomed the health and wellbeing benefits as a result.

Decision

That the contents of the reports be noted.

The meeting concluded at 11.35 am.

CHAIR

Tees Valley Joint Health Scrutiny Committee

MINUTES AND DECISION RECORD

9 January 2025

The meeting commenced at 10.05am in the Civic Centre, Hartlepool.

Present:

Responsible Authority Members:
Darlington Borough Council - Cllr Holroyd
Hartlepool Borough Council - Cllr Boddy (CH), Cllr Roy
Middlesbrough Council - Cllr Cooper, Cllr Morrish
Redcar and Cleveland Borough Council – Cllr Cawley, Cllr Crane,
Stockton Borough Council - Cllr Hall, Cllr Besford, Cllr Coulson (substitute for Cllr Miller)

Also Present:

Matt Neligan, Chief Strategy Officer, University Hospital Tees (UHT)
DR Michael Stewart, Chief Medical Officer, UHT
Karen Hawkins, Director of Delivery [Tees Valley], North East and North Cumbria Integrated Care Board (NENC ICB)
Katie McLeod, Deputy Director of Delivery, (NENC ICB)
DR Nicky Miller, Clinical Lead, (NENC ICB)
Mark Cotton, Assistant Director of Communications and Engagement, North East Ambulance Service (NEAS)
Victoria Court, Deputy Chief Operating Officer, NEAS
Kimm Lawson, Strategic Head of Commissioning (Tees Valley), (NENC ICB)
Joe Walker, Service Manager, Respite Day and Residential Services, Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
Hannah Warburton, Communications Manager, TEWV

Officers:
Claire Jones (MC)
Gemma Jones, (HBC)
Caroline Leng (R&CBC)
Chris Lunn (MC)
Joan Stevens (HBC)
Gary Woods (SBC)

22. Apologies for Absence

Cllr Kay, Cllr Layton, Cllr Moore, Cllr Miller, Cllr Scott and Hannah Miller.

23. Declarations of Interest

None

24. Minutes of the meeting held on 7th November 2024

Confirmed.

25. Minutes of the Tees Valley Area Integrated Care Partnership (ICP) meeting held 9th August 2024 (to note)

Noted. Members requested that the most recent meeting notes be brought to a future committee.

26. Clinical Services Strategy Update – Group Model - *Group Chief Medical Officer and Group Chief Strategy Officer, NHS University Hospitals Tees*

The Committee received information on this item in 2023, this included the progress and ambition for working as a group across North Tees NHS Foundation Trust (FT) and South Tees Hospitals NHS FT.

An update was presented to the Committee on the progress of the development of the Clinical Services and Group (now known as University Hospitals Tees) strategy. Areas of discussion also focussed on identifying areas that will require further engagement with Local Authorities and Partners.

The primary drivers for joint working as a Group were outlined and included –

- Better tackling of population health challenges
- Delivering high quality and sustainable services
- Creating a voice for the health needs of communities
- Making the most of estates
- Addressing disparities in care by adopting joint models
- Collaborative working across sites

Representatives advised the Committee on the ways in which the two separate trusts of North Tees and South Tees were now working together, including joint governance arrangements and a joint executive leadership team.

The Group Objectives were in development and had included drawing on extensive engagement with the public and involving Healthwatch Hartlepool in working towards identifying what people want from the service. The Group Chief Strategy Officer praised the work of Healthwatch Hartlepool for their help on this matter. The report highlighted that people wanted to be provided with good care and have good communication with their hospital. It had also informed on issues such as hospital parking.

The Group Chief Medical Officer presented to the Committee the highlights of the work across the Group. This included patient and community voice,

staff engagement / communications, Group clinical strategy development and digital enablers.

Clinical boards had welcomed the findings of the Healthwatch report and were developing proposals to reduce waiting times, standardise care and ensure expensive equipment is used to capacity. Making sure that patient care is delivered as close to home as possible was also key. Members were also informed about plans to develop a single point of access across the Tees Valley including one phone number across services and the development of the hospital at home model. Plans also included the number of hospital at home beds to be scaled up to 500 and to continue to develop Women and Children's services in the community. University Hospital Tees was intended to be viewed as one service operating from multiple hospital sites.

Some services have been identified for testing as a single service with consideration being given as to how to bring services together and make them stronger and more resilient. This also included the better use of estates and plans to attract more colleagues. Some elements of the plan may require further consultation and engagement with patients, families and carers. It was discussed that future updates could be brought back to the Committee on this issue.

Members were invited to ask questions, the following information was ascertained–

- Significant work is ongoing to address health inequalities such as thinking about how services are tailored and creating better health literature and education in schools.
- Hospital and communities do experience staffing challenges. Work is ongoing with Teesside University, Local Authorities and the Health and Social Care Academy to address some of these issues.
- The increase of hospital at home beds to 500 is a long-term plan with gradual growth happening over time. All plans are designed to manage the growing demand for hospital services.
- It was acknowledged that the issue of large waiting lists was challenging and that no one solution would resolve this. The intention was for waiting lists to begin to reduce and that the community hubs would contribute to this.
- Alternative routes were being designed to assist those that may not be able to access technology to use digital services. There are also work streams on digital poverty.
- Work continues in moving towards the integration of different electronic records and a link between hospital computer systems.
- Improvements have been made to the time taken to discharge patients from hospital to home. Nurses and allied health professionals also provide support to enable patients go home faster. This includes a push on integrated neighborhood teams.
- Referencing concerns expressed by Members regarding patients having to travel between hospital sites, Representatives explained that it was the plan for more services to be delivered closer to home,

with a concentration of services in one place and an increase in elective care through the hubs.

Representatives were thanked for their updates on this item.

C **Decision**

(i) The content of the presentation was noted.
(ii) That the Healthwatch Hartlepool report be circulated to Members of the Committee.
(iii) That Representatives be invited to a future meeting to provide further updates on the Group strategy.

27. NEAS: Staff Safety and performance update – *Deputy Chief Operating Officer* and *Assistant Director of Communications and Engagement, NEAS NHS Foundation Trust*

Representatives from NEAS provided the Committee with an update on performance data and staff safety. Information presented to the Committee referred to call performance data and it was reported that this has improved significantly in the last 3 years. There are now more health advisors and a new call centre in operation in Stockton. There has been a small but steady increase in 111 calls where the outcome is visits to Urgent Treatment Centres and a small decline in visits to Primary Care services. Calls have also increased in the winter months. Call handlers are trained to take both 111 calls and 999 calls and Hear and Treat rates are not as high as other areas in the UK. Due to having dual trained call handlers there has been significant improvements to Hear and Treat cases. Future plans include extra health advisors and extra clinicians.

An overview was given in terms of Ambulance response times which are split into 4 categories, category 1 being the most serious. Data was provided in terms of the NEAS response times for all categories as detailed in the presentation. It was recognised that although NEAS has the fastest response times to Category 2 calls, work continues towards improving those targets. In terms of hospital handovers, NEAS are also the fastest performing in the country. It was recognised that hospitals were under significant challenges such as bed capacity and pressures due to flu and norovirus. It was also highlighted that patient transport had significantly improved over the last 3 years.

Members were also provided with data relating to staff safety. It was explained that regrettably the number of assaults against staff had increased. This could partially be explained by the use of better reporting mechanisms, but NEAS had also seen a visible increase. Concerns were expressed that convictions were only pursued in 1 in 8 cases of assault with some lower-level assaults against staff being reported as ‘being part of the job’. This was deemed unacceptable but could explain the lower levels of reporting. Alcohol misuse and mental health issues were deemed to be contributing factors with the use of weapons also increasing. Over half of the assaults against staff reported had taken place in the patient’s home.

Members commented the data and information around assaults against staff was appalling and expressed concern for staff.

With reference to the data regarding Ambulance handover times, Members questioned if any ambulances were being diverted from James Cook Hospital to North Tees Hospital. Representatives commented that James Cook Hospital had carried out intensive work regarding this issue and had seen significant improvements in ambulance hand over times.

Reflecting upon information provided regarding the increase in staff on the Hear and Treat service, Members were interested to find out if there was data available regarding this. Whilst exact figures were not available, Representatives were able to confirm that front line staff numbers had increased by 400. It was explained that recruitment was improving and that strong links with Local Universities were attributed to there being more qualified paramedics. In terms of extra ambulance vehicles, some are provided through private companies due to not having big enough ambulance stations to store them. This is something to be considered as part of the long-term estates strategy.

The issue of staff safety was discussed. Responding to a question about the use of body cams for the safety of the paramedic's team the Committee was informed that all paramedics wear them. In a response to a question about the underreporting of assaults and the increase in reports of sexual assaults it was determined that NEAS were targeting encouraging reporting of all assaults. Individual addresses are also flagged up if there were potential for there to be incidences at the property.

Representatives were asked what measures had been in put in place following the report by the CQC in 2022. Members were advised that NEAS had worked hard to address the areas of concern flagged in the report. The oversight from NHS England and the Integrated Care Board had now come to an end. Representatives explained that NEAS have made strong improvements in certain areas such as the management of controlled drugs and the adoption of the new wider patient safety incident report framework. After an independent review, commissioned by NHS England, they were satisfied that the significant improvements and changes to the service had meant the service was now moving in the right direction. NEAS also confirmed, in response to a Member question, that NEAS takes part in the NHS staff survey and results from this had improved. The hope is that this would improve again once the next one takes place in March 2025.

Concerns were raised about patients potentially missing appointments if the patient transport was not on time. It was confirmed that only 4% are late. NEAS had received no feedback suggesting appointments had been missed due to late patient transport.

Concluding the discussion and returning to the issue of staff safety a question was raised about lone working. It was confirmed that there are

strict criteria in place for single responders. Crews are trained in carrying out risk assessments and that police support is available if necessary.

Representatives were thanked for their presentation.

Decision

(i) The content of the presentation was noted.

28. Improving Palliative and End of Life Care across the Tees Valley - *Deputy Director of Delivery and Clinical Lead, Tees Valley Local Delivery Team, NENC ICB*

Representatives were in attendance to present an update on improving palliative and end of life care across the Tees Valley. Members were advised of the engagement work with families, carers and providers which formed the basis of the Palliative and End of Life Care Strategy. Surveys and workshops were also carried out. Feedback on this matter was welcomed to enable improvements and change to services and provisions. Key themes that were important to providers was also discussed and included the willingness to explore new funding models and how to work collaboratively. The strategy has been co-produced with colleagues from the Foundation Trust. Although work has not finished there has been some significant achievements to date. An investment programme has been agreed with some additional funding. Other aspects considered were the training packages available and utilising one phone number to access support across the service. The importance of focussing on relationships with providers was also discussed. This work has gained very positive feedback. Representatives indicated they could come to a future meeting to provide further updates.

In the questions that followed Members were advised that local hospices had also been involved in the work that had been carried out. Issues such as funding and the wellbeing of staff had also been considered in detail.

A Member raised a query regarding the commissioning of a rapid response service in Darlington. Representatives advised that this service had gone through a procurement process and the service has now been provisioned. Data around the use of services is closely monitored and Representatives confirmed that this provision of care was still available to Darlington residents.

Representatives were thanked for their presentation.

29. Tees Respite Care/ Short Breaks Service Update – *Strategic Head of Commissioning (Tees Valley), NENC ICB and* Service Manager, Respite Day and Residential Services, TEWV

Representatives from the NENC ICB and TEWV were in attendance to provide the Committee with an update in relation to the consultation with families and carers regarding the changes to respite care. This item was previously presented to the Committee at its meeting on the 19th September 2024.

A series of listening events have been held with a survey also sent out to parents and carers. A full report on this matter will be produced at a later date. Task and Finish groups have also been held to help determine what services need to be commissioned going forward. Meetings have also taken place with staff at both sites affected, with information being shared with families via a newsletter and a monthly update. Representatives were hoping for more engagement and had also offered one to one sessions with those affected. With the engagement from as many as possible, the aim is to create a sustainable service in a building that is fit for purpose and meets the needs of the patients. Meetings will also take place with colleagues from Local Authorities where the sites are held. Procurement of future services will take place in the next 3 months. Communication with service users and their families and carers is ongoing. Representatives also advised that the importance of communication with staff was paramount and commented that staff at the respite services were doing a good job in difficult circumstances. Representatives explained they were committed to improving the provision of respite care in the Tees Valley.

In the discussion that followed it was confirmed that respite services are not funded in the same way children services and services that provided the best value for the public purse was being considered. A number of other factors were also being considered including getting this model right for the future. A member queried the 12 month time line and assurance was given that this service would continue until another provision could take its place. It was also discussed that a wider piece of work needed to take place around services for those aged 18-25.

Data was provided in terms of the number of people accessing the service and consideration was being given to parents and carers of the service users.

A Member asked that thanks be passed to the staff who continue to support those that rely on the services affected.

Future events were being considered such as coffee mornings where parents would be able to bring along their family members who use the service. Discussions were also held regarding the involvement of people that could use the service but did not.

It was confirmed that future services would not be in NHS buildings, but that NHS clinical staff would be based in the provision.

Representatives were thanked for the update.

30. Work Programme for 2024/2025

The work programme for 2024/25 was discussed following updates from the previous meeting. It was confirmed that the future updates would be welcomed in the Clinical strategy of the group model and the ongoing changes to respite care in the Tees Valley.

A previous item suggested in relation to the impact of waste incinerators was discussed and it was confirmed that consideration must be given to the most appropriate forum for this item given the footprint of the areas included.

(i) The amended work programme for 2024/25 was agreed.
(ii) An update on Clinical strategy of the group model be provided at a future meeting.
(iii) An update on the provision of respite care be provided at a future meeting.

31. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 12.50pm.

CHAIR

North East North Cumbria Health & Care Partnership

Confirmed MINUTES

Tees Valley Area Integrated Care Partnership (ICP) Meeting

Meeting held on: 8 November 2024, 12pm – 2pm

Held at: Boardroom, North East and North Cumbria (NENC) Integrated Care Board (ICB), Trinity Mews, North Ormsby Health Village, Middlesbrough, TS3 6AL

Item No:	Meeting Notes	Action
TVICP/24/13	**Welcome and Introductions**	
	Councillor Cook, as Chair, welcomed colleagues to the Tees Valley Area Integrated Care Partnership (ICP) Meeting. **Present**: • Councillor Bob Cook (Chair) – Health and Well-being Board Chair (HWBB) and Leader of Stockton Borough Council • David Gallagher – Chief Contracting and Procurement Officer • Levi Buckley - Chief Delivery Officer, NENC ICB • Martin Short - Director of Delivery, NENC ICB • Karen Hawkins – Director of Delivery, NENC ICB • James Bromiley – Associate Director, North Tees and Hartlepool Foundation Trust (NTHFT) • Rowena Dean – Chief Operating Officer, NTHFT • Dr Ann French – Dean, School of Health and Life Science, Teesside University • Lorraine Hughes – Director of Public Health, Darlington Council • Rebecca Morgan (RM) – Project Development Manager / Healthwatch Sub-Regional Co-ordinator, Healthwatch • Richard Morris - Associate Director of Operations, County Durham and Darlington NHS FT • Matt Neligan – Chief Strategy Officer, NTHFT • Jane O'Neil – Associate Director of Nursing & Quality, Tees, Esk and Wear Valley (TEWV) • Lisa Oldroyd – Chief Executive and Monitoring Officer, Office of the Police and Crime Commissioner for Cleveland • Lucy Owens – Voluntary Sector Lead/3rd Sector, Catalyst Stockton • Julian Penton - Voluntary Sector Lead/3rd Sector, Hartlepool Community Trust	

	• Ann Richards - Voluntary Sector Lead/3rd Sector, Redcar & Cleveland Voluntary Development Agency • Erik Scollay - Director of Adult Services, Middlesbrough Council • Patrick Scott - Deputy Chief Executive Officer, TEWV • Mike Smith, Redcar and Cleveland Primary Care Network (PCN) (deputising for Dr Goh) • Ian Turnbull – Chief Inspector, Cleveland Police • Grace Wall – Strategic Health and Wellbeing Manager, Stockton Council **In Attendance:** • Jane Smailes (Note Taker) – Corporate Governance Support Officer, NENC ICB • Sanmi Ayuba – Corporate Business Assistant, NENC ICB	
TVICP/24/14	**Apologies for Absence**	
	• Mark Adams - Joint Director Public Health Middlesbrough, Redcar and Cleveland • Professor Derek Bell – Chair, NTHFT / South Tees Hospitals NHS FT (STHFT) • Sarah Bowman-Abouna – Director of Public Health, Stockton Council • Craig Blundred – Director of Public Health, Hartlepool Council • Sandra Britten – Chief Executive (Operational) Alice House Hospice • Cllr Alec Brown - Joint HWWB Chair, Redcar and Cleveland Council • Mayor Chris Cooke – Joint HWBB Chair Live Well South Tees Board – Middlesbrough Council • Dr Dhirendra Garg – Stockton PCN Representative • Dr Teik Goh – PCN Clinical Director Representative, Redcar and Cleveland PCN • Mike Greene – Chief Executive, Stockton Council • Jill Harrison - Director of Adult and Community Based Services, Hartlepool Council • Clive Heaphy – Interim Chief Executive, Middlesbrough Council • Sue Jacques – Chief Executive, County Durham and Darlington NHS FT (CDDFT) • David Jennings, Chair, TEWV • Brent Kilmurray – Chief Executive, TEWV • Cllr Mary Layton – Darlington Council • Majella McCarthy, Director of Children's Services, Stockton Council • Denise McGuckin – Managing Director of Hartlepool Council • Jacqueline McKenzie – PCN Clinical Director, One Life Hartlepool PCN	

	• Dr Helen McLeish – PCN Clinical Director, Darlington PCN • Cath Monaghan – Medical Director, NENC ICB • Carolyn Nice – Director of Adult Services, Stockton Council • Chris Piercy - Director of Nursing, NENC ICB • Helen Ray – Chief Executive, North East Ambulance Service (NEAS) • Sally Robinson - Director of Children's Services, Hartlepool Council • Cllr Matthew Roche - Darlington Council • John Sampson – Managing Director and Chief Executive – Redcar and Cleveland Council • Richard Scothon - Chair, CDDFT • Jeanette Scott - Director of Nursing, NENC ICB • Peter Strachan – Chair, NEAS • James Stroyan – Director of People (Children & Adult), Darlington Council • Joe Tynan – Director Children's Services, Middlesbrough Council • Lynne Walton – Director of Finance, NENC ICB • Ian Williams – Chief Executive, Darlington Council	
TVICP/24/15	**Declarations of Interest**	
	Councillor Bob Cook (BC) reminded colleagues of the importance of the robust management of conflicts of interest and asked individuals to raise any potential conflicts of interest as the meeting progressed. No conflicts of interest were raised.	
TVICP/24/16	**Minutes from previous meeting held 9th August 2024**	
	The minutes of the meeting, held 9 August 2024, had previously been circulated to members for comment. There were no amendments requested and therefore the minutes were **AGREED** as an accurate record. Confirmed minutes have also been shared with Health and Wellbeing Boards for information.	
TVICP/24/17	**Matters Arising & Action Log**	
	Action Log Actions were noted as complete. **Matters Arising** <u>Health Innovation Zone</u>	

	David Gallagher (DG) advised there had been a planned Health Innovation Zone (HIZ) Board meeting the previous day which had been cancelled and DG had planned to give an update from that. As an addition to the presentation made at the previous TVICP meeting, DG described a number of workstreams that were underway for this initiative based in Stockton for Tees Valley. There had been a meeting with the chair of the ICB about the initiative which had been useful and raised some helpful ideas to play into the work. A number of organisations were playing a role in developing a model including the FTs, Teesside University, Stockton BC and the ICB. DG proposed a regular agenda item to feedback progress on a six monthly basis. **ACTION** Health Innovation Zone to be added to the forward planner as an agenda item every six months. There were no other matters arising to note.	JS
TVICP/24/18	**Healthwatch Update**	
	The Healthwatch quarterly update (July – September 2024) had been circulated to members before the meeting. Rebecca Morgan (RM) highlighted the following key points from the report. Across the Tees Valley the local Healthwatch groups have been involved with Women's Health: The Big Conversation with the second annual women's health conference held on 11 July 2024 to ask women what matters to them in terms of their health and wellbeing. There have been nearly 5k responses to the survey, and whilst the final report is still being prepared for the ICB a brief review of the initial data show the top 3 priorities are; • Mental Health • Healthy ageing and long-term conditions • Bone, joint and muscle health Dentistry services continue to a priority for the public. Healthwatch has completed a dentistry engagement exercise across the region with draft recommendations based on the experiences and opinions of residents across	

	the NENC ICB region, which are constructive and realistic in terms of the model of service provision. Healthwatch organisations across the North East (excluding North Cumbria) are working with Voluntary Organisations Network North East (VONNE) to engage public and patients as part of the North East Ambulance Service's (NEAS) intention to review their clinical strategy. The report also drew attention to the local workplan priorities in 2024/25 for Healthwatch in Hartlepool, Darlington, South Tees and Stockton-on-Tees. From Healthwatch South Tees, RM specifically highlighted the calls that had been received from individuals following prison release and the difficulties they were experiencing obtaining their medication, repeat prescriptions and registering with a GP. From Healthwatch Hartlepool, RM highlighted a long case study from an individual who, whilst not a crisis point, was struggling on a day to day basis with their mental health and how they felt they were being passed from one service to another. Following a query from Martin Short (MS), RM confirmed the matter had been flagged to local services. In respect of the Women's Health report, and following a query from MS, RM believed there would be geographical and characteristic data available on both a regional and local footprint. RM agreed to share the report once it was available. **ACTION**: Rebecca Morgan to share the Women's Health report when it was finalised. Matt Neligan (MN) explained that the draft report from Healthwatch regarding the Hospital Trusts Group Model public listening event had been helpful and instructive in helping the Group develop priorities and the need to focus on fundamentals for patients such as appointments and car parking. He said that the Group was keen to develop and co-design services with Healthwatch and other partners. RM said that Healthwatch had been pleased to be involved so early in the process. Referring to the long case study regarding mental health support, Julian Penton (JP) advised there was a common theme across the Tees Valley of fragmented care for people. He explained that similar issues were being reported to Hartlepool Community Trust.	RM

	David Gallagher (DG) welcomed the report noting the importance for planners to hear about the themes that the public were raising, for example the prison release issues highlighted in the report.	
	ACTION: DG requested access to urgent dentistry care be added to the agenda for the next meeting in February. Ann Richards (AR) provided an example of positive joint transformation with TEWV. Redcar and Cleveland Voluntary Development Agency (RVDA) had received a query regarding two individuals for whom the usual referral pathway was not appropriate due to concerns around confidentiality. Following contact with the relevant TEWV Director, and recognising there was a gap in the model, changes were made by TEWV to the model to accommodate the exception.	JS
TVICP/24/19	**Hospitals Trust Group Update**	

	Matt Neligan (MN) and James Bromiley (JB) provided an update on the Hospitals Trust Group work, which provided an opportunity to develop community care with partners.
	
	The presentation highlighted the following key areas:
	
	• Achievements over the past 6 months, including,
	  ○ Recruiting clinical boards from across the Trusts.
	  ○ Carrying out full engagement survey on patient preferences via Healthwatch.
	  ○ Defining time horizons for strategic work over 12-18 months; 1-5 years and 5+ years.
	
	• Next steps, including,
	  ○ Internal finalisation of clinical proposals to test with partners.
	  ○ A University Hospitals Trust (UHT) strategy by April 2025 bringing together clinical, estates and digital proposals (plus other enabling strategies) in an integrated way.
	
	• Discussion points with partners, including,
	  ○ How to best join up and align to existing place-based plans and development work across the Tees Valley.	

	Following a comment from Richard Morris (RM) regarding the work of County Durham and Darlington FT (CDDFT) and the integration across Tees Valley of digital solutions, JB noted that UHT and CDDFT would be working together where clinical pathways existed or needed to be included. David Gallagher (DG) noted the importance of ensuring the early, underlying stages in the development of the UHT work were completed properly before moving on to any potential formal public consultation. Referencing the future UHT strategy, Lucy Owens (LO) explained that across the Voluntary and Community Sector (VCS) there were difficulties in identifying the key strategies they should be linking in with, acknowledging it was not possible for the VCS to work on all the strategies. She highlighted the need from the VCS to be able to demonstrate to funders how the VCS work is linked into, for example, reducing health inequalities. **ACTION** It was agreed the UHT strategy would be brought back to a future meeting for an update, and would be added to the forward plan, with a date to be agreed. **ACTION** It was agreed the presentation would be circulated to members.	JS JS
TVICP/24/20	**Darzi Investigation Report Overview - Presentation**	

	Karen Hawkins (KH) provided an overview of the Darzi Report, which is a rapid investigation over a 9 weeks' period into the state of the NHS focusing on access, quality, and performance.
	
	The presentation highlighted the following areas,
	
	• Summary findings, including,
	  ○ Public satisfaction with the NHS is at its lowest ever.
	  ○ Time spent in ill health has increased.
	  ○ Surge in multiple long-term conditions particularly among children and young people in mental health needs.
	  ○ Unwarranted variations in the number of patients per GP and shortages of GPs, particularly in deprived communities.
	
	• Drivers of performance, including.	

	○ Not enough spent on capital or digital technology. ○ Impact of Covid. ○ Patient voice is not loud enough. • 10 Year plan themes, including, ○ Re-engage and re-empower patients. ○ Simplify and innovate care delivery for a neighbourhood NHS. ○ Tilt towards technology. • Tees Vally: initial reflections for the future, including, ○ Collaborative working with Local Authorities to consider their focus areas on the back of the report and opportunities for joint plans. ○ Support plans to improve patient flow out into the community. Levi Buckley (LB) explained that the 10 Year Plan is likely to be published in June 2025. He noted that the Chief Executive of Healthwatch, Louise Ansari, was leading on some of the themes that were coming out of the work of the UHT Group. Following a query from Julian Penton (JP) regarding the likelihood of a reorganisation of ICBs/ICSs with the new Government, LB responded that there did not seem to be any appetite to redesign the current model. Martin Short (MS) advised a 3 weeks' consultation, "Creating a new 10-Year Health Plan", had been launched which was seeking views, experiences, and ideas to shape the new 10 Year Plan for England. **ACTION** It was agreed the link for the consultation would be circulated to members. **ACTION** It was agreed the presentation would be circulated to members.	JS JS
TVICP/24/21	**Winter Plan 2024/25 – Tees Valley**	
	Karen Hawkins (KH) and Rowena Dean (RD) provided an overview of the Winter Plan 2024/25 (Tees Valley). It was noted that whilst every organisation had its own winter plan assured through its own governance arrangements the presentation covered the Tees Valley system plan for winter	

	2024/25 co-ordinated through the Local Accident and Emergency Delivery Board. The presentation highlighted the following key areas, • System approach to winter planning, including, • Assurance Process • System Priorities • Local Priorities • Public Messaging Cllr Bob Cook (BC) acknowledged the need for health and social care to work together to provide the best outcomes for the local population, with RD noting that locally partners worked well together and aimed to support each other. Rebecca Morgan (RM) referenced previous Healthwatch work regarding Pharmacy First and some of the public frustrations with use of the service. It was acknowledged there had been some challenges with the new service, for example confusion on Urinary Tract Infection pathways and the relevant exclusion criteria which determined when patients needed to be referred back to a GP. David Gallagher (DG) welcomed any feedback that could be included in the review / management of contracts and he noted the need for ongoing dialogue to improve services. **ACTION** It was agreed the presentation would be circulated to members.	JS
TVICP/24/22	**Right Care Right Person (RCRP)**	
	Martin Short (MS) introduced Lisa Oldroyd (LO), Ian Turnbull (IT) and Jane O'Neil (JN) explaining that Right Care, Right Person is an approach designed to ensure people who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. The presentation highlighted the following areas, • The key stages in implementing RCRP, as set out in the national agreement. • The Tees Valley RCRP partners. • The four RCRP phases to be delivered in Cleveland working with partners, ○ Concern for welfare.	

	○ Walk out of healthcare facilities, Absent Without Leave (AWOL) from mental health establishments. ○ Transportation of patients. ○ Section 136 of Mental Health Act and voluntary health patients. • The phased rollout of RCPC across Tees Valley. • TEWV Implementation ○ Concerns for welfare / safety policy. ○ AWOL and missing from hospital. • Acute Trust Implementation. • Review and reflection. • Next steps. Levi Buckley (LB) noted the strength of the partner relationships that had allowed this work to progress. He also recognised the development of NHS111 Press 2 for mental health and the need to support people with the appropriate support. It was acknowledged that for those who were clearly at risk of harm to self or others then the police would continue to attend. MS explained there would be a full evaluation of the RCRP process after completion of the 4 implementation phases. It was agreed that the Right Care Right Person evaluation would be brought back to a future meeting. **ACTION** It was agreed a link to an informative video be circulated to the members. **ACTION** It was agreed the presentation would be circulated to members. **ACTION** It was agreed that the Right Care Right Person evaluation would be brought back to a future meeting, date to be confirmed. This item would be added to the forward planner.	JS JS JS
TVICP/24/23	**NENC ICB Strategic Update**	
	David Gallagher (DG) advised at the most recent NENC ICB Strategic ICP meeting in October there was a conversation regarding current and future ICP	

	arrangements. It had been agreed to have three area ICPs across the NENC ICB area. This would mean a merging of the North and Central area ICPs to mirror the new NE combined authority. The plan is to undertake an independent review of the ICPs and consider developing leadership groups for the area ICPs to be the engine room to drive the Strategic ICP. David Gallagher noted some of the key points discussed at the meeting; • An update om pregress in delivering the ICP strategy • NHS England planning rounds due late 2024 and early 2025 • A presentation on child poverty • Housing and health and the importance of joint planning.	
TVICP/24/24	**Suggested Items for Next / Future Meetings**	
	Suggestions for discussion at future meetings; • Access to urgent dentistry care in February 2025 • Right Care Right Person evaluation, date to be confirmed	
TVICP/24/25	**Any Other Business**	
	Cllr Cook advised he had received an email to request a representative from the Tees Valley Area Integrated Care Partnership into the newly established NENC's Children and Young Person's Health and Wellbeing Strategic Oversight Group. He noted that the work will be aligned to benefit the Children and Young People of the region. **ACTION** It was agreed that the membership of the group would be circulated to members following the meeting. The Chair noted there were no further items of business advised and thanked members for their attendance and contributions to the meeting. *The meeting closed at 2.20pm*	**JS**
	<u>Next Meeting</u> Date: Friday, 7th February 2025	

	Time: 12-2pm Venue: tbc	

Signed: **Date: 04.03.25**

Cllr Bob Cook (Chair)