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CHESTERFIELD
BOROUGH COUNCIL

Please ask for Amanda Clayton
Direct Line: 01246 34 5273
Email committee.services@chesterfield.gov.uk

The Chair and Members of Standards
and Audit Committee

9 July 2019

Dear Councillor,

Please attend a meeting of the STANDARDS AND AUDIT COMMITTEE to be held on WEDNESDAY, 17 JULY 2019 at 2.00 pm in Committee Room 1, Town Hall, Rose Hill, Chesterfield, the agenda for which is set out below.

AGENDA

1. Declarations of Members' and Officers' Interests relating to Items on the Agenda

2. Apologies for Absence

3. Minutes (Pages 3 - 10)

4. Summary of Internal Audit Reports Issued (Pages 11 - 30)

5. Appointment to independent remuneration panel (To Follow)

6. Annual Report of the Standards and Audit Committee (Pages 31 - 40)

7. Internal Audit Consortium Annual Report 2018/19 (Pages 41 - 54)

8. Management of Unreasonable Complaints and complainants - Annual Review 2019 (Pages 55 - 70)

9. Audit Report on the 2018/19 Statement of Accounts (To Follow)

10. Risk Management Strategy and Annual Review (Pages 71 - 98)

Yours sincerely,

Local Government and Regulatory Law Manager and Monitoring Officer

STANDARDS AND AUDIT COMMITTEE

Wednesday, 24th April, 2019

Present:-

Councillor Rayner (Chair)

Councillors	Caulfield Hollingworth	Councillors	Tidd

*Matters dealt with under the Delegation Scheme

65 DECLARATIONS OF MEMBERS' AND OFFICERS' INTERESTS RELATING TO ITEMS ON THE AGENDA

No declarations were received.

66 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bean and A Diouf.

67 MINUTES

RESOLVED –

The Minutes of the previous meetings of the Standards and Audit Committee held on 6 February 2019 were approved and signed by the Chair as a correct record.

68 CBC AUDIT STRATEGY MEMORANDUM

Mike Norman, Senior Manager of Mazars, presented the completed Audit Strategy Memorandum. An error on page 17 of the report was indicated; the 2018/2019 fee should read £40,383.

*RESOLVED –

That the Audit Strategy Memorandum Year Ending 31 March 2019 be noted

69 CBC STANDARDS AND AUDIT COMMITTEE APRIL 2019 PROGRESS REPORT

Mike Norman, Senior Manager of Mazars, presented a report for members to consider the External Audit Plan Progress for 2018/19.

The committee heard that there were no significant matters arising from the audit and that an update would be provided in July 2019 when the audit work was completed.

It was noted that CIPFA was seeking views on a proposed new Financial Management Code. The CIPFA bulletin on Closure of 2018/19 accounts was highlighted and Mike Norman explained that he had discussed the contents with the officers involved and was happy that the points were being addressed.

The Director of Finance and Resources commented that Chesterfield Borough Council had a risk adverse approach to investments and used Arlingclose for independent treasury strategy advice. It was also confirmed that officers of the council had visited Mazars for updates on the closure of accounts and the Director of Finance and Resources advised the committee that he anticipated that the accounts for 2018/2019 would be closed within 6 weeks of the year end.

*** RESOLVED –**

That the External Audit Plan Progress Report for 2018/19 be received.

70 INTERNAL AUDIT PLAN 2019/20

The Internal Audit Consortium Manager presented a report for members to consider and agree the Internal Audit Plan for 2019/20.

The detailed plan for 2019/20 was attached at Appendix B to the report and had been prepared in consultation with the Senior Leadership Team and the Corporate Management Team, taking into account the following factors:

- The Council's objectives and priorities;
- Local and national issues and risks;
- The requirement to produce an annual internal audit opinion;
- The Council's assurance framework;

- An update of the internal audit risk assessment exercise covering the financial control and other procedures subject to audit;
- The Council's strategic risk register;
- The views of the Corporate Management Team.

The plan outlined the assignments to be carried out during 2019/20, their respective priorities and the estimated resources needed. The plan allocated 560 days to Chesterfield Borough Council for 2019/20, which was the same allocation as in the previous three years.

The Internal Audit Consortium Manager was satisfied that the plan would provide sufficient data to form an audit opinion.

***RESOLVED –**

That the Internal Audit Plan for 2019/20 be agreed.

71 SUMMARY OF INTERNAL AUDIT REPORTS ISSUED

The Internal Audit Consortium Manager presented a report summarising the internal audit reports issued during the period 19 January 2019 to 1 March 2019, in respect of reports issued relating to the 2018/19 internal audit plan.

It was noted that four reports had been issued during this period and had been given the following levels of assurance:

- 'Reasonable Assurance' – 3

- 'Limited Assurance' – 1

The committee was informed that no fraud had been discovered.

It was noted that the Limited Assurance Level was given to Laptops and Other Removable Media. The Assistant Director for Customers, Commissioning and Change and the Head of ICT Improvement attended the meeting to update the committee. It was explained that 13 of the 17 recommendations had been implemented and the other four were in the process of being implemented.

It was acknowledged that the database for recording laptops and other removable media was not fit for purpose and the committee was informed

that a new system would be in place by the end of the year. The processes for handling equipment held by staff leaving the organisation had been reviewed to ensure that all hardware was returned to ICT before being issued to a new member of staff. This was to be communicated to all service areas.

The Head of ICT Improvement advised that the issue of former employees featuring in the database would be rectified by the planned upgrade of all systems to the latest version of Windows and the introduction of Office 365. These software changes would be implemented by the end of the year and would ensure that old user profiles are automatically deleted.

The committee heard that the management of mobile phones was split over three departments and this would all move back into ICT. Some internal reorganisation may be necessary to facilitate this. A procurement process was underway for a new supplier with particular focus on the management information services provided in addition to achieving best value.

*** RESOLVED –**

That the report be noted.

72 OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS

The Internal Audit Consortium Manager presented a report summarising the outstanding internal audit recommendations. There were no particular concerns raised.

***RESOLVED –**

1. That the report be noted

2. That this update continue to be delivered at 6 month intervals.

73 RIPA - ANNUAL REPORT TO STANDARDS COMMITTEE

The Local Government and Regulatory Law Manager presented an annual report to members on activities relating to surveillance by the Council and associated policies under the Regulation of Investigatory Powers Act 2011.

The committee was advised that no directed surveillances were authorised by the Council in 2018, though the police used the Council CCTV for a RIPA organised operation. RIPA training using an Aspire Learning module had been undertaken by 71 employees and the Monitoring Officer had completed external training. No inspection had taken place in the last year.

The Local Government and Regulatory Law Manager referred to the updated guidance issued in 2018 and highlighted the following areas;

- Social Media had been identified as a new area of risk.
- The use of drones (not currently used at Chesterfield Borough Council).
- A new responsibility to report errors.
- A new duty for the Senior Responsible Officer to ensure that all authorising officers were appropriately trained.

The committee was informed of the planned activity for the current year including a thorough review of the corporate policy for CCTV and development of policy for the use of bodycams.

The Chief Executive had been notified of a routine Investigatory Powers Commissioner's Office Inspection to take place during the year.

RESOLVED –

1. That the report be noted.
2. That the Surveillance Policy be updated as set out in the report with the Local Government and Regulatory Law Manager authorised to make any further consequential amendments in the light of current guidance and best practice.
3. That the proposed activity for 2019/20 be progressed.

74 **REVIEW OF THE CODE OF CORPORATE GOVERNANCE AND THE ANNUAL GOVERNANCE STATEMENT**

The Internal Audit Consortium Manager submitted a report to present Members with the Annual Governance Statement and associated Action Plan, and to review Council compliance with the Code of Corporate Governance during 2018/19.

The Annual Review of the Code of Corporate Governance, as attached at Appendix A to the officer's report, showed that compliance had largely been achieved in 2018/19, with areas of partial compliance addressed in the Annual Governance Statement Action Plan, as attached at Appendix D to the officer's report.

The Annual Governance Statement and associated Action Plan had been presented to Cabinet and the Corporate Management Team and no comments were received.

***RESOLVED** –

1. That, the Annual Governance Statement, the Annual Governance Statement and Action Plan be approved.

2. That a review of the Code of Corporate Governance be undertaken in 12 months' time.

3. That progress on the Action Plan be monitored by the Corporate Management Team.

75 **COMMITTEE ON STANDARDS IN PUBLIC LIFE REVIEW OF LOCAL GOVERNMENT ETHICAL STANDARDS**

The Monitoring Officer presented a report to members of the review by the Committee on Standards in Public Life (CSPL) on local government ethical standards. The CSPL report set out best practice and recommended to government changes to the standards system and the committee reviewed whether changes to the Council's system were appropriate at this stage as a result.

The report summarised how ethical standards had operated at Chesterfield under the current standards system. It commented on the effective use of independent persons for standards matters and the review's proposal to limit their appointment to two years.

The Monitoring Officer highlighted a number of the CSPL review's best practice recommendations as follows;

- Whether or not bullying and harassment be referred to in the code of conduct.
- An obligation of members to comply with any formal investigations.

- The code of conduct should be reviewed annually
- The code to be readily accessible
- Quarterly updating of the gifts and hospitality register and gifts and hospitality totalling £100 over a year from a single source should be registered.
- The authority's public interest test should be published.
- Procedural recommendations for town and parish councils
- Greater awareness of standards in Council external bodies.

The Monitoring Officer drew the committee's attention to some of the CSPL recommendations to government and other bodies arising from the review:

- Improved member training and guidance on registering and declaring interests
- Disclosure of independent persons' view and legal indemnity
- Annual publication of standards statistics including number of complaints, their nature, outcome and any sanctions applied.
- Strengthened sanctions
- That political groups should require councillor attendance at formal induction.

RESOLVED –

1. That the CSPL report be noted.

2. That the council's performance against the CSPL proposals and suggested and recommended changes to the Council's standards system are reviewed and supported.

3. That the Members' Code of Conduct and the Council's procedures for consideration of complaints against members be amended accordingly.

76 **ANY OTHER BUSINESS**

The Chair thanked the members of the committee for their service and the officers and staff for their involvement over the last four years.

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For publication

Summary of Internal Audit Reports Issued 2018/19

Meeting:	Standards and Audit Committee
Date:	17th July 2019
Cabinet portfolio:	Governance
Report by:	Internal Audit Consortium Manager

For publication

1.0 Purpose of report

1.1 To present for members' information a summary of Internal Audit Reports issued during the period 2nd March 2019 to 31st May 2019 in respect of reports issued relating to the 2018/19 internal audit plan.

2.0 Recommendation

2.1 That the report be noted.

3.0 Report details

3.1 The Public Sector Internal Audit Standards require that the Internal Audit Consortium Manager reports periodically to the Standards and Audit Committee in respect of performance against the audit plan. Significant risk and control issues should also be reported.

3.2 Attached, as Appendix A, is a summary of reports issued covering the period 2nd March 2019 to 31st May 2019, for audits included in the 2018/19 internal audit plan. This period 8 reports have been issued 3

with substantial assurance, 4 with reasonable assurance, 1 with Limited assurance (sickness absence management) and 1 with inadequate assurance (Rufford Close New Build Project). Members have received copies of the limited report and a summary of the points arising are included at Appendix B. The inadequate report is in relation to Rufford Close new build project. This report has not been provided at this meeting because the project is subject to a wider management investigation that will be reported in full by management at a later date once investigations are complete.

3.3 It should be noted that the final audit report for 2018/19 (housing repairs) is in the process of being finalised. Work has started on the 2019/20 internal audit plan although this has been later than usual due to staff vacancy periods during the year and due to an employee commencing an apprenticeship in order to achieve their CIPFA qualification (20% time commitment).

3.4 Appendix A shows for each report a summary of the scope and objectives of the audit, the overall conclusion of the audit and the number of recommendations made / agreed where a full response has been received.

3.5 The conclusion column of Appendix A gives an overall assessment of the assurance that can be given in terms of the controls in place and the system's ability to meet its objectives and manage risk in line with the definitions below.

Assurance Level	Definition
Substantial Assurance	There is a sound system of controls in place, designed to achieve the system objectives. Controls are being consistently applied and risks well managed.
Reasonable Assurance	The majority of controls are in place and operating effectively, although some control improvements are required. The system should achieve its objectives. Risks are generally well managed.
Limited Assurance	Certain important controls are either not in place or not operating effectively. There is a risk that the system may not achieve its objectives. Some key risks were not well managed.
Inadequate Assurance	There are fundamental control weaknesses, leaving the system/service open to material errors or abuse and exposes the Council to significant risk. There is little assurance of achieving the desired objectives.

3.6 In respect of the audits being reported, it is confirmed that there were no issues arising relating to fraud that need to be brought to the Committees attention.

3.7 The production of this report ensures that Members charged with governance are aware of any internal control weaknesses or fraud identified by internal audit.

4.0 Alternative options and reasons for rejection

4.1 The report is for information.

5 Recommendation

5.1 That the report be noted.

6 Reasons for recommendation

6.1 To inform Members of the internal audit reports issued in order that the strength of the internal controls in place can be assessed.

Decision information

Key decision number	N/A
Wards affected	All
Links to Council Plan priorities	This report links to the Council's priority to provide value for money services.

Document information

Report author	**Contact number/email**
Jenny Williams – Internal Audit Consortium Manager	**01246 345468** **Jenny.williams@chesterfield.gov.uk**
Background documents These are unpublished works which have been relied on to a material extent when the report was prepared.	
Appendices to the report	
Appendix A	Summary of Internal Audit Reports Issued
Appendix B	Summary of points arising in relation to the Limited audit report – Sickness Absence Management
Appendix C	Sickness Absence Management Report

Appendix A

Chesterfield Borough Council – Internal Audit Consortium

Report to Standards and Audit Committee

Summary of Internal Audit Reports Issued 2018/19– Period 2nd March 2019 to 31st May 2019

Report Ref No.	Report Title	Scope & Objectives	Assurance Level	Date			Number of Recommendations	
				Report Issued	Response Due	Response Received	Made	Accepted
24	Sickness Absence Management	To ensure that sickness absence is being appropriately managed and reported	Limited	5/3/19	17/5/19	11/6/19	7 (5M 2L)	7
25	Agresso FMS	To review the main accounting systems and procedures	Substantial	27/3/19	17/4/19	N/A	0	0
26	Sheffield City Region Projects	To ensure that monies are appropriately spent and accounted for	Substantial	3/4/19	24/4/19	N/A	0	0
27	Commercial Works	To review the processes and procedures in place	Reasonable	5/4/19	29/4/19	15/5/19	13 (4M 9L)	13

Report Ref No.	Report Title	Scope & Objectives	Assurance Level	Date			Number of Recommendations	
				Report Issued	Response Due	Response Received	Made	Accepted
28	Accounts Receivable	To ensure that invoices are raised promptly and accurately and that there are debt collection procedures in place.	Substantial	9/4/19	30/4/19	25/4/19	2 (1M 1L)	2
29	Housing Capital Programme – Excluding Rufford Close	To ensure that housing capital programme projects are appropriately managed	Reasonable	9/4/19	30/4/19	1/5/19	2L	2

Report Ref No.	Report Title	Scope & Objectives	Assurance Level	Date			Number of Recommendations	
				Report Issued	Response Due	Response Received	Made	Accepted
30	Rufford Close New Build Project	The findings of this report will form part of the Council's wider investigation reporting. These investigations are currently ongoing and developing and cannot be reported at this time. When the investigations report is concluded in the coming months it will be reported back to the Audit and Standards Committee.	Inadequate	9/4/19	30/4/19	1/5/19	2H	2
31	Core Fleet	To review the controls and procedures around vehicles and plant	Reasonable	20/05/19	11/6/19	7/6/19	8 (4M 4L)	8

Appendix B

Sickness Absence Management – Main points arising

- The handling of sensitive sickness information is inconsistent
- Sickness records were being retained for many years longer than GDPR guidance
- Managers don't have access to Resource Link therefore numerous spreadsheets are being maintained by managers
- Not all sickness documentation is completed promptly and accurately
- Sickness absence review meetings are not always taking place when trigger points are reached
- There was no contract in place with the current occupational health provider
- Sickness reports were found to contain inaccuracies

The risks are that:-

- Sickness is not managed effectively potentially leading to greater sickness levels and a failure to identify trends or give support where it is needed.
- Sickness levels are understated /figures are inaccurate so a true picture is not obtained
- The General Data Protection Regulations are not being complied with which could lead to fines and reputational damage
- The current occupational health provider may not be providing value for money or the service expected

Bolsover, Chesterfield and North East Derbyshire District Councils'

Internal Audit Consortium

Internal Audit Report

Authority:	**Chesterfield Borough Council**
Subject:	**Sickness Absence Management**
Date of Issue:	**5th March 2019**
Assurance Level	**Limited Assurance**

Report Distribution:	**Assistant Director – Customers, Commissioning and Change**

INTERNAL AUDIT REPORT
PAYROLL SYSTEM

Introduction

An internal audit of the Council's sickness absence management and occupational health arrangements has recently been undertaken in line with the Internal audit plan.

Scope and Objectives

The objectives of the audit was to review the following:

- Sickness absence policies and procedures
- Duties and responsibilities of officers and managers
- Pre-employment sickness checks
- Recording of sickness absences
- Adequate use of trigger points
- The use of support services (e.g. Occupational health)
- Review performance monitoring and reporting procedures

During this audit no review of Sickness payments were conducted as this was completed as part of the recent Payroll audit.

Conclusion

The conclusion as a result of the audit it was that the internal controls operating in the system provide **Limited Assurance** (Certain important controls are either not in place or not operating effectively. There is a risk that the system may not achieve its objectives. Some key risks were not well managed), see Appendix 1.

Acknowledgement

The assistance of HR and Support Services staff during the audit is gratefully acknowledged.

Findings and Recommendations

Sickness Absence Policies and Procedures

1. The Council's Managing Attendance policy was approved by the Employment and General Committee on 25th January 2016

2. Review of the Absence management policy established that detailed and comprehensive instruction is provided for the managers, all supporting documents and forms are attached to the policy and that the policy is readily available to all council staff via the Aspire Intranet. In addition to this further guidance has been provided via detailed posts on Aspire on the following areas:
    - Managing Attendance
    - Phased Returns
    - Return to Work Interviews
    - Managing Staff and Difficult Conversations

3. The current sickness reporting procedures require that S1 and S2 forms are completed by managers; these are then passed to support services. The resource link system is then updated and the sickness absence details are transferred on to the BT3 forms to be sent to payroll. Fit notes are also retained with the S1 and S2 forms within support services. Where employees hit sickness triggers it is the manager's responsibility to take further action. During the audit the following issues were identified:
    - Due to support services being spread out across the council departments it was identified that sensitive sickness documents are stored in at least 7 different locations.
    - In each location the document handling is inconsistent, it was evidenced that in some areas all sickness records are stored digitally where as other areas keep physical records of all sickness records.
    - During the audit it was identified that sickness records dated 2003 were retained. Under GDPR guidelines and the council's retention policy only sickness records from the previous 3 years should be kept.
    - Managers are required to maintain a record of their employee's sickness absences and should be aware of when triggers are reached by the employees however managers have to create and maintain their own sickness records as they do not have access to the resource link system, these sickness records are completely unmonitored.
    - Where a manager does not keep adequate records of sickness absences the employee's sickness history would to be requested from support services or HR.
    - Parts of the support services department retain records of sickness to inform the managers when triggers are reached and if any further documents are required. This is not consistently applied across the council.
    - Discussion with two senior support services officers established that they both believed the responsibility for senior management sickness reporting lie with the other officer. This has been resolved as part of the audit.
    - If a manager did not report a sickness absence via an S1 or S2 the absence would be unreported this would be undetectable to support services or HR.

Recommendation	
R1	It should be ensured that a fit for purpose sickness management process be introduced to ensure centralised and consistent record keeping, correct disposal of information and that managers have direct access to sickness information where needed to reduce duplication of records and input errors. ***(Priority: Medium)***

Duties and Responsibilities of Officers and Managers

4. It is detailed within the employment contract that all employees will report sickness in line with the Council's managing attendance policy

5. The new starter induction checklist includes showing all employees how to access the managing absence policy and other essential policies via the Aspire Intranet and allow the employee time to read it.

6. It was identified that a module has been created within the Aspire Learning training system and that face to face absence management training is being provided by HR. The last training session was completed in October 2018 and was attended by 15 people.

7. It was identified that where training is provided all training on absence management is optional.

Recommendation	
R2	Consideration should be given to making the Absence Management training course compulsory for all managers across the council to complete. ***(Priority: Low)***

Pre-employment Sickness Checks

8. A review of the Council's reference form identified that sickness absence history from previous employers is being requested however a conversation with the HR Administrator identified that the majority of employers do not complete this section.

9. Prior to starting employment for the council a health questionnaire is completed by all employees, this is sent directly to COPE (the Council's occupational health partner) who assess the questionnaire and provide the council with a "fit to work" certificate or notify the council of conditions.

Recording of Sickness Absences

10. Testing of 10 employee's sickness records taken from S1 forms was completed, this resulted in 22 sickness occasions being reviewed between April 2018 and January 2019. The following was identified:
    - 21 out of 22 (95%) occasions had S1 and S2 forms completed; the 1 instance which did not had a fit note provided on the first day of absence.
    - All 22 occasions had been correctly transferred to the BT3 forms.
    - 19 out of 22 (86%) had been transferred correctly onto the resource link system.
    - 2 out of the 10 employees returned to work on phased returns, in both these instances the correct documentation was evidenced.

- 8 out of 8 occasions which lasted over 7 days had a fit note to be provided and retained

11. Testing of 5 Sickness occasions identified from the BT3 records between April 2018 and January 2019 was completed. The following was identified:
    - 4 out of 5 (80%) occasions had S1 and S2 forms completed.
    - 4 out of 5 (80%) occasions had been transferred correctly to the BT3 form.
    - All 5 Occasions had been correctly transferred to the resource link system.
    - All 3 occasions that were over 7 days long had adequate fit notes provided for the time of absence

12. Testing of 10 employee's sickness records selected from the resource link system was completed. This resulted in 22 further occasions of sickness being reviewed between April 2018 and January 2019. The following was identified:
    - 19 out 22 (86%) occasions had S1 and S2 form fully completed, in 1 instance where no S1 had been completed the sickness dates on the S2 form were also incorrect.
    - All 22 occasions had been transferred correctly to the BT3 forms
    - 21 out of 22 (95%) occasions had been input correctly onto the resource link system
    - 2 employees had returned to work on a phased return. Only 1 of these had completed the correct documentation.
    - 7 out of 7 occasions which lasted over 7 days had a fit note provided and retained.

13. In the case of 1 employee tested it was identified that the sickness policy had not been complied with in the following ways:
    - The employee had used annual leave days in the middle of a sickness period created 2 long term periods, the policy states:

      "An employee who falls sick during the course of annual leave shall be regarded as being on sick leave from the first date of sickness"

    - The employee only contacted their line manager by email during the course of the sickness period, the policy states:

      "this [notification of absence] must be in person by phone unless exceptional circumstances prevent the employee from making contact."

14. Over the 3 samples selected a total of 49 absence occasions (from 25 employees) were reviewed cumulative results are listed below:

	Correct	Occasions Tested	% Correct
S1 and S2s completed correctly	44	49	89.8%
BT3s completed correctly	48	49	98.0%
Resource link records correct	45	49	91.8%
Phased return documents	3	4	75.0%
Fit notes provided	18	18	100.0%

Adequate use of Trigger Points

15. Where an employee reaches a trigger point with their sickness absence the manager is required to conduct a Sickness Absence Review Meeting (SAR). The aim of this review is establish any reasons for sickness that may have not been previously disclosed and to identify any issues where the council can help the employee with the return to work. Formal warnings for sickness absence can also be given during these meetings with aim of improving the employee's attendance. Details of the SAR Meeting are passed to the HR Department.

16. During the audit 25 employee's sickness records for 2018/19 were reviewed, this resulted in 49 absence occasions. A comparison of these records to the trigger points set out in the absence policy identified the following:
    - 21 out of 49 absence occasions reviewed reached a trigger point as stated in the council's policy.
    - 13 out of 21 (61%) occasions that reached trigger points had SAR Meetings evidenced.
    - 12 out of 21 (57%) occasions that reached trigger points had SAR meeting and issued a formal warning to the employee as detailed in the Council's absence management policy.

17. Where trigger points are reached some support services staff advise the managers however this approach is inconsistent across the council. It should be noted that the Absence Monitoring policy states:

    "HR will provide reports to managers detailing the absence levels in their department and those employees who have hit various trigger points for action."

18. It was established that where trigger points are reached it is the managers responsibility to identify that the trigger point has been reached and to conduct the SAR meeting. Currently no follows ups are being made by the HR department to ensure that managers complete the SAR meetings and pass the details through.

19. It should be noted that the absence management policy is not being complied with in regard to SAR meetings and trigger points. This was evidenced across the whole of the council including within senior management.

	Recommendation
R3	Consideration should be given to informing managers and following up where trigger points have been reached to ensure that SAR meetings are being completed and that the correct details are recorded. Should this not occur the Council must accept the risk that the policy will not be complied with fully. ***(Priority: Medium)***

The use of Support Services (e.g. Occupational Health)

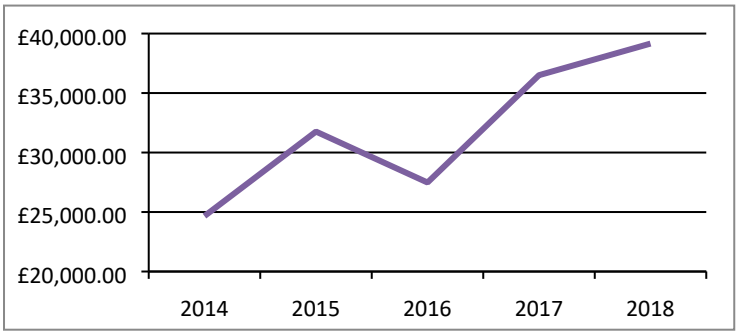
20. Where additional support is need by the employee or manager the council has access to an occupational health service (OHS). The referral of an employee to the OHS is based on further trigger points described in the Absence management policy.

21. A review of 25 the employees (49 sickness occasions) tested as part of the audit it was established that 8 employees had reached a trigger to be referred to OHS. In these instances all employees were adequately referred to the OHS as detailed.

22. A conversation with the Procurement and contract law manager established that the council is currently undergoing a procurement exercise to renew the contract for the OHS. It was established that no contract could be evidenced for the current service being provided by COPE.

23. It was established that the cost of occupational health is coded to "Personnel", which is then recharged evenly across the council in proportion to the amount of staff in each area. Over the last 2 years the cost of Occupational health has increased, this is mainly due to the increased use of the service.

Occupation Health Cost	
2014	£24,660.31
2015	£31,760.57
2016	£27,480.82
2017	£36,501.45
2018 to P10	£39,157.56



Recommendation	
R4	It should be ensured the contract for the procurement of the new occupational health service is completed in line with the council's procurement guidelines ***(Priority: Medium)***

Review Performance Monitoring and Reporting Procedures

24. It was established that while the HR service was operated by Arvato monthly reports were being compiled and reported to the client officer.

25. A conversation with the Assistant HR Business Partner established that service area reports are being sent to assistant directors on a monthly basis these detail individual sickness absences from the respective month and as a total for the current year.

Recommendation	
R5	Consideration should be given to reporting sickness absences to department managers to ensure that the reports being produced are relevant and practical. ***(Priority: Low)***

26. Currently Sickness absence days and reasons are being reported to the health and safety committee on a quarterly basis.

27. A review of the reports provided for the period April 2018 to January 2019 identified multiple inaccuracies detailed below:
    - The total sickness reported on the Commercial Services report was calculated by adding all individual instances together to be 6,990 days, however the total days on the report stated 7,046 days. The total instances reported on the

housing report, adding all individual instances together, was 2,930 days but the report stated 2,961 days.

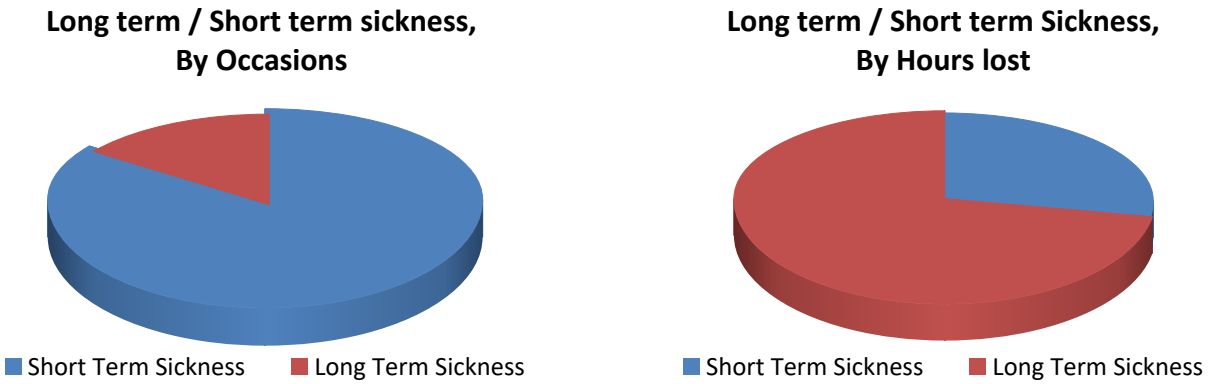
- It was evidenced that in some records the calculation for amount of days sickness is inconsistent as detail below:

		From HR Report		Audit Calculation	
Absence start date	Absence end date	Total sickness days	Days Since 1st April	Total sickness days	Days Since 1st April
01/02/2018	30/04/2018	118	0	89	30

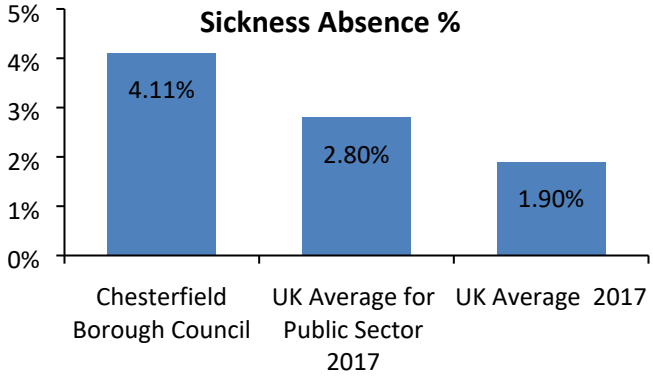
- It was evidenced that within some records the amounts of days an employee was recorded as absent for was doubled by the resource link system (in some cases quadrupled).
- Where incorrect days are recorded the number of hours of sickness is also affected however it was evidenced that in some case the number of hours reported were incorrect when the number of days was correct. In 1 instance an employee with 0.5 FTE would have had to work 7.5 hours 7 days per week
- It was identified that the sickness reports were not comprehensive as 1 employee from the crematorium was not included on the report when other crematorium employees were included.

Recommendation	
R6	It is essential that a review of the reports being produced is completed to identify and remedy the cause of the errors being reported to ensure correct and comprehensive reports are produced ***(Priority: Medium)***

28. Using the reports provided by HR and making adjustments to the calculations for days and hours the following was identified:

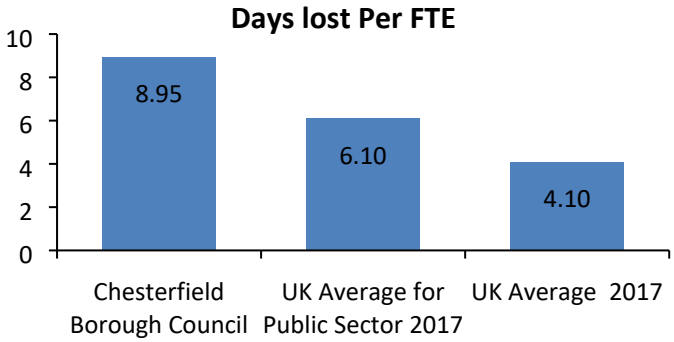


Comparison of short term and long term sickness absences between April 2018 and January 2019 identified that while 83.7% of sickness absences were classified as short term sickness this only equated to 27.8% of the overall sickness hours lost by the council. Only 16.3% of the councils total sickness absences were classified as long term sickness however this accounted for 72.2% of the councils total sickness hours lost by the council.



29. A review of the councils overall sickness absence percentage (between April 2018 and January 2019) in comparison with the UK averages for 2017, Released by the Office of National Statistics, established that the overall sickness absence for Chesterfield Borough Council is higher than the national average. (The CBC absence % was calculated using Sickness hours per FTE)

30. Comparison of the total days lost per FTE (Between April 2018 and January 2019) within the council with the UK averages for 2017, released by the Office of National Statistics, established that the council's average is 8.95 days of sickness per FTE, This is higher than the UK averages



31. In addition to this the sickness frequency rate was calculated as 0.73 (Total Sickness occasions in comparison to total number of employees within the council). This shows the average number of sickness periods per employee within the council.

32. The individual frequency rate for the council was calculated as 44.6% (employees who have taken a sickness absence between April 2018 and Jan 2019 compared to total employees in the council). This identifies that 55.4% of council employees have not registered any sickness periods between April 2018 and January 2019)

Appendix 1

Internal Audit Report

Internal Audit Consortium Opinion Definitions

Assurance Level	Definition
Substantial Assurance	There is a sound system of controls in place, designed to achieve the system objectives. Controls are being consistently applied and risks well managed.
Reasonable Assurance	The majority of controls are in place and operating effectively, although some control improvements are required. The system should achieve its objectives. Risks are generally well managed.
Limited Assurance	Certain important controls are either not in place or not operating effectively. There is a risk that the system may not achieve its objectives. Some key risks were not well managed.
Inadequate Assurance	There are fundamental control weaknesses, leaving the system/service open to material errors or abuse and exposes the Council to significant risk. There is little assurance of achieving the desired objectives.

Internal Audit Report – Implementation Schedule

Report Title:	Sickness Absence Management	**Report Date:**	5th March 2019
		Response Due By Date:	26th March 2019

Recommendations		**Priority (High, Medium, Low)**	**Agreed**	**To be Implemented By:**		**Further Discussion Required**	**Comments**
				Officer	**Date**		
R1	It should be ensured that a fit for purpose sickness management process be introduced to ensure centralised and consistent record keeping, correct disposal of information and that managers have direct access to sickness information where needed to reduce duplication of records and input errors.	**Medium**	**Y**	**K Harley**	**March 2020**		This will be actioned in two phases. Firstly a Project will be established to review end to end processes and make improvements in processes in the short term. Secondly (in parallel) the resourcelink system will be developed to implement automated absence and manager direct input of absence through Myview.
R2	Consideration should be given to making the Absence Management training course compulsory for all managers across the council to complete.	**Low**	**Y**	**K Harley**	**June 2019**		This will be done.
R3	Consideration should be given to informing managers and following up where trigger points have been reached to ensure that SAR meetings are being completed and that the correct details are recorded. Should this not occur the Council must accept the risk that the policy will not complied with completely	**Medium**	**Y**	**K Harley**	**Sept 2019**		The process will be reviewed as part of response to R1.

Recommendations		Priority (High, Medium, Low)	Agreed	To be Implemented By:		Further Discussion Required	Comments
				Officer	Date		
R4	It should be ensured the contract for the procurement of the new occupational health service is completed in line with the council's procurement guidelines	**Medium**	**Y**	**K Harley**	**July 2019**		OH contract out to tender and closes June 14th 2019
R5	Consideration should be given to reporting sickness absences to department managers to ensure that the reports being produced are relevant and practical	**Low**	**Y**	**K Harley**	**July 2019**		There are significant issues with the cognos reporting tool and the data in the system. To meet this recommendation would require a different process to be established. It will be considered as part of response to R1
R6	It is essential that a review of the reports being produced is completed to identify and remedy the cause of the errors being reported to ensure correct and comprehensive reports are produced	**Medium**	**Y**	**K Harley**	**Sept 2019**		New reports are being implemented as part of the upgrade in Resourcelink and it is hoped this will resolve this issue.

Please tick the appropriate response (✓) and give comments for all recommendations not agreed.

Signed Head of Service:		Date:	

For publication

Annual Report of Standards and Audit Committee

Meeting:	(1) Standards and Audit Committee (2) Council
Date:	(1) 17th July 2019 (2) 17th July 2019
Cabinet portfolio:	Governance
Report by:	Chair of the Standards and Audit Committee, the Internal Audit Consortium Manager and the Local Government and Regulatory Law Manager

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For publication

1.0 Purpose of report

1.1 To set out the work of the Standards and Audit Committee for 2018/19 in an annual report in line with best practice.

2.0 Recommendations

2.1 That the Standards and Audit Committee consider the attached Standards and Audit Committee Annual Report and refer to Council for approval.

2.2 That Council approve the Annual Report of the Standards and Audit Committee.

3.0 Report details

3.1 The Chartered Institute of Public Finance and Accountancy (CIPFA) in their guidance note "Audit Committees – Practical Guidance for Local Authorities", recommend that an Audit Committee should produce an annual report on their activity. The Standards and Audit Committee, after a self - assessment of its effectiveness, agreed that the production of an Annual Report would help assess how the Committee was performing. It would also raise the profile of the Committee.

3.2 The Annual Report in Appendix 1 summarises the work of the Standards and Audit Committee for the financial year 2018/19.

4 Alternative options and reasons for rejection

4.1 The report is for information.

5 Recommendations

5.1 That the Standards and Audit Committee consider the attached Standards and Audit Committee Annual Report and refer to Council for approval.

5.2 That Council approve the annual report of the Standards and Audit Committee.

6 Reasons for recommendation

6.1 To ensure that the Standards and Audit Committee are following good practice guidelines in line with CIPFA's guidance note "Audit Committees – Practical Guidance for Local Authorities" in terms of performance and effectiveness.

Decision information

Key decision number	N/A
Wards affected	All
Links to Council Plan priorities	This report links to the Council's priority to provide value for money services.

Document information

Report author	**Contact number/email**
Jenny Williams – Internal Audit Consortium Manager and the Local Government and Regulatory Law Manager	**01246 345468** **Jenny.williams@chesterfield.gov.uk**
Background documents These are unpublished works which have been relied on to a material extent when the report was prepared.	
CIPFA's Audit Committees – Practical Guidance for Local Authorities	
Appendices to the report	
Appendix 1	Annual Report of the Standards and Audit Committee

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CHESTERFIELD
BOROUGH COUNCIL

STANDARDS AND AUDIT COMMITTEE

ANNUAL

REPORT

2018/19

Standards and Audit Committee

Chesterfield Borough Council

Annual Report 2018/19

1. Background

1.1 The Chartered Institute of Public Finance and Accountancy (CIPFA) in their guidance note "Audit Committees – Practical Guidance for Local Authorities", recommend that an Audit Committee should produce an annual report on their activity.

1.2 Following a self- assessment the Standards and Audit Committee collectively agreed that it would be useful to produce an annual report as a means of assessing how the Committee is performing and raising the profile of the work of the Committee across the Council. This is the Committee's second annual report.

1.3 Audit Committees are widely recognised as a core component of effective governance, their key role is to independently oversee and assess the internal control environment, comprising governance, risk management and control and advise the Council on the adequacy and effectiveness of these arrangements. At Chesterfield Borough Council the statutory duty to promote and maintain high standards of conduct by members is also overseen by the Committee.

1.4 The Committee is responsible for: –

- Promoting and maintaining high standards of conduct
- Good governance
- Internal Audit
- External Audit
- Risk Management

- The control environment
- Anti-fraud and anti- corruption arrangements
- Carrying out hearings into alleged misconduct by councillors

Details of the responsibilities of the Committee are set out in the Council's Constitution (Part 2, Article 9).

1.5 The Committee meets on a regular basis. Chaired by Councillor Mark Rayner it is advised by the Director of Finance and Resources, Kevin Hanlon, the Internal Audit Consortium Manager, Jenny Williams, and the Monitoring Officer, Gerard Rogers.

2. Membership and Meetings

2.1 The Standards and Audit Committee is composed of seven members, 5 councillors and 2 parish representative members (appointed by Brimington Parish Council and Staveley Town Council respectively). During 2018/19 these members were:-

Councillor Rayner (Chair)
Councillor A Diouf (Vice-Chair)
Councillor Caulfield
Councillor Hollingworth
Councillor Derbyshire
Councillor Bean (Brimington)
Councillor Tidd (Staveley)

2.2 The meetings are also attended by the Council's external auditor Mazars (previously KPMG).

2.3 During the 2018/19 financial year the Standards and Audit Committee met on 9 occasions (6 programmed meetings and 3 extraordinary meetings).

3. Standards and Audit Committee Business

3.1 During the year the Committee conducted the following business:-

- Received the annual internal audit report for 2017/18
- Approved the internal audit plan for 2018/19
- Received internal audit updates of progress against the audit plan for 2018/19
- Monitored the implementation of internal audit recommendations
- Received full copies of limited and inadequate internal audit assurance reports and requested managers to attend the Committee to provide an update on progress made against the recommendations
- Approved the revised Internal Audit Charter
- Considered external audit progress reports
- Reviewed and approved the Code of Corporate Governance and Annual Governance Statement
- Received an update on progress in the delivery of the 2017/18 Annual Governance Statement Action Plan
- Considered the results of CIPFA's Fraud and Corruption Survey 2018
- Approved the revised Anti- Fraud Bribery and Corruption Policy including Money Laundering
- Approved the revised Employee Code of Conduct
- Approved the annual report of the Standards and Audit Committee
- Approved the 2017/18 statement of accounts
- Considered the treasury management 2017/18 annual report and monitoring report 2018/19
- Approved the 2019/20 Treasury Management Strategy
- Considered the Risk Management Strategy and annual review
- Undertook a self -assessment of their own effectiveness against a best practice CIPFA framework
- Approved Constitution updates
- Noted a report on politically restricted posts

- Considered a report from the Information Assurance Manager in respect of National Audit Office Guidance on Cyber Security and Information Risk Guidance for Audit Committees
- Reviewed a report on and suggested changes to the unreasonable complaints policy
- Considered a complaint referred for determination against a Councillor
- Considered the Monitoring Officers annual report on the Standards of Conduct and adopted the revised hearing procedure

4. The Committee's Main Achievements / Outcomes

The Standards and Audit Committee aims to add value through its activity and, in particular has:-

4.1 Invited senior managers and officers to account for services where financial or internal control weaknesses have been identified. This helps to ensure that agreed actions are moved forwards promptly thereby reducing risk.

4.2 Reviewed progress against the implementation of internal audit recommendations which has led to a vast improvement in the number of recommendations implemented and a corresponding improvement in the control framework.

4.3 Asked for a further audit in 2019/20 of a high risk area which will give the Council assurance that the issues have been addressed.

4.4 Reviewed the strategic risk register to ensure that risks are being appropriately mitigated thus providing additional assurance that risk is being managed appropriately.

4.5 Scrutinised the statement of accounts prior to approval thereby ensuring that they are an accurate reflection of the Council's finances.

4.6 Reviewed the Code of Corporate Governance and approved the Annual Governance Statement and monitored progress against the Annual Governance Statement action plan. This ensures that the Annual Governance Statement is a true and fair view of the Council's governance and risk management arrangements.

4.7 Considered a complaint raised for determination against a Councillor. This ensures that Standards are upheld in a transparent way.

5 Conclusion

5.1 In conclusion, the Committee has continued to make a positive contribution to the Council's overall governance and control arrangements, including risk management. It is recognised that the Council has continued to face severe financial challenge however it is essential that good governance is maintained.

5.2 The Committee will continue to support the Council in the year ahead. In particular, it will continue to support the work of internal and external audit to ensure that recommendations are implemented in a timely fashion.

Councillor Mark Rayner (Chair)
Chesterfield Borough Council Standards and Audit Committee

For publication

INTERNAL AUDIT CONSORTIUM ANNUAL REPORT 2018/2019

Meeting: Standards and Audit Committee

Date: 17th July 2019

Cabinet portfolio: Governance

Report by: Internal Audit Consortium Manager

For publication

1.0 Purpose of report

1.1 The purpose of this report is to:-

- Present a summary of the internal work undertaken during 2018/19 from which the opinion on the internal control environment is derived.
- Provide an opinion on the overall adequacy and effectiveness of the Council's control environment including any qualifications to that opinion.
- Draw attention to any issues that need to be considered for inclusion in the Annual Governance Statement.
- Compare work actually undertaken with that which was planned and summarise performance.
- Comment on compliance with the Public Sector Internal Audit Standards (PSIAS).

- Comment on the results of the internal quality assurance programme.
- Confirm the organisational independence of internal audit
- Review the performance of the Internal Audit Consortium against the current Internal Audit Charter.

2.0 Recommendation

2.1 That the Internal Audit Consortium Annual Report for 2018/19 be accepted.

3.0 Report details

SUMMARY OF WORK UNDERTAKEN

3.1 Appendix A details the audit reports issued in respect of audits included in the 2018/19 internal audit plan. The appendix shows for each report the overall assurance level provided on the reliability of the internal controls and the assurance level given at the last audit. The report opinions can be summarised as follows:

Assurance Level	2017/18 Number	2018/19 Number	2018/19 %
Substantial	7	11	36
Reasonable	16	14	45
Limited	10	5	16
Inadequate	2	1	3
Total	**35**	**31**	**100**

3.2 A definition of the above assurance levels is shown in Appendix A.

3.3 There were no issues relating to fraud arising from the reports detailed in Appendix A.

3.4 The following table summarises the performance indicators for the Internal Audit Consortium as detailed in the Internal Audit Service Plan:

Description	2018/19		2019/20
	Plan	Actual	Plan
Cost per Audit Day	£287	£256	£285
Percentage of Plan Completed (CBC)	96%	97%	96%
Sickness Absence (Average Days per Employee)	8.0 (Corporate Trigger)	2.1	8.0
Customer Satisfaction Score (CBC)	85%	94%	85%
To issue internal audit reports within 10 days of the close out meeting (CBC)	90%	100%	90%
Number/proportion of audits completed within time allocation (CBC)	80%	79%	80%
% 2017/18 Agreed recommendations implemented (CBC) as at end March 19	80%	No longer calculable as audit recommendations in some areas have been built in to wider action plans	
Quarterly reporting to Standards and Audit Committee	100%	100%	100%

OPINION ON THE ADEQUACY AND EFFECTIVENESS OF THE CONTROL ENVIRONMENT

3.5 The Internal Audit Consortium Manager is responsible for the delivery of an annual audit opinion that can be used by the council to inform its governance system. The annual opinion concludes on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

3.6 In my opinion reasonable assurance can be provided on the overall adequacy and effectiveness of the council's framework for governance, risk management and control for the year ended 2018/19.

3.7 Assurance can never be absolute. In this context "reasonable assurance" means that arrangements are in place to manage key risks and to meet good governance principles, but there are some areas where improvements are required.

3.8 Overall, 81% of the areas audited received Substantial or Reasonable Assurance demonstrating that there are effective systems of governance, risk management and control in place.

3.9 There were 5 Limited Assurance reports issued during the year and 1 Inadequate Assurance report (careline, OSD property safety inspections, outdoor facilities, laptops and other removable media, sickness absence management and Rufford Close new build project), where only limited assurance on the reliability of internal controls can be given. Management have agreed the recommendations made and have either implemented them or are actively working towards implementing them.

3.10 Previous areas of weakness identified such as Health and Safety, ICT and Procurement are being addressed through longer term improvement plans and programmes.

3.11 Performance management procedures are in place to ensure that CMT receive regular reports in relation to outstanding audit recommendations in order that appropriate action can be taken.

3.12 The Standards and Audit Committee also receive a 6 monthly report in relation to outstanding audit recommendations. Where a limited or inadequate assurance audit report is issued, managers are also required to attend the Standards and Audit Committee to discuss progress and to provide assurance that recommendations are being implemented in a timely fashion.

3.13 In addition to the issues highlighted by internal audit Members should also be aware of other high risk areas that are highlighted within the Council's Corporate Risk Register. In particular:-

- Having a sustainable financial plan;
- Managing change effectively to deliver the required transformational changes and savings
- Workforce – ensuring the council has the right skills and capacity
- Investment and development of the ICT infrastructure
- Provision of social housing
- Emergency planning and business continuity arrangements
- The full impact of BREXIT is also unknown and may lead to further risks for the Council.

ISSUES FOR INCLUSION IN THE ANNUAL GOVERNANCE STATEMENT

3.14 The internal control issues arising from audits completed in the year have been considered during the preparation of the Annual Governance Statement. The issues surrounding budget and non-housing property repairs have been raised as significant governance issues within the annual governance statement. A recurring theme throughout audits was also in relation to workforce

capacity and capability and this too has been highlighted as a significant issue.

3.15 Other previous significant issues such as procurement, ICT and health and safety have been discussed with the Corporate Management Team and the Standards and Audit Committee. Action plans for these areas are in place and being monitored so whilst not fully resolved substantial progress has been made. These items are therefore not included within the Annual Governance Statement but are within the Annual Governance Statement action plan.

COMPARISON OF PLANNED WORK TO ACTUAL WORK UNDERTAKEN

3.16 The Internal Audit Plan for 2018/19 was approved by the Standards and Audit Committee on the 4th April 2018. All but one audit has been completed (rechargeable repairs / leaseholders – this audit has been deferred until the new computer system is in place). One further audit (housing repairs) has been completed but is in the process of being discussed with management and issued.

COMPLIANCE WITH THE PUBLIC SECTOR INTERNAL AUDIT STANDARDS AND OTHER QUALITY ASSURANCE RESULTS

3.17 During 2018/19 a self- assessment was undertaken to review compliance with the Public Sector Internal Audit Standards. The review confirmed that there were no significant areas of non- compliance.

3.18 In October 2016 the internal audit consortium was subject to an external review to ensure compliance with the Public Sector Internal Audit Standards. The review

concluded that the Consortium was compliant with and in places exceeded the requirements of the PSIAS but a number of recommendations were made to further enhance the service provided by the Consortium. This action plan has now been completed. An improvement spreadsheet has been introduced to identify further areas for improvement.

3.19 It can also be confirmed that the internal audit activity is organisationally independent. Internal audit reports directly to the Director of Finance and Resources but has a direct and unrestricted access to the Corporate Leadership Team and the Standards and Audit Committee.

3.20 Quality control procedures have been established within the internal audit consortium as follows:

- Individual Audit Reviews – Working papers and reports are all subject to independent review to ensure that the audit tests undertaken are appropriate, evidenced and the correct conclusions drawn. All reports are reviewed to ensure that they are consistent with working papers and in layout. Whilst these reviews may identify issues for clarification, the overall conclusion of the quality assurance checks is that work is being completed and documented thoroughly.

- Customer Satisfaction – A Customer Satisfaction Survey form is issued with each report. This form seeks the views of the recipient on how the audit was conducted, the report and recommendations made.

- Client Officer Views – A survey form has been issued to the client officer seeking his views on the overall performance of the Internal Audit Consortium for the

year in achieving the objectives set out in the Internal Audit Charter.

- All staff have been provided with a copy of the Public Sector Internal Audit Standards and the Internal Audit Manual has been updated to reflect the requirements of the standards and issued to all staff. A further review of the audit manual is scheduled for the summer of 2020.

3.21 The above quality control procedures have ensured conformance with the PSIAS.

3.22 Based on the customer satisfaction survey forms returned, the average score was 94% for customer satisfaction during 2018/19 (2017/18 result 95%).

3.23 The results of the Client Officer survey for Chesterfield were a score of 97% (a score of 34/35 over 7 questions).

REVIEW OF PERFORMANCE OF THE INTERNAL AUDIT CONSORTIUM AGAINST THE CURRENT INTERNAL AUDIT CHARTER

3.24 The Audit Charter was last reported to and approved by the Audit and Standards Committee in July 2018. The Charter is scheduled to be reviewed again in the summer of 2020.

3.25 Based on the information provided in this report on the completion of the 2018/19 internal audit plan, it is considered that the requirements of the Charter were met during the year.

3.26 There are no human resources implications.

3.27 There are no financial implications

3.28 There are no legal or data protection implications.

3.29 Risk Management **-** This report ensures that Members are aware of the work undertaken by internal audit during 2018/19 and their opinion on the adequacy and effectiveness of the systems in place at Chesterfield Borough Council.

3.30 Equalities Impact Assessment (EIA) - Not Applicable.

4 Alternative Options and Reasons for Rejection

4.1 Not Applicable.

5.0 Recommendation

5.1 That the Internal Audit Consortium Annual Report for 2018/19 be accepted.

6.0 Reasons for recommendation

6.1 To present to Members the annual report for the Internal Audit Consortium in respect of Chesterfield Borough Council for 2018/19.

6.2 To ensure compliance with the Public Sector Internal Audit Standards.

6.3 To provide an opinion on the overall adequacy and effectiveness of the Council's control environment including any qualifications to that opinion.

Decision information

Key decision number	
Wards affected	
Links to Council Plan priorities	Internal audit work aids in the Council's priority to provide value for money.

Document information

Report author	**Contact number/email**
Jenny Williams Internal Audit Consortium Manager	01246 345468 Jenny.williams@chesterfield.gov.uk
Background documents These are unpublished works which have been relied on to a material extent when the report was prepared.	
Appendices to the report	
Appendix A	Internal Audit Reports Issued 2018/19

Form to return to Democratic Services with report
(will be removed before publication)

Officers/members consulted on the report	
Communications	☐
Human Resources	☐
Finance	☐
Legal	☐
Information Assurance	☐
Consultation and Engagement	☐
Equality, diversity and human rights	☐
Cabinet member portfolio holder (and consultee cabinet member if applicable)	☐
Comments from Cabinet Member (if applicable)	
Went to Corporate Management Team on the 11th June 2019	

Appendix A

Chesterfield Borough Council – Internal Audit Reports Issued 2018/19

Ref	Report Title	Overall Opinion/ Assurance	
		2018/19	Previous Audit
1	Social Media	Reasonable	N/A
2	Market Hall Cafe	Reasonable	N/A
3	OSD Property Safety Inspections	Limited	Satisfactory
4	Careline	Limited	Marginal
5	Crematorium	Substantial	Reasonable
6	Council Tax	Reasonable	Reasonable
7	Healthy Living Centre Income	Substantial	Satisfactory
8	Non Domestic Rates	Substantial	Reasonable
9	Queens Park Sports Centre	Reasonable	Marginal
10	QPSC Café Income	Reasonable	N/A
11	Treasury Management	Substantial	Substantial
12	Bank Reconciliation	Substantial	Satisfactory
13	Insurance	Reasonable	Satisfactory
14	Housing Benefit / CTax Support	Substantial	Substantial
15	Outdoor Facilities Income	Limited	Satisfactory
16	Markets Income	Reasonable	Satisfactory
17	Private Sector Housing Grants	Reasonable	Satisfactory
18	Cash and Banking	Substantial	Substantial
19	Housing Rents Accounting System	Substantial	Reasonable
20	Accounts Payable	Reasonable	Reasonable
21	Laptops and Removable Media	Limited	N/A
22	Payroll	Reasonable	Reasonable
23	Payroll Client Officer	Reasonable	N/A
24	Sickness Absence Management	Limited	N/A
25	Agresso FMS	Substantial	Substantial
26	Sheffield City Region Projects	Substantial	Substantial
27	Commercial Works	Reasonable	N/A
28	Accounts Receivable	Substantial	Substantial
29	Housing Capital Programme	Reasonable	Good
30	Rufford Close new build project*	Inadequate	N/A
31	Core Fleet	Reasonable	N/A

*This report will form part of the Council's wider investigation reporting into Rufford Close. These investigations are currently ongoing and developing and cannot be reported on at this time. When the Rufford Close investigations report is concluded in the coming months it will be reported back to the Audit and Standards Committee.

Internal Audit Assurance Level Definitions

Assurance Level	Definition
Substantial Assurance	There is a sound system of controls in place, designed to achieve the system objectives. Controls are being consistently applied and risks well managed.
Reasonable Assurance	The majority of controls are in place and operating effectively, although some control improvements are required. The system should achieve its objectives. Risks are generally well managed.
Limited Assurance	Certain important controls are either not in place or not operating effectively. There is a risk that the system may not achieve its objectives. Some key risks were not well managed.
Inadequate Assurance	There are fundamental control weaknesses, leaving the system/service open to material errors or abuse and exposes the Council to significant risk. There is little assurance of achieving the desired objectives.

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For publication

Review of Unreasonable Complaints Policy

MEETING:	1.	Standards and Audit Committee
DATE:	1.	17TH July 2019
REPORT BY:		Local Government And Regulatory Law Manager Monitoring Officer

For publication

1.0 **Purpose of report**

1.1 To report to members on the use and application of the Council's Policy and Procedure on the Management of Unreasonable Complaints or Customers ("the Policy").

2.0 **Recommendations**

2.1 That the report is noted.

2.2 Information is added about its application to paragraph 1.11 of the Policy.

3.0 **Background**

3.1 On 4th October 2016 the Cabinet Member for Governance approved the Council's policy for dealing with unreasonable complainants or complaints. This replaced an earlier policy.

3.2 It is a requirement of the Policy that it be reviewed annually by this Committee. This report is the second review of the Policy, the first review was considered by this committee on 23rd May 2018.

3.3 A copy of the Policy is attached at Appendix A. The Policy provides guidelines for its application, taking account of current Ombudsman advice and relevant legal cases. The policy sets out a clear and proportionate procedure for warning the complainant and imposing restrictions, with provision for review and right of appeal.

4.0 Application of the Policy

4.1 Since the adoption of the Policy the Council has continued to manage complaints received from the public through the Complaints, Comments and Compliments Policy. During this time there have been only a very small number of complaints which may have warranted consideration of whether or not to apply the Policy.

4.2 The Policy was first applied in March 2017, and the May 2018 report considered the effectiveness of the use of the policy, use of which was also examined and upheld by the Local Government and Social Care Ombudsman. Some changes were incorporated into the policy as a result of the experience of its application.

4.3 A review of the 2017 application of the Policy was facilitated by a meeting in summer 2018 between the relevant assistant director, the complainant and the single point of contact. It led to the withdrawal of the restrictions which had been placed on the complainant because of a satisfactory change in their behaviour.

4.4 The policy was applied in February 2018 in relation to the high number, persistence, duration, repetition and often threatening phone calls from a complainant on a tenancy related matter, taking up an unreasonable amount of staff time, engaging staff at different levels and leading to duplication of effort and the need for detailed communication between those staff to avoid issues being overlooked. The contact prevented staff carrying out other work and caused harassment and distress.

4.5 A single point of contact was appointed. In addition the complainant was warned to modify their behaviour, and was asked to accept that the matters complained about needed to be investigated stage by stage and to ask for updates only when there had been a reasonable opportunity to progress matters. They were asked to avoid repetition of information when contacting the council. The complainant was asked to stop making threats of taking legal action, going to the media, or using a threat of potential violence to another tenant, as a way of securing faster action. The complainant was also advised on how to make a complaint about staff if they chose to. The complainant did not appeal against the warning.

4.6 The policy was applied again in August 2018 by a service manager. This use related to a longstanding complaint about staff and followed a letter to the complainant from the Chief Executive at the final stage of the complaints procedure. The policy was applied because the complainant had acted towards staff in a way that caused, or was likely to cause them nuisance, annoyance, harassment or distress. The complainant had also made unfounded and unjustified allegations against specific staff and had addressed them using insulting terms on repeated occasions.

4.7 It was considered appropriate to apply the policy in order to protect council staff, using the Policy rather than taking legal action (which was also considered justifiable). A warning was issued, with a request that any contact with the council should be without using words or conduct threatening, intimidating, abusive, aggressive or malicious to council staff. It was made clear that this did not restrict access to council services, or the right to express dissatisfaction about them.

4.8 The complainant appealed against the application of the Policy. The appeal was considered by one of the Executive Directors in December 2018. The complainant had asked for an independent public hearing of his complaint. They also complained about delay in their appeal being dealt with which they saw as evasive and a cover up. An independent hearing was not considered appropriate as under the Policy the Executive Director was a senior officer with no previous involvement with the matter available to consider the matter. The delay had been due to the Council's email security filter preventing delivery.

4.9 The Executive Director reviewed the decision to apply a warning under the policy and, after carefully considering relevant documents, other evidence and interviewing staff, concluded that there was sufficient evidence for the council to take action under the policy. Allegations of fabrication, criminality and vindictiveness of staff were rejected. Use of a warning was considered proportionate, and language used by the complainant when pursuing his appeal was also evidence of breach of the warning. The complainant was reminded of their right to take their complaint about application of the Policy to the Ombudsman. There has been no further contact by the complainant since the Executive Director's review and here have been no further incidents. I am not aware of this matter being taken to the Ombudsman at the time of writing this report.

4.10 In both cases the complainant was provided with a copy of the policy and their right of appeal, complain to the Ombudsman and to take independent legal advice.

5.0 **Review of the Policy**

5.1 The Policy has again proved to be an effective way of managing a persistent/unreasonable complaint. It has achieved its intended outcome by reducing inappropriate contact with services and has protected staff.

5.2 While use of the policy is still fairly slow to apply and fairly cumbersome in view of the various appeal stages, these stages help ensure that the complainants' rights are protected and proper consideration is given before the policy is applied. It is important to ensure that any application of the Policy follows these procedures in order to help ensure a complaint to the Ombudsman will be less likely to succeed on procedural grounds.

5.3 No changes to the policy are recommended as the result of its application or this review, other than to add the number of times the Policy has been applied, and it appears to have been robust enough to deal with the issues.

6.0 **Recommendations**

6.1 That the report is noted.

6.2 Information is added about its application to paragraph 1.11 of the Policy.

7.0 **Reason for recommendations**

7.1 To enable completion of the review of the Policy by the Committee and to ensure an effective Policy in the light of experience from its application.

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POLICY AND PROCEDURE ON THE MANAGEMENT OF UNREASONABLE COMPLAINTS OR CUSTOMERS

1.0 Introduction

1.1 This policy and procedure is aimed at providing a framework:

(i) to help identify what might be classed as an unreasonable complaint or customer;

(ii) to manage the Council's limited resources to help ensure that customers have access to our limited resources in a way which is proportionate to the issues being raised and the need for other customers to be able to access these limited resources;

(iii) to set out openly how we will deal with unreasonable complaints or customers, what steps we will take if action is required and who can authorise these actions

(iv) which we can provide to customers where this policy and procedure is applied so that the customer can understand the process. This may help to manage the customer's expectations and behaviour.

1.2 The council aims to deal with complaints and customers in a way which is fair and impartial. On occasion customers may behave unreasonably or make unreasonable complaints. Unreasonable customers or complaints can hinder the proper consideration of their cases and may delay consideration of other customers' cases. Unreasonable complaints or customers can have significant resource implications for the Council.

1.3 Customers may sometimes act out of character at times of anxiety or distress and/or their conduct may relate to a disability. Reasonable allowances should be made for such factors. Ultimately, however, the council does not expect its staff to suffer behaviour or complaints by customers which is/are unreasonable in content, tone or persistence. In appropriate circumstances the Council will take proportionate action to protect the wellbeing of its staff, members and contractors and also the integrity of its processes and limited resources.

1.4 If the Council considers that any unreasonable conduct or complaint is or might be related to a disability, or because the customer's first language is not English, the Policy and Communications Manager should be consulted for advice and assistance to manage the issues arising under this policy and procedure where appropriate.

1.5 When considering this policy and procedure the Council will also have regard to other relevant policies and procedures operated by the Council which may include (but not be limited to):

- Chesterfield Borough Council Access statement (https://www.chesterfield.gov.uk/living-here/people-and-families/equality-and-diversity/access-statements.aspx)
- Equality, Diversity and Social Inclusion Policy (https://www.chesterfield.gov.uk/living-here/people-and-families/equality-and-diversity/equality-diversity-and-social-inclusion-policy.aspx)
- Aggressive customer behaviour – guidance to employees (https://aspire.interactgo.com/Interact/Pages/Content/Document.aspx?id=1670)

When this policy is engaged it shall take precedence over these policies in the event of any uncertainty as to different processes to be applied.

1.6 Where this policy and procedure is engaged the Council may take action to restrict conduct of the customer and access to Council services . Examples of the sort of restrictions which may be imposed are given in section 3.6 below. In the most serious cases the Council may bypass this policy and procedure and inform the police and/or take legal action with or without notice to the individual(s) concerned.

1.7 Where restrictions are applied and/or legal action taken the Council will take steps to inform those who it reasonably determines ought to be aware of the steps / action taken and the outcome. The steps taken will depend on the facts of each case.

1.8 It is to be emphasised that this document is a framework. It is not intended to be prescriptive since it is recognised that in those rare situations where customers behave unreasonably or make unreasonable complaints such that this policy and procedure is or might be engaged, each case will need to be considered on its own facts.

1.9 This policy and procedure has been drafted with regard to the Local Government Ombudsman's current guidance note on managing unreasonable complainant behaviour[1]. It will be reviewed annually and such reviews will take account of any updated guidance from the Local Government Ombudsman.

1.10 When the Council is faced with what it regards as vexatious Freedom of Information Act [FOIA] requests it will have regard to relevant guidance from the Information Commissioner's Office [ICO][2] and its own internal policies and procedures when determining such matters, noting that a request may be

[1] http://www.lgo.org.uk/information-centre/reports/advice-and-guidance/guidance-notes/guidance-on-managing-unreasonable-complainant-behaviour

[2] https://ico.org.uk/media/for-organisations/documents/1198/dealing-with-vexatious-requests.pdf

refused if it is vexatious[3] but that in that situation the test as to whether the request is vexatious applies to the request itself and not to the individual who makes it. Accordingly the engagement of this policy and procedure cannot of itself remove the obligations of the Council under the FOIA. Similarly with a subject access request the Council will have regard to such guidance as is available from the ICO[4] as well as its own policies and procedures for dealing with such matters.

1.11 It is anticipated that this policy will be invoked in only a very small number of cases. During the period between adoption in December 2013 and August 2016 the previous version of this policy was not invoked at all. Since adoption of this current policy it was applied once in 2017 and twice in 2018.

2.0 Unreasonable Complaints or Customers

2.1 There is no single definition of an unreasonable complaint or customer. Each case must be judged on its merits.

2.2 An unreasonable customer may pursue a justified complaint or concern but in an inappropriate way. Alternatively they may pursue a complaint which has no substance or which has previously been addressed in which case the complaint might be judged to be unreasonable. The concept of 'unreasonableness' is typically identified by a customer conducting themselves in such a manner as to hinder the Council's consideration of their own or other people's complaints and by the customer conducting themselves in such a manner as to place a disproportionate demand on the Council's resources. The conduct of an unreasonable customer may cause a disproportionate or unjustified level of disruption, irritation, stress or distress to Council staff or the Council's contractors / partners.

2.3 Whilst each case will ultimately turn on its own facts this policy and procedure may be engaged by one or two isolated unreasonable incidents or a build-up of incidents or behaviour over time which amount to unreasonable conduct. The focus is whether in all of the circumstances the complaint and/or customer are unreasonable. Examples of the sort of customer complaint and/or conduct which might be covered by this policy and procedure include (but are not limited to):

- Refusing to specify the grounds of a complaint despite offers of help
- Making a complaint or complaints which have no proper grounds

[3] The term 'vexatious' involves the manifestly unjustified, inappropriate or improper use of procedures. All circumstances must be considered but there will typically be a disproportionate or unjustified level of disruption, irritation or distress. When considering whether a request is 'vexatious' the focus should be on the impact of the request(s) rather than the behaviour of the requester

[4] https://ico.org.uk/for-organisations/guide-to-data-protection/principle-6-rights/subject-access-request/ See section *What about repeated or unreasonable requests?*

- Unreasonably frequent or lengthy contacts and/or repetitive information
- Pursuing a complaint only to annoy or disrupt or for reasons that are not identified or are not obvious
- Refusing to co-operate with the complaints investigation process but still wanting the complaint to be resolved
- Making unjustified complaints about staff who are dealing with issues and trying to have them replaced
- Refusing to accept that issues are not within the remit of the Council's Complaints, Comments and Compliments Procedure despite having been provided with information about the procedure's scope
- Insisting on the complaint being dealt with in ways which are incompatible with the Complaints, Comments and Compliments procedure or with good practice (for example insisting that there should be no written record of a complaint or aspects of a complaint)
- Electronically recording meetings and conversations without the prior knowledge and consent of the other person involved
- Where a complainant pursues a disproportionately large number of complaints with the Council or raises a multitude of unimportant questions
- Where a complainant pursues a 'scatter gun' approach of approaching multiple external organisations with parallel complaints about the Council
- Unreasonably repeating complaints which have previously been addressed (and as part of that perhaps seeking to add minor or immaterial additions to earlier complaints after the event as a basis for seeking to re-open investigations)
- Obstructing reasonable access for council staff (or agents) to tenanted properties or insisting upon unreasonable conditions for access
- Persistently seeking to complain about matters that occurred outside of the one year time period usually allowed for the investigation of complaints without good reason
- Acting towards staff or Council contractors or partners in a manner which causes or is likely to cause them nuisance or annoyance or harassment or distress
- Persisting in conduct which the customer has been told is unreasonable

3.0 Managing Contact

3.1 The Council operates a policy and procedure which has proved effective when addressing Complaints, Comments and Compliments. This policy and procedure for the management of unreasonable complaints or customers will be used only where the Council's day to day policies are unable to resolve the issues arising and where the complaint and/or the customer are deemed to be unreasonable.

3.2 If an officer of the Council considers that a complaint and/or customer are unreasonable they should discuss their concerns, and the reasons for their concerns, with a member of the Corporate Management Team or Senior Leadership Team.

3.3 **Warning**: A Service Manager, a member of the Corporate Management Team or Senior Leadership Team may determine that the complaint and/or customer are unreasonable and that it is proportionate to issue a warning to the customer under this policy and procedure. The officer who determines that a warning shall be issued will write to the customer concerned within 3 working days of that determination setting out:

(i) why their complaint or conduct has been considered unreasonable
(ii) that this policy and procedure has been invoked
(iii) that a warning is being given to them under paragraph 3.3 of this policy and procedure
(iv) what the customer is being asked to do to address the concerns raised
(v) a request for the customer to consider the letter and amend their complaint or conduct (as appropriate)
(vi) the actions which may be taken by the Council if the concerns raised are not addressed adequately (this will include informing the customer of the power of the Council to impose a restriction or restrictions on contact with the Council, the fact that any restriction(s) may be applied for a specified time period and how any restriction(s) might enable any continuing complaint or information request to be managed within the complaints policy or such other policy as is relevant)
(vii) the right of the customer to appeal against the decision to invoke this policy and issue a warning (with reference to paragraphs 3.11 - 3.16 of this policy and procedure)
(viii) an opportunity for the customer to write to the author of the letter to respond to the warning if he / she has proposals to address the Council's concerns and avoid further escalation
(ix) suggestions on how the customer might obtain independent legal or other advice
(x) details of the customers right to complain to the Local Government Ombudsman or Housing Ombudsman about the engagement of this policy and procedure and/or any determinations made pursuant to it

The customer should be sent a copy of this policy and procedure at this stage.

The circumstances of the complaint might mean that a warning under this policy is not appropriate, for example (but not limited to) where there have been previous warnings given in relation to the behaviour, or in the event of behaviour by the complainant causing serious distress.

3.4 **Apply an appropriate restriction:** If, notwithstanding a warning, the unreasonable complaint(s) persist(s) and/or the customer continues to be unreasonable then the officer of the Council who issued the formal warning (or another officer of the Council being of equal seniority or more senior to that officer) will determine whether a restriction or restrictions ought to be applied and, if so, the details of the restriction(s) (including their duration and the period of time after which the restriction(s) may be reviewed).

3.5 The customer will be notified in writing of any determination to apply a restriction or restrictions. A decision letter applying a restriction or restrictions

will be written by the officer who has made the determinations set out in paragraph 3.4 above. The decision letter should contain:

(i) the date of the warning
(ii) a summary of the concerns raised previously and the previous steps required of the complainant to address the concerns
(iii) the determination that the concerns have not been addressed adequately or at all and the reason(s) supporting this determination
(iv) the restriction(s) imposed on the customer's contact with the council (which will be proportionate and aimed at addressing the customer's unreasonable complaint(s) and/or conduct and removing ongoing or future prejudice to the Council and/or its staff and/or contractors)
(v) the period of time the restriction(s) is/are being put in place for
(vi) the period of time before the restriction(s) will be reviewed (this is typically 6 months but will depend on the facts of the case)
(vii) the customer's right of appeal against the determination (pursuant to paragraphs 3.11 - 3.16 of this policy and procedure)
(viii) suggestions on how the customer might obtain independent legal or other advice
(ix) details of the customers right to complain to the Local Government Ombudsman or Housing Ombudsman about the engagement of this policy and procedure and/or any determinations made pursuant to it

The letter should also enclose a further copy of this policy and procedure.

3.6 Any restrictions which may be applied by the Council (under paragraphs 3.4 and 3.5 of this policy and procedure) will be determined on consideration of the facts of the individual case at the time but they may include one or more of the following:

- Placing limits on the number and duration of contacts with staff
- Restricting telephone calls to specified days and limited times
- Limiting the customer to one method of contact (e.g. letter or email)
- Requiring the customer to communicate with one named member of staff
- Requiring any personal contacts to take place in the presence of a witness and in a suitable location
- Managing contacts with the assistance of an independent advocate
- Refusing to register and process further complaints save for new matters which are considered by the Council to be appropriate for investigation
- Stating that future correspondence will be read by a designated officer and placed on the file but not acknowledged unless it contains material new information
- Ending correspondence on particular issues and referring the matter to the Ombudsman where appropriate

This list is not exhaustive since each case must be considered on its facts.

3.7 **Reviews:** When the time comes for the restriction(s) to be reviewed the review shall be conducted by the officer who applied the restriction(s) or by

another officer who is of equal or greater seniority to the officer who applied the restriction(s).

3.8 The outcome of a review may be that the restriction(s) shall remain in force, be varied or be discharged. The officer who has made the determination on review should write to the customer with the decision on review within three working days of making the decision.

3.9 Where the review results in the restriction(s) being discharged the customer should be informed of this within the timescale set out at paragraph 3.8 of this policy and procedure.

3.10 Where the outcome of the review is that the restriction(s) remain in place following a review (whether in the form originally determined or in some varied form) then a decision letter should be sent within the timescale set out at paragraph 3.8 of this policy and procedure. The decision letter should contain:

(i) the date of the imposition of the original restriction or restrictions and a copy of that decision letter
(ii) a summary of the decision on review and key reasons for the decision
(iii) the period of time before the restriction(s) will next be reviewed
(iv) the customer's right of appeal against the decision (pursuant to paragraphs 3.11 - 3.16 of this policy and procedure)
(v) suggestions on how the customer might obtain independent legal or other advice
(vi) details of the customers right to complain to the Local Government Ombudsman or Housing Ombudsman about the decision

The letter should also enclose a further copy of this policy and procedure.

There might be circumstances where it is impracticable for a review to be carried out or it needs to be postponed, for example during an Ombudsman investigation into application of the policy. In such cases the customer should be kept informed of the reasons why the review has not taken place and anticipated timescale for its completion.

3.11 **Right to Appeal:** Subject to the time limits set out in paragraph 3.12 of this policy and procedure the customer has a right of appeal to the Council against:

(i) the decision to invoke this policy and issue a warning (including the determination sent to the customer under paragraph 3.3 of this policy and procedure);
(ii) the decision to apply any restriction(s) and/or the decision as to the duration of the restriction(s) and/or the decision as to the period of time after which the restriction(s) may be reviewed (including the determination sent to the customer under paragraph 3.5 of this policy and procedure); and
(iii) the decision to keep a restriction or restrictions in place following review (whether in their original form or a varied form) including the

determination sent to the customer under paragraph 3.10 of this policy and procedure.

The customer may also make a complaint to the Local Government and/or Housing Ombudsman (as appropriate) at any time.

3.12 Any request to appeal to the Council must be made in writing and must be received by the Council's Monitoring Officer within 21 calendar days of the date of the decision being appealed. For the purpose of calculating the deadline for receipt of an appeal the date of the decision being appealed will be taken to be two working days after the date of the decision letter.

3.13 A request for an appeal made within time shall be considered and determined by an officer of the Council who has had no previous involvement with the case and who is more senior than the officer whose decision is being appealed. Where there is no officer in the Council who is able to determine the appeal the Monitoring Officer may appoint a suitably qualified or experienced senior officer from another authority or a solicitor/barrister to determine the appeal. Where an officer of another authority is appointed to determine an appeal they shall be more senior than the officer whose decision is being appealed.

3.14 The decision on appeal should ordinarily be sent to the customer within 21 days of receipt of the appeal by the Council. An appeal is by way of review of the earlier decision.

3.15 A decision letter on appeal should contain:

(i) the date of receipt of the appeal
(ii) a summary of the decision on appeal and key reasons for the decision
(iii) any practical implications arising from the decision on appeal (e.g. if a restriction is retained in principle but varied then what that means for the customer and when the next review of the varied restriction will be)
(iv) a statement that there is no further right of appeal to the Council against this decision
(v) suggestions on how the customer might obtain independent legal or other advice
(vi) details of the customers right to complain to the Local Government Ombudsman or Housing Ombudsman about the decision.

The letter should also enclose a further copy of this policy and procedure.

3.16 A decision on appeal is a final decision by the Council on those matters contained within the decision. There is no second appeal from a decision on appeal to the Council. The decision letter on appeal will signpost the customer to the Local Government Ombudsman or Housing Ombudsman (as appropriate) should they be dissatisfied at this stage.

3.17 **Where a customer ignores the restrictions applied:** If the issue(s) of unreasonableness persist(s) after the imposition of a restriction or restrictions

then the officer who applied the restriction(s) or an officer more senior than the officer who applied the restrictions (and in any event an officer of at least Executive Director level) may make the decision to impose further restrictions e.g. terminating further contact with the customer on current issues and/or ending any ongoing investigations which are underway. In such a case the customer will be informed in writing of this decision and the reasons for it. There will be no right of appeal to the Council against such a decision. The customer will instead be signposted to the Local Government Ombudsman and/or Housing Ombudsman (as appropriate) should they wish to make a complaint. In a serious case the Council may bypass this policy and procedure and make a report to the police and/or take legal action with or without notice to the customer(s) concerned.

3.18 Where further restrictions are applied and/or legal action is taken the Council will take steps to inform those who it reasonably determines ought to be aware of the steps / action taken and the outcome. The steps taken will depend on the facts of each case.

3.19 **New Matters**: Where a customer who is subject to any restriction(s) raises a new matter following the imposition of the restriction(s) the Council will consider whether the new matter has merit and ought to be considered further. The Council will inform the customer whether the new matter will be considered and, if so, how the restrictions in force will apply (if at all) to the new matter. Where the Council declines to consider a new matter the customer will be informed in writing and signposted to the Local Government Ombudsman and/or Housing Ombudsman as appropriate should they wish to complain further.

3.20 **Where a breakdown in communication occurs:** Very occasionally relations between a council and a customer might break down completely while a complaint is under investigation such that there is little prospect of achieving a satisfactory outcome. In such cases there may be nothing to gain from following through all stages of an organisation's complaints procedure. In such exceptional circumstances the Ombudsman may be prepared to consider a complaint before the Council's own procedures have been exhausted. The Council may seek advice from the Ombudsman and/or request the Ombudsman to consider the matter if it considers that such a situation has arisen. Where the Council does so it will inform the customer in writing so that the customer may express his or her views to the Council and/or Ombudsman if they wish to do so.

4.0 Recording and Reporting use of this policy

4.1 Records relating to the application of this policy and procedure will be kept by the Customers, Commissioning and Change Manager and shared with appropriate senior managers and as necessary within the Council. These records should include:

- details of requests to invoke this policy and procedure which are not supported by the relevant senior manager
- the name and address of each customer where this policy and procedure has been invoked
- the number of warnings which have been issued
- what restriction(s) is / are in force and for what period
- the number of determinations which have been appealed and the outcome of those appeals
- the number of reviews carried out and the outcome of those reviews
- whether legal action was taken and, if so, details of the action taken and the outcome(s)
- who within the Council was advised of any restrictions
- all correspondence relating to this policy and procedure sent between customer(s) and the Council (and any relevant third party e.g. Local Government Ombudsman or Housing Ombudsman)
- the success of the policy in those cases where it has been invoked
- the number of Ombudsman referrals and the outcome of each referral

4.2 An annual report will be provided to the Standards & Audit Committee with information about the application of and success of this policy and procedure during the year and any recommendations for amendment

Reviewed July 2019

For publication

Risk Management Strategy and Annual Review

Meeting:	(1) Council (2) Standards and Audit Committee
Date:	(1) 17th July 2019 (2) 17th July 2019
Cabinet Portfolio	Cabinet Member for Governance
Report by:	Director of Finance & Resources

For publication

1.0 Purpose of report

1.1 To provide a report on the Risk Management developments during 2018/19 and to update the Risk Management Policy, Strategy and the Corporate Risk Registers for 2019/20.

2.0 Recommendations

2.1 To note the progress made on developing the Council's approach to risk management during 2018/19.

2.2 To recommend to the Full Council the approval of the Risk Management Policy, Strategy and the Corporate Risk Register for 2019/20.

3.0 Background

3.1 The Risk Management Strategy requires an annual review to be reported to the Council at the end of the financial year and the Corporate Risk Register at the start of the year.

3.2 The Standards and Audit Committee is required to consider the effectiveness of the Council's risk management arrangements.

4.0 Annual Insurance Review 2018/19

4.1 The Council has numerous revised insurance lots and insurance providers appointed across all policies which became active on the 1st October 2017.

4.2 Contracts were awarded for 7 years with an option for the Council to cancel the contract at the end of either year 3 and 5.

4.3 The tender process completed in 2017/18 enabled the Council to:-

- Achieve an annual savings of £187k per annum
- Maintain existing levels of cover / excesses and in some area obtain better coverage e.g. additional perils such as 'escape of water' for municipal buildings
- Appoint insurance companies who are well established in the local government market (Aspen and Zurich Municipal)

5.0 Risk Management Policy and Strategy

5.1 The Policy and Strategy documents are designed to clarify the corporate and operational elements and to further embed Risk Management within the organisation. The documents for 2019/20 are included in Appendix A.

6.0 Corporate Risk Register (CRR)

6.1 The management of corporate risks is an essential component of good governance and helps to ensure the delivery of services. It is therefore important that the CRR is reviewed regularly to take account of any changes in risk levels and to identify any new risks.

6.2 The content of the CRR had been reviewed and updated for 2019/20 via the Risk Management Group. Many of the corporate risks will be a permanent feature within the CRR whilst others, which relate to one-off type projects, will appear only for a limited period. The CRR Summary for 2019/20 is shown in Appendix B and the detailed Corporate Risk Register is shown in Appendix C.

6.3 The challenge for 2019/20 will be to implement the further actions highlighted or any other actions subsequently developed to bring the risk ratings to the 'target' level which reflects the Council's risk appetite i.e. the level of risk it is prepared to accept.

7.0 Risks and Uncertainties

7.1 The failure to have effective risk management arrangements in place which will identify and manage risk could have serious consequences for the Council. The current key (red) risks to the Council in Appendix B/C are currently:

Description of Risk
CR1- Having a Sustainable Financial Plan - the ability to deliver priority services with the resources available. Note: resourcing (staffing) is a continued constraint for a number of services
CR4 - Investment & development of the ICT infrastructure - to ensure that a modern, efficient and reliable infrastructure is in place to support service delivery.

CR9 - Procurement & Contract Management - to ensure that contracts are procured properly and deliver value for money. Note: The Veolia waste services contract renewal will be a key procurement in 2019
CR 15 – Non-Housing Maintenance Programme & Funding i.e. funding and delivering the backlog in investment needed across our estate

7.2 An evaluation of each of the Corporate Risks is included in Appendix B and C.

8.0 Financial Implications

8.1 The Council transfers funds during the year to maintain a £5k balance on the Risk Management Reserve which is managed by the Corporate Risk Management Group. The movements on the reserve during 2018/19 were as follows:

Description	**£**
Balance b/fwd April 2018	5,000
Add contribution for the year	5,000
Less expenditure/commitments:	
Transfer to Budget Risk Reserve	(5,000)
Balance c/fwd at 31st March 2019	5,000

8.2 The Council also maintains a number of earmarked reserves and provisions to cover the financial risks that it faces. The funds include the General Working Balance, the Budget Risk Reserve and the Insurance Reserve.

9.0 Equalities Consideration

9.1 None arising from the contents of this report.

10.0 Recommendations

10.1 To note the progress made on developing the Council's approach to risk management during 2018/19.

10.2 To recommend to the Full Council the approval of the Risk Management Policy, Strategy and Corporate Risk Register for 2018/19.

11.0 Reason for Recommendation

11.1 To ensure that effective risk management monitoring and reporting arrangements are in place.

Decision information

Key decision number	**884**
Wards affected	**All**
Links to Council Plan priorities	

Document information

Report author	**Contact number/email**
Kevin Hanlon	**Ext. 5451**
Background documents These are unpublished works which have been relied on to a material extent when the report was prepared.	
Appendices to the report	
Appendix A	Risk Management Policy and Strategy
Appendix B	Corporate Risk Register Summary
Appendix C	Corporate Risk Register (Detail)

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APPENDIX A

Chesterfield Borough Council

Risk Management Strategy

Version:	June 2019
Ratified By:	Corporate Risk Management Group
Date Ratified	TBC
Name of Executive Lead	Director of Finance and Resources
Date Issued	July 2019
Review date:	June 2019

Contents

Risk Management Statement

It is the Council's policy to proactively identify, understand and manage the risks inherent in our services and associated within our plans and strategies, so as to encourage responsible, informed risk taking.

Risk management is all about understanding, assessing and managing the Council's threats and opportunities. The Council accepts the need to take proportionate risk to achieve its strategic objectives, but expects these to be appropriately identified, assessed and managed. Through managing risks and opportunities in a structured manner, the Council will be in a stronger position to ensure that we are able to deliver our objectives.

As a result, through risk management, the aims & objectives of Chesterfield's Risk Management Strategy are:

- Ensure that risk management becomes an integral part of corporate and service planning, decision making & project management.
- Enable the Council to deliver its priorities and services economically, efficiently & effectively.
- Protect the council's position when entering into new partnerships and/or evaluating existing partnerships.
- Align risk management and performance management to drive improvement and achieve better outcomes.
- Guard against impropriety, malpractice, waste and poor value for money.
- That risk management training forms part of the normal training / induction programmes that are given to officers and members on an on-going basis.
- Ensure compliance with legislation, such as that covering the environment, health and safety, employment practice, equalities and human rights.
- Minimise the prospects of any damage to the Council's reputation and/or undermining of public confidence in the organisation.
- To have a performance framework that continues to allow managers to proactively track performance, and assess / deal with risk in a timely fashion.

We recognise that it is not always possible, nor desirable, to eliminate risk entirely. However, visibility of these areas is essential, so that the Council can explore external options, such as insurance.

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Risk Management Strategy

1. Introduction

The effective management of risk is an important principle for all businesses to properly address. For local authorities such as Chesterfield, managing risk is a key element of our Corporate Governance responsibilities.

Risk Management has become an important discipline across all sectors of the economy since the turn of the decade. The Audit Commission has previously highlighted Risk Management as one of the key elements to having effective governance arrangements in place to meet corporate objectives.

This risk management strategy seeks to promote the identification, assessment and response to key risks that may adversely impact upon the achievement of the Council's stated aims and objectives. It also seeks to maximise the rewards that can be gained through effectively managing risk.

Risk Management is not new; the Council has been doing it effectively for many years. However, to comply with the Corporate Governance requirements the Council must ensure that its procedures are sufficiently formalised and reviewed at regular intervals to identify areas for improvement.

This strategy has been updated to clarify the arrangements for managing risk and to further embed Risk Management within the thinking of all Council employees, Officers and Members.

1.1 Purpose and objectives of the Strategy

The purpose of this Risk Management Strategy is to establish a framework for the effective and systematic management of risk, which will ensure that risk management is embedded throughout the Council and makes a real contribution to the achievement of the Council's vision and objectives. As a result, the objectives of this strategy are to:

- Define what risk management is about and what drives risk management within the Council;
- Set out the benefits of risk management and the strategic approach to risk management;
- Outline how the strategy will be implemented; and
- Identify the relevant roles and responsibilities for risk management within the Council.

Effective risk management will require an iterative process of identification, analysis, and prioritisation, action, monitoring and reporting of material risk. The processes required to deliver these objectives will need to ensure:

- Clear identification of corporate aims and priorities, service objectives and key actions.
- Specification of roles and responsibilities in respect of risk management activities.
- Consideration of risk as an integral part of corporate and business processes.
- Requirements to analyse, prioritise, respond to, monitor and report on material and significant risks.
- Specification of guidance and support arrangements to assist officers in their consideration of risk.
- Facilitation of shared organisational intelligence and learning.

1.2 The Scope of Risk Management

Risk is anything that may prevent the Council from achieving its stated objectives. Risk management is the process of identifying what can:

a. Go wrong, and then doing something about it; and/or
b. Be an opportunity, and then trying to take advantage of it.

Risks will be managed through a series of provisions applying at different levels. These include:

- Expression of the corporate risk tolerance in corporate aims and service plans through application of our risk scoring methodology.
- At operational level by budget allocation and monitoring through effective performance management arrangements.
- At project level through application of established risk assessment techniques in compliance with business continuity planning.
- Good corporate governance provisions as provided by the Standards & Audit Committee's Terms of Reference.
- Incorporated into the Council's Annual Governance Statement.
- Examination of corporate and insurable risks to identify risk reduction measures (Corporate Risk Management Group).
- Provide for risk assessment evidence in all decision making processes of the Council by inclusion in Committee reportage.

- Maintain documented procedures, toolkits and guidance for use across the Council by application of the risk register process and usage advice.

- Provide officers with suitable information and training to enable them to perform their duty (Corporate Risk Management Group).

- Make all partners, providers and delivery agents aware of the Council's expectations on risk, both generally as set out in the Risk Management Policy, and where necessary, in particular areas of service delivery

1.3 Risk Management Definitions

There are a number of ways in which organisations express risks and as a result, the risk management definitions can vary. Therefore, we have included a risk management glossary of the Councils risk management definitions.

A full glossary of definitions can be found in **Appendix B**.

1.4 What is risk management?

Risk can be defined as ***"As a threat that an event or action will adversely affect the Council's ability to achieve its objectives, perform its duties or meet expectations of its stakeholders"***

> ***Risk Management -*** Risk is unavoidable, organisations' must manage risk in a way that can be justified to a level which is tolerable and as a result, risk is the chance that an event will occur that will impact upon the Organisation's objectives. It is measured in terms of impact and likelihood.

The holistic approach is vital to ensure that all elements of the organisation are challenged including decision making processes, working with partners, consultation, existing policies and procedures and also the effective use of assets – both staff and physical assets.

The risks facing the Council will change over time, some changing continually, so this is not a one off process. Instead the approach to risk management should be continual and the risks and the approach to managing them should be reviewed regularly.

It is important to note that **risks can also have an upside**; their impact can in some cases be positive as well as negative. Risk is also often said to be the flipside of opportunity so the whole risk management process can also help the Council identify positive opportunities that will take it forward. Risk management needs to be seen as a strategic tool and will become an essential part of effective and efficient management and planning.

1.5 Why do we want (and need) to do risk management?

Risk management will, by adding to the business planning and performance management processes, strengthen the ability of the Council to achieve its objectives and enhance the value of the services provided.

We are required to do it - Risk management is something that the Council is required to do, for example:

- The CIPFA/SOLACE framework on Strategic Governance requires the Council to make a public assurance statement annually, on amongst other areas, the Council's Risk Management Strategy, process and framework. The framework requires the Council to establish and maintain a systematic strategy, framework and processes for managing risk.

Benefits of risk management - Successful implementation of risk management will produce many benefits for the Council if it becomes a living tool.

- Achievement of the Councils objectives and vision;
- A consistent approach to the way risks are managed throughout the Council;
- Improved informed decision making – risks reported and considered within Council decision making;
- Becoming less risk averse in innovation (because you understand) and hence are more innovative;
- Improved business planning through a risk based decision making process;
- A focus on outcomes not processes;
- Improved performance (accountability and prioritisation) - feeds into performance management framework;
- Better governance - and demonstration of it to stakeholders; and
- Helping to protect the organisation.

1.6 Where does risk management fit?

In short the answer is ***"everywhere".*** Effective risk management should be applied within all decision making processes at an *appropriate scale*. So the risk management approach should encompass all types of risks and the table below may aid in the identification of risks to the Council.

Sources of risk	Risk examples
STRATEGIC	
Infrastructure	Functioning of transport, communications and infrastructure. Impact of storms, floods, pollution.
Legislative and Regulatory	Effects of the change in Central Government policies, UK or EU legislation, local and national changes in manifestos. Exposure to regulators (auditors/inspectors).
Social Factors	Effects of changes in demographic profiles (age, race, social makeup etc.) affecting delivery of objectives. Crime statistics and trends. Numbers of children/vulnerable adults 'at risk'.
Technological	Capacity to deal with (ICT) changes and innovation, product reliability, developments, systems integration etc. Current or proposed technology partners.
Competition and Markets	Cost and quality affecting delivery of service or ability to deliver value for money. Competition for service users (leisure, car parks etc). Success or failure in securing funding.
Stakeholder related factors	Satisfaction of the Council's taxpayers, Central Government and other stakeholders.
Political	Local or national political issues that may impact on the Council meeting its Objectives
Economic	Affecting the ability of the Council to achieve its commitments
Social	Relating to the Council's ability to meet the effects of changes in demographic, residential or social/economic trends
Environmental	Environmental impact from Council, stakeholder activities (e.g. pollution, energy efficiency, recycling, emissions, contaminated land etc). Traffic problems and congestion.
OPERATIONAL (Internal influences)	
Finance	Associated with accounting and reporting, internal financial delegation and control, e.g. managing revenue and capital resources, neighbourhood renewal, funding taxation and pensions.
Human Resources	Recruiting and retaining appropriate staff and applying and developing skills in accordance with corporate objectives, employment policies, health and safety.
Contracts and Partnership	Failure of contractors to deliver services or products to the agreed cost and specification. Procurement, contract and life cycle management, legacy. Partnership arrangements, roles and responsibilities.
Tangible Assets	Safety and maintenance of buildings and physical assets i.e. plant and equipment, ICT equipment and control
Environmental	Pollution, noise, licensing, energy efficiency of day-to-day activities.
Processes	Compliance, assurance, project management, performance management, revenue and benefits systems, parking systems etc.
Legal	Relating to potential breaches of legislation
Physical	Related to physical damage, security, accident prevention and health & safety
Professional Judgement and Activities	Risks inherent in professional work, designing buildings, assessing needs (children and adults).

Sources of risk	Risk examples
CORPORATE GOVERNANCE	
Integrity	Fraud and corruption, accountability, transparency, legality of transactions and transactions and limit of authority.
Leadership	Reputation, authority, democratic changes, trust and branding.
Policy and Strategy	Clarity of policies, communication. Policy planning and monitoring and managing performance.
Data and information for decision making	Data protection, data reliability and data processing. Control of data and information. E-government and service delivery.
Risk Management	Incident reporting and investigation, risk analysis or measurement, evaluation and monitoring. Taking advantage of opportunities.

There is therefore a consistent approach from the top to the bottom of the Council. So a mechanism will exist for risks to be escalated up (bottom up) within the Council whilst the top risks are also explicitly identified and managed (top down).

In practice this means that the Council will carry out risk assessments and develop the following risk registers:

In practice, risks within the Council exist at many different levels (e.g., high level corporate risks to lower level everyday service based risks). For the purpose of this strategy, risks are split into two levels as follows:

- **Corporate Risk Register** – the strategic, high level council risks related specifically to the achievement of the Councils objectives; and

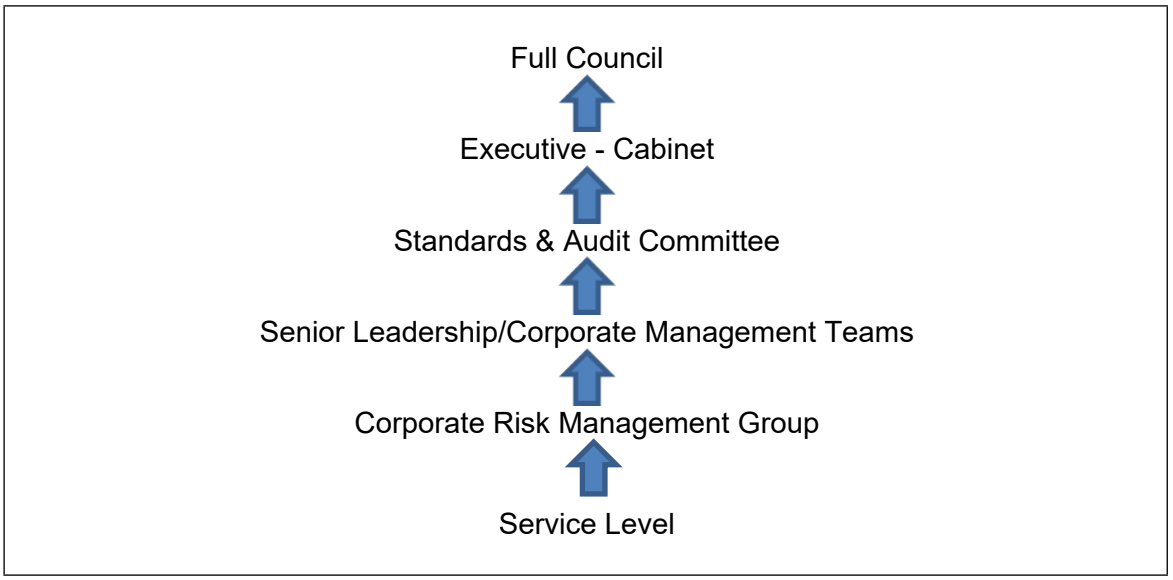
- **Operational Risks** – service based risks that may prevent individual service aims and objectives being met (and therefore impact upon the attainment of corporate objectives).

Given the changing landscape of local government the importance of projects and partnerships are ever increasing, so a more specific and tailored risk management approach is required.

2. Risk Management Organisational Structure

2.1 Reporting structure

The reporting structure for risk management is summarised below:



The risk management process is a continuous one and risks can therefore be reported at any time. However risks will be formally reported as follows:

- The Full Council will receive a report on the Council's key risks twice a year.
- The Executive Members will receive quarterly risk management reports for information purposes.
- Standards & Audit Committee will review the effectiveness of the Risk Management arrangements and receive risk management reports twice a year.
- The Senior Leadership Team and Corporate Management Team will consider the Corporate Risk Management Group minutes and summary risk management reports on a quarterly basis.
- Overall responsibility for ensuring that the Council has the appropriate systems in place to manage business risk lies with the Council's Corporate Risk Management Group (CRMG). In effect, CRMG are the sponsors for Risk Management within the Authority. Responsibility for managing specific business risks at an operational level lies with Service Managers and their dedicated Officers. The Director of Finance and Resources will 'champion/coordinate' the process on behalf of CRMG.
- Service Managers are required to carry out a comprehensive review of their risk registers as part of the annual service planning process. In addition the service risk registers need to be reviewed every 2 months (prior to the CRMG meetings). All Service Risk Registers need to be posted on the Council's intranet site. Risk also needs to be a standing regular item at service management and team meetings, and service risks need to be communicated to relevant staff.

3. Roles and Responsibilities

In cases of operational risk, risk management will follow existing service management arrangements. Corporate risks will be managed at Senior Officer Level. The Corporate Risk Management Group will be accountable to the Corporate Management Team and will be the "driving force" behind developing and implementing the Council's Risk Management Strategy. Membership of the Group is shown at **Appendix D**. The Group will seek to enhance the linkage between Service Line Managers and the Corporate Management Team.

Risk needs to be addressed at the point at which decisions are being taken. Where Members and Officers are asked to make decisions, they should be advised of the risks associated with recommendations being made as necessary. The Council needs to be able to demonstrate that it took reasonable steps to consider the risks involved in a decision. Risks must be addressed within Committee reports, as part of the corporate check.

There needs to be a balance between the efficiency of the decision making process and the need to address risk. All key reports, including new and amended policies and strategies, need to include a section to demonstrate that risks have been addressed.

In order to ensure the successful implementation of the strategy, roles and responsibilities have been reviewed and are updated in the following table;

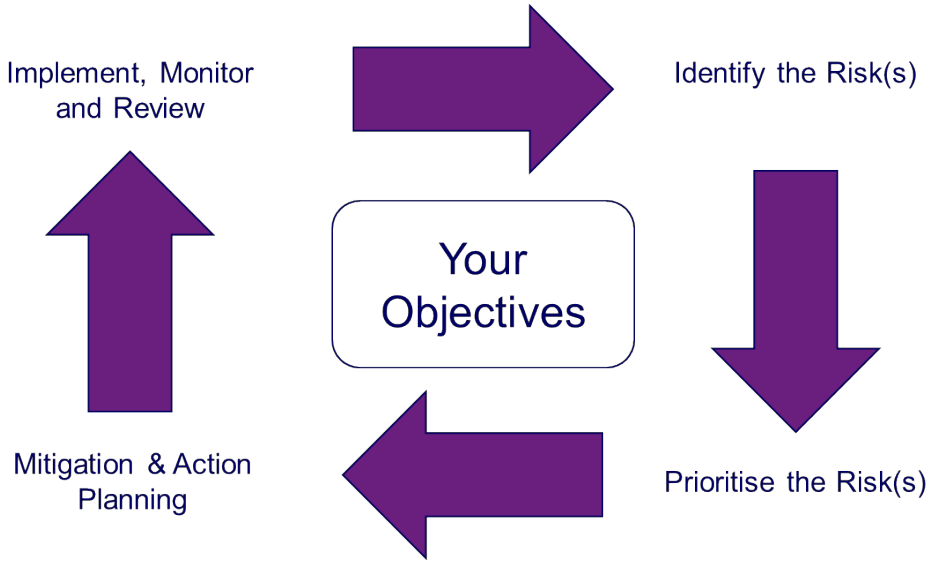
Group or individual	Roles & Responsibilities
Full Council	▪ Formal approve and adoption of the Risk Management Strategy (annually or as required); ▪ Approve the Corporate Risk Register (annually); ▪ Receive monitoring reports (mid and end of year);and ▪ Contribute to the identification of Corporate risks.
Cabinet	▪ To review the Strategy and monitoring reports before going to the Full Council.
Standards & Audit Committee	▪ To review the effectiveness of the Risk Management arrangements; and ▪ Receive reports including the annual statement of Internal Control/external audit reports/effectiveness of internal audit.
Senior/ Corporate Management Team	▪ Scrutinise significant risks in more detail as part of their annual work programme, as appropriate; ▪ Take corporate responsibility for risk; ▪ Address issues that cannot be addressed within service budgets or risk management fund of an extreme or high assessment; ▪ Receive report of all extreme or high assessments; ▪ Receive minutes of Corporate Risk Management Group. ▪ Nominate an Officer Champion for Risk Management; ▪ Champion and take overall responsibility for implementing the Risk Management Framework and embedding risk management throughout the Council;

Corporate Risk Management Group (CRMG)	▪ Meet (4 times a year) as per the CRMG timetable ▪ Overall responsibility for ensuring that processes are in place to effectively manage risks within the Council; ▪ Increase awareness of RM – cascade to service management teams and other team meetings; ▪ Produce the Strategy and monitoring reports for members; ▪ Identify and commission projects for Risk sub-groups; ▪ Receive and consider reports from any Risk sub-groups; ▪ Formulate monitor and update the Corporate risks register; ▪ Review Service risk registers as per the CRMG timetable ▪ Report to CMT at the defined frequency all highly scored risks; ▪ Preparing and recommending changes to the risk management strategy; ▪ Identifying and assessing risks; ▪ Review Insurance claims analysis in order to identify ways of reducing or eliminating future claims; ▪ Identify good practice and share learning; ▪ Identify new and emerging risks for inclusion in the Corporate Risk Register or Operational Risk Registers; ▪ Approve the use of the RM budget and Training days; ▪ Arranging and providing risk management training as appropriate.
Service Managers	▪ Ensure that risk management is incorporated into service plans and project plans. ▪ Review Service Risk Registers every 2 months. ▪ Review risk treatment schedules as identified by the line managers and team leaders; ▪ Review risk action plans and ensure they are implemented; ▪ Contribute towards the identification and management of operational risks for their service; ▪ Maintain awareness of and help promote the approved risk management strategy to all staff; ▪ Ensure that risks which have been identified are addressed and mitigated and that any high risks are addressed urgently ▪ Identify, analyse and profile operational risks through their individual monthly performance clinic. The role of the performance clinic is pivotal to challenging and understanding the risk view as well as gaining confidence that the risks will be managed. ▪ To provide annual assurance on the effectiveness of controls in place to identify and mitigate risks within their service through the annual service planning process ▪ To maintain awareness of and promote effective risk management techniques (incl. awareness of the strategy and policy) to all relevant staff; and ▪ Ensure that risk issues are highlighted in reports to Members.
Line Managers & Team Leaders	▪ Identify and analyse risks; ▪ Undertake assessments at service level; ▪ Evaluate risk/perform risk assessment ▪ Prepare risk register entries; ▪ Prepare the risk treatment schedule; and ▪ Prepare risk action plan.
All Employees	All employees have a responsibility to: ▪ Manage risk effectively in their job and report opportunities and risks to their service managers; ▪ Participate in risk assessment and action planning where appropriate; ▪ Adhere to Council policies and procedures; and ▪ Attend training and development sessions as appropriate.

Project Leaders	▪ Project leaders have a responsibility to ensure that the risks associated with their projects are identified, recorded and regularly reviewed as part of the project management process.
Internal Audit (Consortium Audit)	Internal Audit's role is to maintain independence and objectivity. Internal Audit is not responsible or accountable for risk management or for managing risks on management's behalf. Internal Audit will: ▪ Audit the risk management process; ▪ Assess the adequacy of the mechanisms for identifying, analysing and mitigating key risks; ▪ Provide assurance to officers and Members on the effectiveness of controls; And The Risk Register will drive the Internal Audit Plan to ensure resources are used on the areas of highest risk and where the need for assurance is greatest.

4. Risk Management Process

The risk management process is the same for the management of both strategic and operational risks. The process comprises of the following four basic steps; these are indicated in the diagram below and should be driven by the Council's objectives.



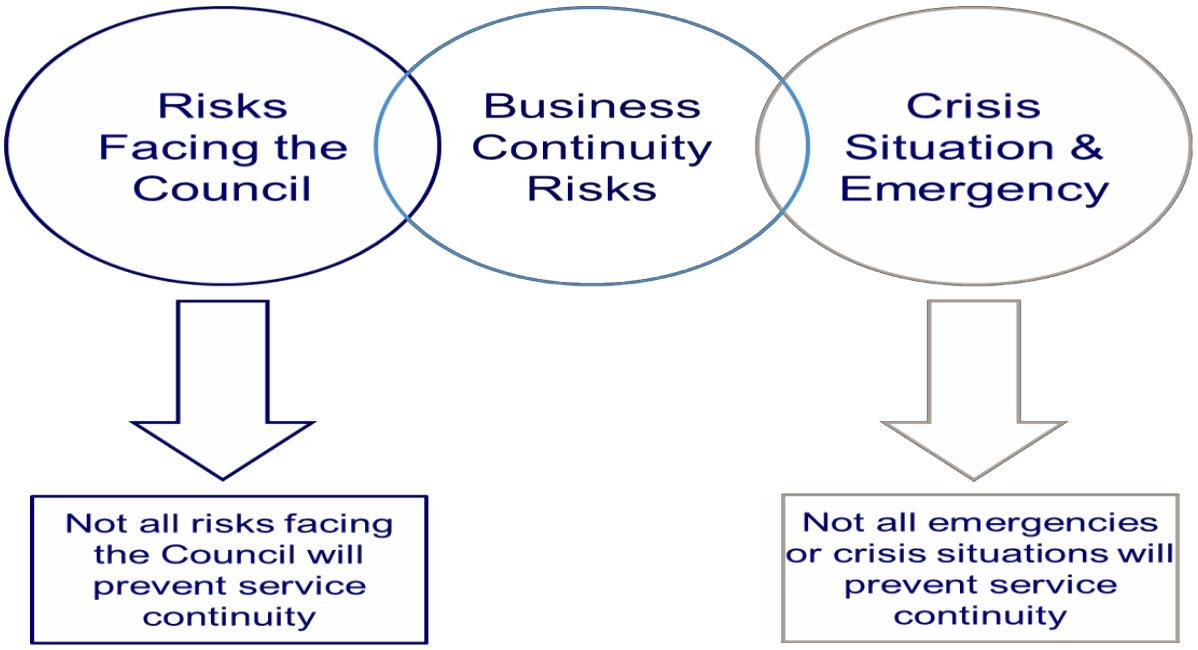
Having identified a risk there are four basic choices about how to deal with it – the 4T's:

- **Treat** the risk (i.e. do something about it)
- **Tolerate** the risk – (i.e. accept it as it is)
- **Transfer** the risk – (i.e. pass it to someone else, for example insurance)
- **Terminate** the risk – (i.e. cease the activity that gives rise to the risk)

5. Links to other Processes

Risk management, emergency planning and business continuity

There is a link between these areas however it is vital for the success of risk management that the roles of each, and the linkages, are clearly understood. The diagram below sets out to demonstrate the differences.



Risk management is about trying to identify and manage those risks which are more than likely to occur and where the impact on the Council's objectives can be critical or even catastrophic.

Business continuity management is about trying to identify and put in place measures to protect the priority functions against catastrophic risks that can stop the organisation in its tracks. There are some areas of overlap e.g. where the I.T infrastructure is not robust then this will feature as part of the organisation risk assessment and also be factored into the business continuity plans.

Emergency planning is about managing those incidents that can impact on the community (in some cases they could also be a business continuity issue) e.g. a plane crash is an emergency, it becomes a continuity event if it crashes on the office.

6. Communication

The Risk Management Strategy can be found on the Council's intranet site so that all members of staff can have access and easily refer to it. The strategy will be reviewed each year and following any key changes e.g. Central Government policy, inspection regimes and following any internal reorganisation. The Strategy will be re-issued annually via the intranet site.

7. Training

Workshops will be facilitated by experienced Officers and/or specialists in Business Risk Management. After attending the workshops, Officers should be sufficiently confident to undertake the process of risk identification within their service areas.

Risk analysis, control and monitoring, will lead to the determining of targets for improvements for inclusion in service plans.

8. Monitoring of Risk

The Council will monitor risk in the following ways:

- Risk Assessments will be undertaken annually to reflect Service Plan Objectives and Key Actions.
- The Council risk register, both strategic and operational will be the prime record which contains risk assessments, mitigation controls and review frequency information in accordance with the Councils Risk Management Methodology.
- The Corporate Risk Management Group will comply with their Terms of Reference.
- Internal Audit will review the Council's risk management arrangements as part of its strategic audit plan.

9 Conclusion

This strategy will set the foundation for integrating risk management into the Council's culture. It will also formalise the process to be applied across the Council to ensure consistency and clarity in understanding the role and benefits of corporate risk management.

Every two months reporting and escalation of risks should interlock with the existing arrangements for performance reporting. The intention being that the management of risk is incorporated into business plans and monitored through the performance management framework.

The adoption of the strategy will formalise the risk management work undertaken to date and will move the Council towards meeting the requirements of recognised best practice and inspection.

APPENDIX A -RISK MANAGEMENT FRAMEWORK

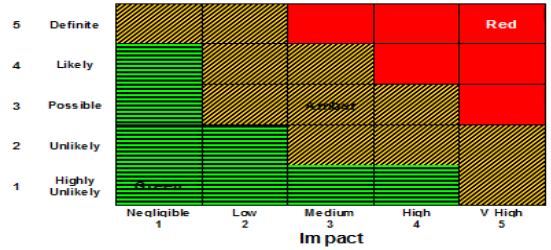
Corporate Risk Register
(owner: Director of Finance and Resources)

Risk Register	Resources	Customers Commissioning and Change	Housing	Economic Growth	Commercial Services	Health and Wellbeing	Policy and Communications
Risk Register Owner	Director of Resources (Kevin Hanlon)	Customers Commissioning and Change Manager *(Rachel O'Neil)*	Housing Manager (Liz Cook)	Economic Growth Manager (Neil Johnson)	Commercial Services Manager (Michael Brymer)	Health and Wellbeing Manager (Ian Waller)	Policy and Communications Manager (Donna Reddish)
Exec Member	Deputy Leader & Cabinet Member for Planning	Cabinet Member for Business Transformation	Cabinet Member for Housing	Leader & Cabinet Member for Regeneration / Cabinet Member for Town Centre & Visitor Economy	Leader & Cabinet Member for Regeneration / Cabinet Member for Housing	Cabinet Member for Health and Wellbeing	Cabinet Member for Governance
Service areas: Including related Business Continuity and Health & Safety issues.	Accountancy	Property and Procurement	Council Housing. HRA Business Planning & Strategy.	Development & Growth.	Landscape & Street-scene	Landscape & Street-scene	Policy
	Internal Audi	Business Transformation		Cultural & Visitor Services.	Operational Services	Environmental Health	Communications & Marketing
	Insurance	Support Services			Customer Services.	Sports & Leisure	
	Regulatory & Local Government Law	PPP Client					
	Democratic & Electoral Services.	GP:GS					
		Customer Services					

APPENDIX B – RISK MATRIX AND REGISTER

A Risk Matrix is used to assess risks in terms of their likelihood of occurring and the impact they could have. The scores for each factor (likelihood and impact) are plotted on a matrix (see below) to identify those that require management action i.e. focus on the 'red' area. The objective is to devise mitigating actions that will reduce the risk and ideally move the assessment into a safer area of the matrix (green or amber).

Total Risk Score = Likelihood x Impact. Rating: 0-4Green, 5-14 Amber, 15+ Red



Score -1 Highly Unlikely	Score - 2 Unlikely	Score - 3 Possible	Score – 4 Likely	Score - 5 Definite
Previous experience at this and other similar organisations makes this outcome highly unlikely to occur.	Previous experience discounts this risk as being unlikely to occur but other organisations have experienced problems.	The Council has in the past experienced problems in this area but not in the past three years.	The Council has experienced problems in this area in the last three years.	The council is currently experiencing problems in this area or expects to within the next 12 months.

Risk Impact	Score -1 Negligible	Score - 2 Low	Score - 3 Medium	Score – 4 High	Score - 5 Very High
PRIORITIES	No impact on the delivery of the Council's corporate objectives	It may cost more or delay in delivery of one of the Council's priorities	A number of Council priorities would be delayed or not delivered	The majority of Council priorities would be delayed or not delivered	Unable to deliver all Council priorities
FINANCIAL	Little or no financial impact (less than £5k)	The financial impact would be no greater than £25k	The financial impact would be no greater than £100k	The financial impact would be no greater than £500k	The financial impact would be greater than £500k
SERVICE IMPACT	Council services are no disrupted	Some temporary disruption of activities of one Council service	Regular disruption to the activities of one or more Council service	Severe service disruption or regular disruption affecting more than one service	Serve disruption to the activities of all Council services
INFORMATION	Minor, none consequential	Embarrassment, none last effecting	Isolated, personal details compromised	Severe personal details compromised	All personal details compromised
PUBLIC ENGAGEMENT	No loss of confidence and trust in the Council	Some loss of confidence and trust in the Council felt by a certain group or within a small geographical area	A general loss of confidence and trust in the Council within the local community	A major loss of confidence and trust in the Council within the local community	A disastrous loss of confidence and trust in the Council locally and nationally
REPUTATION	No media attention	Disciplinary action against employee	Adverse coverage in local press	Adverse coverage in National press/Front page news locally	Front page new story in National Press

APPENDIX C: GLOSSARY

Risk	Risk can be defined as a threat that an event or action will adversely affect the Council's ability to achieve its objectives, perform its duties or meet expectations of its stakeholders.
Hazard	Anything that has the potential to cause harm.
Risk Management	Risk is unavoidable, organisations' must manage risk in a way that can be justified to a level which is tolerable and as a result, risk is the chance that an event will occur that will impact upon the Organisation's objectives. It is measured in terms of consequence and likelihood.
Assessing risks	The approach and process used to prioritise and determine the likelihood of risks occurring and their potential impact on the achievement of the Councils objectives.
Contingency	An action or arrangement that can be put in place to minimise the impact of a risk if it should occur.
Control (control measures)	Any action, procedure or operation undertaken to either contain a risk to an acceptable level, or to reduce the likelihood.
Corporate Governance	Set of internal controls, processes, policies, affecting the way the Council is directed, administered or controlled.
Service risk	Significant operational risks which affect the day-to-day activities of the council.
Identifying risks	The process by which events that could affect the achievement of the Council's objectives, are drawn out and listed.
Risk Prioritisation	Risk prioritisation is the process used to evaluate the hazard/ risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk.
Impact	The effect that a risk would have if it occurs.
Issue	An event or concern that has occurred or is taking place and needs to be addressed (as opposed to a risk which has not yet, or might not, occur).
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Risk Treatment	The action(s) taken to remove or reduce risks
Managing and controlling risks	Developing and putting in place actions and control measures to treat or manage a risk.
Control	The control of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures.
Mitigation (Plan)	A strategy that reduces risk by lowering the likelihood of a risk event occurring or reducing the impact of the risk should it occur.
Objective	Something to work towards – goal.
Operational risk	Risks arising from the day to day issues that the Council might face as it delivers its services.
Overall risk score	The score used to prioritise risks – impact multiplied by likelihood.
Risk Assessment	Analysis undertaken by management when planning a new process or changing an existing procedure to identify risks that may occur, their potential impact and likelihood of occurrence. It will also identify the controls needed to control the risk and who is responsible for this.
Risk Register	A risk register is a log of risks of all kinds that threaten an organisations success in achieving its objectives. It is a dynamic living document which is populated through the organisations risk assessment and evaluation process. The risk register enables risks to be quantified and ranked. It provides a structure for collating information about risks.

APPENDIX D – CORPORATE RISK MANAGEMENT GROUP – MEMBERSHIP

Member	Officer	Title	Role
Member/Chair	Kevin Hanlon	Director of Finance and Resources	Chair and Resources Risk Lead
Member	Rachel O'Neil	Customers, Commissioning and Change Manager	Customers, Commissioning & Change Risk Lead
Member	Liz Cook	Housing Manager	Housing Risk Lead
Member	Neil Johnson	Economic Growth Manager	Economic Growth Risk Lead
Member	Michael Brymer	Commercial Services Manager	Commercial Services Risk Lead
Member	Ian Waller	Health and Wellbeing Manager	Health & Wellbeing Risk Lead
Member	Donna Reddish	Policy and Communications Manager	Policy & Comms. Risk Lead
Member	Cllr Sharon Blank	Cabinet Member for Governance	Independent
Attendee	Sam Sherlock	Emergency Planning & Business Continuity	Business Continuity Support
Attendee	Gerard Rogers	Regulatory & Local Government Law Manager	Legal Service and Monitoring Officer
Attendee	Jenny Williams	Head of Internal Audit	Internal Audit Representative
Attendee	Marc Jasinski	Health and Safety	Health & Safety Representative
Attendee	Karen Ludditt	Group Financial Accountant	Finance , Risk & Insurance Representative
Attendee	Anita Gill	Insurance	Insurance Representative
Attendee	Mick Blythe	PPP Client Officer	PPP Client Representative

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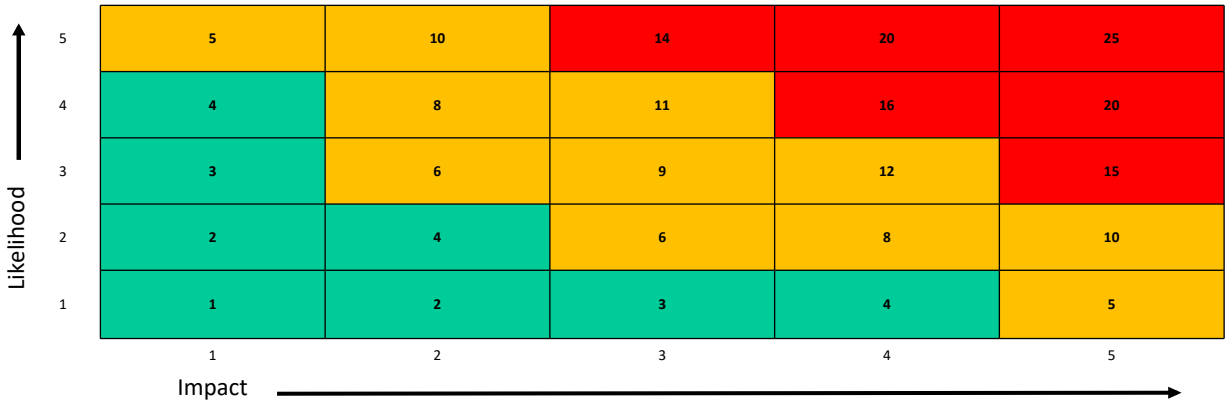
CHESTERFIELD BOROUGH COUNCIL

Corporate Risk Register Summary January 2019



Risk Reference		Risk Rating (Maximum Score = 25)		
		Start of Year	Current	Target
CR1	Having a Sustainable Medium Term Financial Plan - the ability to deliver priority services with the resources available.	15	15	15
CR2	Transformation / Change Management - managing change effectively to deliver the required transformational changes and savings.	12	12	8
CR3	Workforce - to ensure that we have the right skills and capacity to deliver the Council's priorities.	9	12	6
CR4	Investment & development of the ICT infrastructure - to ensure that a modern, efficient and reliable infrustructure is in place to support service delivery.	9	16	12
CR5	Emergency Planning & Business Continuity - to ensure that we are able to respond effectively to unexpected events, minimising any damage caused and keeping services running.	8	8	8
CR6	Protecting the Public & Staff (Health & Safety) - to ensure that we have systems in place to reduce the risk of accidents occuring and their severity.	9	12	12
CR8a	Information Governance - PSN compliance.	8	12	6
CR8b	Information Governance (Data Security) - to comply with the statutory and other requirements to ensure that the data we hold is held securely.	16	12	6
CR9	Procurement & Contract Management - to ensure that contracts are procured properly and deliver value for money.	12	15	12
CR11	Key Partnerships (e.g. PPP, Veolia) - to ensure that partnerships are used to support the delivery of the Council's priorities and that they are delivered to the specified standard.	12	12	12
CR12	The provision of Social Housing - ensuring that the Council is able to support delivery of social housing and that there is a sustainable business plan for the Housing Revenue Account.	15	12	12
CR13	Safeguarding Children and Vulnerable Adults - the ability to fulfill our moral and legal obligations to ensure a duty of care for children and vulnerable adults across our services and facilities.	12	8	8
CR15	Non-Housing Property Maintenance Programme & Funding.	12	16	12
CR16	Brexit	12	12	9

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