AGENDA SUPPLEMENT

Audit and Governance Committee

To:	Councillors J Burton (Vice-Chair), Hollyer (Chair), Fisher, Leigh (Independent Member), Mason, Melly, Rose and Whitcroft
Date:	Tuesday, 12 September 2023
Time:	5.30 pm
Venue:	The George Hudson Board Room - 1st Floor West Offices (F045)

The Agenda for the above meeting was published 4 September 2023. The attached additional documents are now available for the following agenda item:

9. Audit & Counter Fraud Progress Report (Pages 1 - 58)
This supplement contains internal audit reports.

This agenda supplement was published on **4 September 2023**

This page is intentionally left blank

CCTV (Surveillance Camera Code of Practice)

City of York Council

Internal Audit Report

Business Unit: Corporate Services,
Responsible Officer: Director of Governance
Service Manager: Information Governance and Feedback Manager
Date Issued: 7 August 2023
Status: Final
Reference: A1420/003

	P1	P2	P3
Actions	**0**	**3**	**0**
Overall Audit Opinion	Reasonable Assurance		

Veritau

Summary and Overall Conclusions

Introduction

The Biometrics and Surveillance Camera Commissioner (BSCC) has a statutory requirement, under section 29(2) of the Protection of Freedoms Act 2012 (PoFA), to encourage compliance with the Surveillance Camera Code of Practice (Code) issued by the Secretary of State. The council is a 'relevant authority' under the provisions of PoFA and, as such, is bound by responsibilities arising from section 33(1) to have regard to the Surveillance Camera Code (Code) when exercising any functions to which the Code relates.

In practice, this means that the council is expected to operate a system of overt surveillance using legitimate technology in a way that the public would rightly expect and to a standard that maintains public trust and confidence.

The Office of the BSCC issued a survey to all local authorities in July 2022 with the purpose of further assessing compliance with PoFA and the Code. This survey was completed by the council and returned to the BSCC in September 2022.

Objectives and Scope of the Audit

The purpose of this audit was to provide assurance to management that procedures and controls within the system ensure that:

- Roles and responsibilities with respect to the monitoring and maintenance of overt surveillance systems are understood and carried out effectively
- Key data and sources of information necessary to demonstrate compliance with the SC Code are maintained and can be verified

This audit was undertaken in response to the new Commissioner's survey and heightened focus on Code compliance. It is important that the council has arrangements in place for effectively managing its overt surveillance system and that allow it to put forward confident, evidence-based assertions to the Commissioner. The audit did not involve an in-depth review of the council's compliance with the Code. This will be a topic for a future audit. Instead, it sought to provide assurance that a framework is in place to provide satisfactory oversight, awareness and monitoring of surveillance systems such that the council could demonstrate compliance if requested. The audit did not include a detailed review of how the surveillance systems contract with Gough and Kelly (G&K) is managed.

Key Findings

The Code requires that the council has in place a Senior Responsible Officer (SRO) and a Single Point of Contact (SPOC). These are both in place. In practice, the role of SRO is delegated from the Director of Governance to the Information Governance and Feedback Manager (the council's DPO). The SRO is responsible for overseeing compliance, determining the size and scale of systems, maintaining data integrity, and holding supporting compliance information on all surveillance schemes. The council has a nominated Single Point of Contact (SPOC) for the contracted service with G&K and for the surveillance systems it directly operates and manages. Regular meetings take

place between G&K and the DPO to ensure compliance with the Code within the contracted service. The council, through G&K, undertakes due diligence and data protection impact assessments (DPIAs) when contracting third party CCTV systems. However, the process of installing new surveillance schemes or updating existing schemes (either managed by a third party or by the council) in accordance with the surveillance systems governance framework was not reviewed in detail as part of this audit.

The duty to have regard to the Code applies when a relevant authority uses a third party to discharge relevant functions covered by the Code and where it enters into partnership arrangements. The council has such an arrangement with G&K who administer and manage most of the council's CCTV installations (totalling approximately 500 cameras) on its behalf. The DPO meets regularly with the G&K CCTV manager, and G&K also undertake due diligence and DPIAs prior to the installation of new CCTV systems it operates on behalf of the council. G&K use the BSCC self-assessment tool (SAT) template to assess and monitor compliance with the Code.

We found that there are a limited number of services within the council that administer and manage their own surveillance systems. These include camera systems for monitoring fly tipping, supported housing facilities, fleet vehicles and bus lanes. We found that there is no single, central register of all CCTV systems and cameras. This information is only collected as part of the survey return.

We reviewed the completed BSCC survey and responses to the audit survey and found that officers of appropriate senior position had been contacted for information to be included in the response where the systems are not managed by the contracted service with G&K. The information submitted to the Commissioner by the DPO and is based on data from G&K and the knowledge of existing systems operated by the council, provided by service areas. As part of the audit, we issued a survey to officers to confirm their understanding of key Code requirements and to verify responses in the return to the BSCC. Source data can be recreated from all systems to evidence the information submitted in the survey. Inconsistencies with the information in the survey returned to the Commissioner and the data received from service areas during the audit could mainly be explained by changes to existing schemes and implementation of new schemes since the BSCC survey was completed. However, there was no information included in the BSCC survey for traffic enforcement cameras and there were 4 buildings with CCTV identified by the Housing service, not manged by G&K, which were not included in the survey.

Under the current arrangements, there is no process for verifying or obtaining satisfactory assurance that information provided by officers is complete and accurate prior to the submission of the BSCC survey. We found that assurance can be placed on the information provided by G&K due to the regular contact maintained with the DPO and G&K's own procedures for self-assessing compliance with the Code under the contract. The surveillance systems governance framework should provide a means of verifying service information for any new or changed systems but, at stated previously, the council does not have a central record of all CCTV systems and cameras which has been verified as complete.

The Office of the BSCC has developed tools that make it easier for organisations to assess and demonstrate how they continue to comply with the Code in the operation of CCTV systems, including a self-assessment tool (SAT). Completion and publication of the SAT and publishing the results are not mandatory. The council last completed a SAT in 2020 for all known installations. There are different impact and risk assessment templates available from regulators. The council has a Data Protection Impact Assessment template based on these

which is completed by the DPO for the contracted service. The responses to the audit survey provided no assurance that non-G&K managed services are using the council's DPIA template document to self-assess compliance where they manage schemes outside of the contracted service.

The council intranet includes the Surveillance Systems Governance Framework which contains a business case template and links to the regulator's website. It also has a section on CCTV which provides details of the contracted service and links to key legislation but does not name the current SPOC and contains an outdated list of buildings/services with CCTV.

Overall Conclusions

There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. Our overall opinion of the controls within the system at the time of the audit was that they provided Reasonable Assurance.

1 Register of schemes and cameras

Issue/Control Weakness	Risk
There is no single, central register of all CCTV systems and cameras.	Systems in place are not known to the SRO and no information is available on compliance with the Code.

Findings

The BSCC survey requires local authorities operating public space surveillance camera systems to specify how many systems are operating by type, and how many cameras are in operation. The responsibility for maintaining data integrity and holding supporting compliance information on all surveillance schemes lies with the SRO.

Schemes and cameras managed by G&K can be provided in detail from the CCTV system it maintains. However, the council is reliant on responses to an internal survey to complete information for schemes and cameras managed by its service areas. The internal survey was issued to officers in service areas where it was known that cameras were in operation. There may be other systems in place that are not known to the SRO, historic or new, and, as a result, were not contacted to complete the survey form. The lack of a single, centralised record of the council's internally managed CCTV systems also means it is not possible for the SRO to obtain assurance that the returns provided by service areas are complete and accurate or to provide meaningful challenge to the BSCC data returned from them.

We undertook a reconciliation between information provided by services during the audit to an up-to-date record of CCTV systems managed by G&K and to the information submitted to the BSCC in the council's survey. We found inconsistencies in the number of systems managed by the Housing service. Additional buildings identified as having CCTV systems installed were not included in the BSCC survey return. The survey also did not contain any information on CCTV systems in place for traffic enforcement purposes.

Agreed Action 1.1

The council will undertake a complete survey of CCTV systems (undertaken via the Survey Monkey platform and issued to both G&K and council service areas), following which a central log of CCTV systems and locations will be compiled and maintained by the SRO.	**Priority** 2 **Responsible Officer** Monitoring Officer (SRO) (with support from CMT) **Timescale** 31 October 2023

2 Ensuring compliance of internally managed CCTV systems

Issue/Control Weakness	Risk
Compliance information, in the form of a completed SAT and DPIA, is not available for all service-operated CCTV systems.	CCTV systems manged directly by council services do not comply with the requirements of the Code.

Findings

The council last completed a self assessment in 2020. Since then there has been no system-wide review of the CCTV schemes maintained by services.

Knowledge of the compliance of service-operated systems is limited to those where the SRO, and DPO through delegation, are consulted during the procurement and management of new systems, and where updates to existing systems and requests for assistance are received (i.e. as part of the surveaillance systems governance framework). Outside of the contracted service with G&K there is no assessment of whether the services known to operate their own surveillance systems comply with the requirements of the Code, how the systems are managed and how requests for information are processed. There is no confirmation of any expertise in the services operating systems in being able to respond appropriately to requests for information.

The council has its own Data Protection Impact Assessment template which supports the use of systems for public safety and law enforcement. A copy of the DPIA, based on ICO/BSCC templates, covering the installations G&K manages was provided during the audit. Where services manage their own CCTV only one service area could provide a completed DPIA for their system, and this had not been completed using the council's template.

Agreed Action 2.1

A full DPIA will be completed by all CCTV systems owners, utilising the BSCC template, for all systems not maintained by G&K	**Priority** 2 **Responsible Officer** Monitoring Officer (SRO) **Timescale** 29 February 2024

Agreed Action 2.2

Compliance with the Surveillance Camera Code of Practice will be formally assessed via:

- completion of a self-assessment by G&K for the systems that it manages on behalf of the council
- completion of a self-assessment by the council for the systems it directly manages

Priority	2
Responsible Officer	Monitoring Officer (SRO)
Timescale	30 April 2024

Audit Opinions and Priorities for Actions

Audit Opinions

Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.

Our overall audit opinion is based on 4 grades of opinion, as set out below.

Opinion	Assessment of internal control
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Priorities for Actions

Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

This page is intentionally left blank

Climate Change Strategy: Governance Framework

City of York Council

Internal Audit Report

Business Unit: Policy and Strategy
Responsible Officer: Assistant Director of Policy and Strategy
Service Manager: Head of Carbon Reduction
Date Issued: 1 September 2023
Status: Final
Reference: A2050/001

	P1	P2	P3
Actions	**0**	**6**	**3**
Overall Audit Opinion	Reasonable Assurance		

Summary and Overall Conclusions

Introduction

The impacts of climate change are widespread and intensifying, with every region on Earth affected. In response, the UK Government has committed to the legally binding target of reaching net zero carbon output compared to 1990 levels by 2050 and, in 2021, it published its Net Zero Strategy setting out how this will be achieved.

City of York Council (CYC) declared a climate emergency in 2019 and has since published its Climate Change Strategy and Action Plan. These were approved at Council in December 2022. CYC has set an ambition for York to achieve net zero carbon output by 2030, with emissions already having reduced by 39% compared to 2005 levels.

The Climate Change Strategy 2022-2032 (CCS) and Action Plan form part of the York 2032 vision, which aims to make York 'a vibrant, prosperous, welcoming and sustainable city, where everyone can share and take pride in its success.' Alongside the Health and Wellbeing Strategy 2022-2032 and York Economic Strategy 2022-2032, they form the foundation of the vision. The Strategies and the York 2032 10-year plan were approved and adopted by full Council and the Executive on 15 December 2022.

The CCS is organised into eight main themes covering 32 objectives and is guided by five principles. This audit has concentrated on the theme of governance, assessing the effectiveness of the governance arrangements implemented through the Strategy.

Objectives and Scope of the Audit

The purpose of this audit was to provide assurance to management that procedures and controls within the system ensure that:

- There are suitable and effective internal governance arrangements in place to support the Climate Change Strategy, inform decision making, allow for appropriate disclosures to be made, and to monitor performance.
- There are suitable and effective governance mechanisms in place with the council's citywide partners to support the Climate Change Strategy.
- The impacts of climate change are considered in the council's decision-making process and documented in its risk registers.

Key Findings

When Council approved the Climate Change Strategy in December 2022, the council had already begun to put governance arrangements in place and these have continued to develop since. Our review of governance arrangements found that they were generally good but there are areas for improvement, some of which officers were already addressing at the time of the audit.

The council has established the Climate Change Programme Board (CCPB) to provide internal oversight and challenge to delivery groups and projects, make recommendations and provide advice to officers, Council Management Team (CMT) and Members, and monitor progress against the Climate Change Strategy. CCPB regularly reports to CMT and PHCMT. Membership of CCPB is generally appropriate, although it was noted that only three of the council's four directorates are represented. Attendance at meetings is not recorded, but information provided by officers suggests certain key officers do not regularly attend the Board. The terms of reference require review to ensure they remain fit for purpose and align with those of York Climate Commission and Sustainability Leads Group.

The council reports to Carbon Disclosure Project (CDP) and Global Covenant of Mayors (GCoM), two internationally-recognised bodies for climate change action reporting. York was included in the Cities A List 2022 by CDP, which names cities that are leaders in environmental action and transparency, and it also received a 'B-' score in 2021. These results have been reported publicly. No feedback is received from GCoM, but there is a dashboard about York on its website capturing its emissions profile and progress against mitigation and adaptation phases.

Carbon emissions are reported annually, most recently in December 2022 for the 2021/22 financial year. There is a suite of key performance indicators that are reported on through the York Open Data website and a dashboard is being developed that will be reported to the Corporate Services, Climate Change and Scrutiny Management Committee.

The Climate Change Strategy Action Plan was approved by full Council in December 2022. The Strategy states that the Action Plan is intended to be a live document that is reviewed annually. All of the actions have been assigned an impact and cost rating, but only some have been assigned timescales, co-benefits, constraints and influences. A progress update on the Climate Change Strategy Action Plan was reported to the relevant Executive Member in May 2022, but one has not yet been provided for 2023.

The council's Climate Change Strategy states that the council is directly responsible for less than 4% of York's total emissions. The action plan *"Require[s] the climate commission for York, to create a partnership to collaborate, drive, support and track climate change progress across the city"*.

As the council has little direct control over the city's total emissions, being able to effectively influence organisations and residents is crucial to the achievement of the Strategy's objectives. To this end, the council established the Sustainability Leads Group (SLG) and York Climate Commission (YCC) to bring together organisations from across the city. Officers noted that SLG has an operational focus, while YCC had a strategic focus. SLG has been operating since July 2021, with clear evidence of practical actions being taken, but YCC has been on hiatus since December 2022. YCC's terms of reference, while reasonably comprehensive, have not been updated since December 2020. No meeting minutes are kept. SLG's terms of reference do not include version history or meeting frequency. Meetings are held regularly and an action log is maintained, although this does not record attendance at meetings. While the SLG is operating effectively, amendments are required to its terms of reference to ensure they remain fit for purpose. YCC is not currently operating, minutes of its meetings have not been kept and there is no evidence of an annual report having been produced. However, there are plans to reinstate YCC.

The council has implemented changes to its project management process and internal decision making process. Reports will now include narrative on the alignment of a decision to the Climate Change Strategy and the report template recommends that report authors engage with the CCPB and Head of Carbon Reduction to understand the impacts of the decisions they are making. Training on the new report template is due to be provided to officers at Leading Together on 11 September 2023. However, as these changes are recent, it is too early to assess whether they have been effective.

Our review of service plans and risk registers found that key service areas, such as Policy & Strategy and Transport & Planning, have identified climate-related actions in service plans, but others have few (Finance & Procurement) or no references (Adult Social Care & Integration). Climate risks are included in the corporate risk register. However, these are not reflected at the directorate risk register level.

Overall Conclusions

There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. Our overall opinion of the controls within the system at the time of the audit was that they provided Reasonable Assurance.

1 Clarifying the Climate Change Programme Board's governance arrangements

Issue/Control Weakness	Risk
The CCPB terms of reference require review and alignment with YCC and SLG terms of reference. There is a discrepancy between stated CCPB membership and actual meeting attendance and not all council directorates are represented. Action logs do not provide clarity on attendance and updates received from delivery groups and officers.	Failure to ensure that the CCPB remains fit for purpose and is attended by key council officers and delivery groups may impact on the council's ability to deliver actions and meet the aims of the Climate Change Strategy.

Findings

The Climate Change Programme Board's (CCPB) terms of reference are generally suitable, but they do not include a review frequency to ensure they remain fit for purpose. The terms of reference state that CCPB will meet monthly, but notes from the action logs show that officers agreed to meet every six weeks. There is also a discrepancy in reporting arrangements between the terms of reference for CCPB, York Climate Commission and Sustainability Leads Group. The arrangements state that CCPB will receive updates on the work of YCC and SLG, while YCC's terms of reference state it will discuss progress with the council's Climate Change Policy Scrutiny Committee and publish an annual report, and SLG's terms of reference do not include any reporting arrangements.

CCPB does not keep meeting minutes, but instead maintains an action log. The CCPB should receive updates on actions and projects from council delivery groups. While the action logs and agendas indicate officers are attending to provide updates, and are taking actions between meetings, recording information in an action log makes it less clear which delivery groups and officers have attended to provide updates. Until recently, CCPB has relied on the knowledge of its members to ensure that relevant projects are considered. Recent changes to the council's internal decision-making processes should provide CCPB with greater oversight of projects and delivery groups, but it is too early to assess whether these arrangements are effective.

The action log also does not record attendance by officers. The CCPB terms of reference show that there are nine members of CCPB, all of whom are heads of service, assistant directors or directors. However, attendance information provided by the Head of Carbon Reduction suggests that three of these officers have not attended a meeting. Five of the six other officers had attended between six and nine of the 10 meetings held between February 2022 and May 2023. Seven other officers were listed as having attended a meeting, some likely as deputies for CCPB members, but only one (Head of Communities) has attended more than half of the ten meetings.

CCPB membership covers three of the four council directorates, with representatives from Corporate Services, Place and Children and

Education. However, Adult Social Care and Integration is not represented. While the three directorates represented are key to delivery of actions in the Strategy, there may be a role for the Adult Social Care and Integration directorate in making its services more environmentally sustainable. This is recognised in the CCPB terms of reference, which states that the Climate Change Programme 'requires multiple areas of the council working together to deliver climate change action' and that 'climate change influences decisions in all parts of the council'.

Agreed Action 1.1		
Council Management Team (CMT) will review the suitability of current CCPB membership and emphasise the importance of members making best endeavours to attend meetings.	**Priority**	2
	Responsible Officer	Assistant Director of Policy & Strategy & CMT
	Timescale	31 October 2023

Agreed Action 1.2		
The CCPB terms of reference will be reviewed to ensure they are fit for purpose and aligned with YCC and SLG terms of reference. The action log will include attendance records and make clear any recommendations made on projects or decisions for CMT to consider.	**Priority**	3
	Responsible Officer	Assistant Director of Policy & Strategy
	Timescale	31 October 2023

Agreed Action 1.3		
Directorate Management teams will have an agenda item to contact CCPB with upcoming decision reports so that climate change impacts can be reviewed.	**Priority**	2
	Responsible Officer	Assistant Director of Policy & Strategy & CMT
	Timescale	31 October 2023

Agreed Action 1.4		
CCPB's bimonthly report to CMT will include a section on recommendations regarding projects or decisions for CMT to consider.	**Priority**	3
	Responsible Officer	Head of Carbon Reduction
	Timescale	30 Sept. 2023

2 Reviewing the Climate Change Strategy Action Plan

Issue/Control Weakness	Risk
The Climate Change Strategy Action Plan contains actions for which funding and delivery mechanism have not yet been identified. A decision has not been made on whether to provide an action plan update to Members.	There is a lack of progress on or ownership of actions, leading to a failure to achieve the aims of the Climate Change Strategy.

Findings

The Climate Change Strategy Action Plan was approved by full Council in December 2022. A progress update on the Climate Change Strategy Action Plan was reported to the relevant Executive Member in May 2022, but one has not yet been provided for 2023. The Strategy states that an action plan will be developed that 'is clear in its resourcing, responsibilities and timescales while demonstrating progress, transparency and accountability' (p.58). The Strategy also commits to publishing an annual action plan and keeping it up to date with formal annual reviews. The action plan 'provides high-level estimates covering carbon impacts, cost implications, timescales, co-benefits, constraints, level of council influence and current stage of implementation' (p.26).

While some actions are in progress and an update on progress was provided to the Executive Member for Environment and Climate Emergency in May 2022, many actions have not yet been assigned timescales, co-benefits, constraints or influences. Discussion with the Head of Carbon Reduction (HCR) found that the Action Plan timescales and influences are deliberately high-level because not all of the actions have funding at this stage. As funding and delivery mechanisms are identified, specific action owners and timescales will then be allocated. The action plan update taken to the Executive Member for Environment and Climate Emergency in May 2022 gives more precise timescales, although it does not give action owners. The HCR stated that the annual review of the action plan had not yet been scheduled and it had not been decided whether another action plan update would be provided to Members in 2023.

Agreed Action 2.1

The Climate Change Strategy Action Plan will be refreshed to focus on deliverable SMART actions. The refresh will be completed once the Council Plan 2023-27 has been published.	**Priority** 2 **Responsible Officer** Head of Carbon Reduction **Timescale** 30 Sept. 2023

Agreed Action 2.2

The Climate Change Action Update will be updated to cover the period since the previous update. Annual updates will be scheduled with the Executive Members for Environment and Climate Emergency.	**Priority** 2 **Responsible Officer** Head of Carbon Reduction **Timescale** 30 Sept. 2023

3 Ensuring climate change-related risks and actions are reflected in directorate risk registers

Issue/Control Weakness	Risk
Climate risks are included in the corporate risk register. However, these are not reflected at the directorate risk register level.	A lack of visibility of climate change risks at directorate level may mean risks are not adequately addressed.

Findings

Our review of the corporate and directorate risk registers found that climate change risks are included in the corporate risk register, but these are not reflected at the directorate risk register level.

Climate change is recognised in the corporate risk register under Key Corporate Risks (KCRs) 1, 6 and 12. These cover the financial, health and wellbeing, and major incident implications of climate change. The main controls associated with these risks are: Climate change mitigation and adaptation programme; Regular review and reporting of carbon emissions; and Carbon reduction and climate change action plan regular updates to PH/CMT.

Many of the council's service plans recognise the need to take action to address climate change-related issues. Review of the current service plans found that service areas that are central to achievement of the aims of the Climate Change Strategy (Policy & Strategy; Governance; Environment, Transport & Planning; and Economy, Regeneration and Housing) included multiple references to climate change and carbon reduction, as well as actions to take.

However, our review of the corresponding directorate risk registers found that they do not make reference to climate change risks. Directorate risk registers for Place, Customer and Communities, Public Health, and Adult Social Care and Integration were reviewed. Children and Education directorate has not maintained a directorate risk register since 2021 (see Risk Management audit 2022-23). Of the registers reviewed, only the Place directorate referenced climate change. However, this was in relation to KCR 12. It was not explicitly referenced in the Place directorate Risks (PRs) that sit below the KCRs.

Agreed Action 3.1

The Carbon Reduction team will work with council departments to support them to recognise and understand climate change risks in their services. Directorate risk registers will be updated to include relevant climate change risks.

Priority	2
Responsible Officer	Head of Carbon Reduction & Council Management Team
Timescale	31 March 2024

4 Reinstating the York Climate Commission

Issue/Control Weakness	Risk
The York Climate Commission has been on hiatus since December 2022. Its terms of reference are out of date and meeting minutes are not kept.	There is a lack of visible leadership across York to reduce the city's climate impact, preventing the council from achieving the aims of the Climate Change Strategy.

Findings

The council's Climate Change Strategy states that the council is directly responsible for less than 4% of York's total emissions. The action plan 'Require[s] the climate commission for York, to create a partnership to collaborate, drive, support and track climate change progress across the city'. The council established the York Climate Commission (YCC) in December 2020, but it has been on hiatus since December 2022.

The Assistant Director of Policy and Strategy (ADPS) and Head of Carbon Reduction (HCR) explained that YCC met quarterly in its first year and received a small amount of funding from the council. The Executive Member for Environment and Climate Emergency chaired it at that time. In its second year, YCC did not receive funding and officers observed that it was more limited in terms of the actions it could take. Officers also noted challenges with attendance because some of the organisations on YCC also attended the Yorkshire and Humber Climate Commission (YHCC). The ADPS and HCR attend working groups on climate adaptation and net zero on YHCC.

Following the May 2023 local elections, the ADPS and HCR are aiming to reinvigorate YCC. They are intending to meet with Executive Members to discuss reinstating the group, although these discussions had not occurred at the time of the audit.

As part of reinvigorating YCC, officers will need to ensure governance arrangements are fit for purpose. Meeting minutes were not kept under the previous incarnation of the Commission. YCC has terms of reference dating to December 2020. These are reasonably comprehensive, but will require updating when YCC is reinstated.

Agreed Action 4.1

The York Climate Commission will be reinstated. Terms of reference will be reviewed and updated. Meeting minutes or action logs will be kept and attendance will be recorded.

Priority	2
Responsible Officer	Head of Carbon Reduction
Timescale	30 September 2023

5 Updating the Sustainability Leads Group's terms of reference

Issue/Control Weakness	Risk
The Sustainability Leads Group terms of reference are not comprehensive or up to date.	If terms of reference are not suitably defined and kept up to date, the SLG may not meet its aims.

Findings

The Sustainability Leads Group's (SLG) terms of reference has no version history or review frequency included. Meeting frequency is not stated. SLG meetings are held approximately every 2-4 months, with agendas circulated prior to meetings. An action log is kept, rather than formal minutes. This records the members of the group, but not attendance. Members are listed, but key positions, e.g. the chair, are not, and the process for appointing members is not defined. The purpose of the group is stated, as well as points on communications and standing agenda items. However, the terms of reference do not state what, if any, reporting will be done by the group.

Agreed Action 5.1

The Sustainability Leads Group terms of reference will be reviewed and updated to ensure they remain fit for purpose.

Priority	3
Responsible Officer	Assistant Director of Policy & Strategy
Timescale	31 October 2023

Audit Opinions and Priorities for Actions

Audit Opinions

Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.

Our overall audit opinion is based on 4 grades of opinion, as set out below.

Opinion	Assessment of internal control
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Priorities for Actions

Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

Council Tax and NNDR

City of York Council

Internal Audit Report

Business Unit: Customer and Communities
Responsible Officer: Director of Customer and Communities
Service Manager: Head of Customer and Exchequer Services
Date Issued: 25th July 2023
Status: Final
Reference: A1320/001

	P1	P2	P3
Actions	**0**	**2**	**1**
Overall Audit Opinion	Reasonable Assurance		

Veritau

Summary and Overall Conclusions

Introduction

Council tax and national non-domestic rates (NNDR) are key sources of funding for the provision of services by the council. Therefore, as a fundamental financial system, Council Tax and NNDR is audited regularly to provide assurance that risks are managed, and controls are operating effectively.

City of York Council is currently a member of the Leeds City Region (LCR) Business Rates Pool. The pool was formed for 2020/21 and retains 50% of business rates, in line with national policy. The North and West Yorkshire (NWY) Business Rates Pool, of which CYC was a member, disbanded on 31 March 2021.

For 2022/23, the council tax requirement was set at £102 million from a total base of 68,220 and retained NNDR income was projected at £33.3 million. Collection rates for both business rates and council tax were below target at the end of 2021/22 but were higher than in the previous financial year. At the end of the first quarter of 2022/23, the collection rate for business rates was 22%, which was 1.25% above the current year target and 2% above the collection rate in 2021/22. For council tax the collection rate was 20%, 0.62% below current year target but 0.13% above the collection rate in 2021/22.

Objectives and Scope of the Audit

The purpose of this audit was to provide assurance to management that procedures and controls within the system will ensure that:

- The council maintains an accurate database of taxable properties and liable persons.
- Bills and demand notices are calculated and issued correctly, in a timely manner and apply legitimate discounts, exemptions, disregards and reliefs.
- Council tax and NNDR income is correctly accounted for, and income is correctly recorded.
- Arrears are promptly and effectively pursued
- Refunds and write-offs are legitimate, correctly processed and authorised.

Key Findings

Following the emergence from the Coronavirus pandemic, the demand upon the service area to maintain its core activities continued to be severely challenged. Central Government's response to the cost-of-living crisis meant that the council's resources were diverted to implementing financial support measures through Energy Rebate payments. In addition, staff turnover and recruitment to key roles has impacted upon some areas of service delivery. In response to these challenges, the service area were forced to critically prioritise

workloads and operational activities in order to achieve the key priorities and outcomes of the Council Plan. Nevertheless, we found that controls largely continued to operate effectively.

The council's database of taxable properties and liable persons is generally well maintained. Quarterly reconciliations between the Valuation Office (VOA) and the Revenue and Benefits IT system (NEC/SX3) databases are carried out. Discrepancies are identified, investigated, and resolved. However, there has been no Income Officer in post for several months which has meant that council tax completion notices have not been issued or sent to the VOA during this time. Whilst officers confirmed that alternative processes have been used to identify new properties, there is still the risk that some have not been identified and council income lost.

Overall, we found that bills and demand notices were issued and calculated correctly for both council tax and NNDR. Where the council has been notified of a change to the liable party, the account has been updated correctly.

We found that full reviews of historical discounts and exemptions had not been conducted in 2022 with the exception of Single Person Discounts, student and probate related exemptions. Officers confirmed that some discounts and reviews are conducted on a daily basis, for example, new applications for Small Business Rate Relief and change of occupancy for council tax. For NNDR a prioritised schedule of full reviews to be conducted in 2023/24 was provided. For council tax, officers confirmed full reviews are to take place this year.

Quality assurance checks were conducted for the audit period tested. Whilst there was no contextual data to assess whether they were proportionate to the total number of transactions performed, those conducted were in line with procedure. Where transactional errors were identified, feedback was provided to staff to ensure corrective action was taken.

We found that council tax and NNDR income is correctly accounted for, and income is correctly recorded. Suspense accounts are reconciled weekly with corrective action taken. Cash reconciliations are completed periodically and customers with rejected direct debits are contacted in a timely manner with a request for payment. At the end of 2022/23, the collection rate for council tax was 96.84% and 98.02% for NNDR. This was an increase in both areas compared to the previous year. The council were ranked as having the second highest collection rate in their benchmark group of five local authorities.

The council has a comprehensive Corporate Debt Policy which is made available to customers on the council's website. Arrears are promptly and effectively pursued with a detailed debt recovery timetable in place for issuing reminders, final notices, and summons. Accounts on hold are reviewed regularly and Special Payment Arrangements (SPAs) are authorised by the appropriate officers. We found that SPA defaults were reviewed regularly and action taken to recover the debt.

Refunds for individual customer accounts are reviewed regularly and authorised by a suitable officer. However, refund reconciliations between the property database and the finance system had not been completed for the audit period tested. Write offs had been properly authorised and appropriate reasons for write offs were evidenced and documented.

Overall Conclusions

There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. Our overall opinion of the controls within the system at the time of the audit was that they provided Reasonable Assurance.

1 Council Tax Completion Notices

Issue/Control Weakness	Risk
Council Tax Completion Notices are not being issued.	The council's property database is not up to date and income is being lost.

Findings

No council tax completion notices have been issued or sent to the Valuation Office since the Income Officer post became vacant in November 2021. Action to partly address the issue has been put in place using alternative processes to identify new properties and minimise the risk of lost income. However, these are a temporary measure and do not fully compensate for the issuing of completion notices.

Agreed Action 1.1

The new Income Officer has been visiting properties for the last 2 months and will attend a dedicated Completion Notice course in October. Completion notices will be issued before the end of October 2023.

Priority	2
Responsible Officer	Council Tax and Debt Recovery Manager
Timescale	31 October 2023

2 Council Tax Discount Review

Issue/Control Weakness	Risk
Full reviews of historical discounts, disregards and exemptions are not being conducted.	Loss of income to the council and inaccurate customer records.

Findings

Full reviews of historical discounts and exemptions had not been conducted in 2022 with the exception of Single Person Discounts, student and probate related exemptions. Officers confirmed that some discounts and reviews are conducted daily, for example, new applications for NNDR Small Business Rate Relief (SBRR) and change of occupancy for council tax. Whilst, for NNDR, officers provided a prioritised schedule of full reviews to be conducted in 2023/24, council tax officers confirmed that full reviews would be conducted over the coming months, although a structured plan was not in place.

Agreed Action 2.1

The team has already been working through some of the reviews this year and will be on schedule by September 2023.

Priority	3
Responsible Officer	Council Tax and Debt Recovery Manager
Timescale	30 September 2023

3 Refund Reconciliations

Issue/Control Weakness	Risk
Refund reconciliations are not being conducted.	Refunds are made erroneously. Customer accounts are incorrect.

Findings

Refunds for individual customer accounts are reviewed regularly and authorised by a suitable officer. However, refund reconciliations between the property database and the finance system had not been completed for the audit period tested meaning that refunds may have been issued incorrectly.

Agreed Action 3.1

The Service has asked Accountancy if this process is necessary going forward and will act on their response.

Priority	2
Responsible Officer	Revenues/Benefits & Subsidy Manager
Timescale	31 October 2023

Audit Opinions and Priorities for Actions

Audit Opinions

Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.

Our overall audit opinion is based on 4 grades of opinion, as set out below.

Opinion	Assessment of internal control
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Priorities for Actions

Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

This page is intentionally left blank

Health and Safety

City of York Council

Internal Audit Report

Business Unit: Corporate Services
Responsible Officer: Head of Human Resources
Service Manager: Head of Health and Safety
Date Issued: 29 August 2023
Status: Final
Reference: A1800/001

	P1	P2	P3
Actions	**0**	**6**	**0**
Overall Audit Opinion	Reasonable Assurance		

Summary and Overall Conclusions

Introduction

Under the Health and Safety at Work Act 1974, and associated legislation, the council has responsibility for the health, safety and welfare of all its employees, clients and customers accessing services. The council engages in a broad range of activities resulting in diverse areas of risk.

Essential to the management and reduction of health and safety risks is an effective risk assessment process. The council's Safety Management System (SMS) includes guidance and requirements for staff when conducting health and safety risk assessments for premises, work activities and individuals. Risks should be assessed by council managers or supervisory staff for their area of responsibility. Each directorate should maintain a log of its risk assessments, with information on their location, review dates, and the results of observational monitoring.

To improve the management of health and safety risks, incidents, accidents and near-misses must be reported on the council's B-Safe system at the earliest opportunity. Incidents should be investigated to determine root causes and to define actions to take to improve safety management. In some cases, specific work-related incidents are legally required to be reported under RIDDOR to the Health & Safety Executive.

Objectives and Scope of the Audit

The purpose of this audit was to provide assurance to management that procedures and controls within the system ensure that:

- Suitable premises risk assessments, safe systems of work and individual risk assessments are in place, are up to date and follow council guidance.
- Control measures identified in risk assessments have been implemented and are operating effectively.
- Incidents are reported promptly and correctly on B-Safe, investigations are conducted and actions arising from incidents are implemented.

The audit reviewed risk assessments and incident reporting arrangements at a sample of council premises:

Directorate	Premises
Adult Social Care and Integration	Marjorie Waite Court
Adult Social Care and Integration	The Beehive
Customer and Communities	Hob Moor Children's Centre
Customer and Communities	Mansion House
Place	James House Hostel

Key Findings

The council's risk assessment process is guided by the health and safety policy and risk assessment compliance note within the council's Safety Mangement System. The compliance note includes a comprehensive procedure for completing risk assessments. For each of the five sites visited, a sample of risk assessments were evaluated against the risk assessment process outlined in the compliance note. Site visits were conducted and interviews held with the officers responsible for managing health and safety at each site.

The compliance note requires directorates to use Risk Assessment Log F3B (either directorate-wide or locally, eg at department level) to record the name and location of the risk assessment, when it was carried out, when it is to be next reviewed, and details of any observational monitoring conducted. The purpose of the log is to assist managers in maintaining oversight of the risk assessments held by sites for which they are responsible. Whilst a log of activity-related risk assessments was observed at the Beehive, neither premises nor activity-related logs were held at the other sites included in the sample. Logs were also not held at department or directorate level for any site visited. Correspondence with officers during the audit suggested that there is a lack of clarity within the organisation regarding the level of management at which these logs should be held.

The compliance note also requires officers to review risk assessments and record how they have communicated the results of the risk assessments. We found that some risk assessments had no evidence of planned review dates. Conversations with officers established that some risk assessments are reviewed on an 'as and when' basis. Officers stated that the results of risk assessments were communicated to staff in different ways, such as by sharing information at team meetings and via emails. However,evidence of communication was available for only two sites and the risk assessments reviewed during the audit did not routinely record how the results had been communicated. Risk assessments were stored electronically at the sites visited. However, at two sites, they were not readily accessible to site users and employees unless requested.

We found inconsistencies in the way that the five sites managed their risk assessment process. One site had a single premises risk assessment, whilst others had risk assessments for individual rooms and activities. One had risk assessments for specific hazards, for example lone working, slips, trips and falls, and working at height. It appears that officers are unclear on the best way to approach risk assessments. The risk assessments sampled all identified some hazards and controls, but not all of them had been conducted in line with the compliance note. Examples of non-compliance observed included: missed identification of hazards and therefore no corresponding controls; risk matrices not being used to evaluate risk; and action plans not being completed.

Our site visits confirmed that a range of controls identified in the risk assessments were in place and sites use a number of strategies to monitor control measures. For example, fire alarm checks, fire drills, and water flushes were consistently undertaken across the premises visited. We also saw evidence of window restrictor checks at Marjorie Waite Court, flat checks at James house and the use of daily premises checklists at Mansion House. However, our visits also identified instances where controls recorded on risk assessments had not been implemented. For example, at Marjorie Waite Court, controls for supervising contractors and controlling access were not operating effectively. At the Beehive, the medical room risk assessment stated that monthly checks are undertaken by management. However, when queried during our visit, neither the manager nor head of service were aware of this control in the risk assessment.

A range of health and safety courses are available on MyLO, the council's online learning platform. However, there was a wide variation in course attendance for officers responsible for health and safety at the five sites visited. For example, only three of the five officers responsible for health and saefty at the sampled sites had completed the 'CYC essential training: Introduction to Health and Safety' course and two of those officers had also attended the IOSH Managing Safely course (one in October 2017 and the other in January 2022). The policy states that it is the role of the shared health and safety service to advise on health and safety training for staff at all levels and the responsibility of heads of service to arrange for shortcomings in training and instruction to be rectified. However, interviews conducted with officers indicated that they had not received guidance and advice on the training they should attend, and none could recall any recent and formal training on how to conduct the risk assessment process robustly.

Guidance on the use of B-Safe is available for staff on the intranet. There are a series of instructional videos, as well as a compliance note that outlines how B-safe should be used. None of the officers spoken to were aware of the B-Safe videos links provided on the CYC intranet. However, of the officers spoken to during the audit, three had used B-safe and two had been involved conducting health and safety investigations. These officers reported confidence in their use of B-safe, but identified some issues with the system such as it being 'unsmooth' and time consuming to use. All officers spoken to reported that the health and safety team were accessible and helpful, and that they had felt supported during investigations and with any ongoing health and safety issues.

We reviewed incidents reported on B-Safe between April 2022 and May 2023. Four of the five sites reported incidents and/or near-misses. In total, 91 incidents were reported, with the Beehive reporting 80 of those. The Beehive has the B-Safe App installed on iPads, which means that staff can access and update the system promptly. Incidents are generally reported promptly, with the majority of incidents across sites (69, 76%) reported within two days of occurrence and all except one within nine days of occurrence.

Overall Conclusions

There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. Our overall opinion of the controls within the system at the time of the audit was that they provided Reasonable Assurance.

1. Oversight and review of risk assessments

Issue/Control Weakness	Risk
F3B risk assessment logs were not available for the sites visited at the department or directorate level. Not all risk assessments sampled had scheduled review dates or records of any changes made following reviews.	Service areas fail to ensure that risk assessments are kept up to date and that observational monitoring is undertaken, leading to an increased risk of incidents occurring.

Findings

The risk assessment compliance note stipulates that 'Directorates must ensure that a log (either Directorate-wide or local eg service/department) is available that records the existence of all their risk assessments, log number, where they are held, when they were carried out, when they are next to be reviewed and observational monitoring has taken place (and what action, if any, was taken).' The purpose of the log is to assist managers in maintaining oversight of the risk assessments held by sites for which they are responsible. Risk assessments should be reviewed annually or where a need is identified.

We could not identify logs of risk assessments for four of the five premises visited. We enquired with site managers, relevant heads of service and health and safety champions regarding the F3B logs. The Beehive had created its own log for activities-related risk assessments, but not for premises risk assessments. However, the activities-related risk assessment log was held at the site, not at the departmental or directorate level. While officers observed that they discussed health and safety matters with their line managers in 121s, there does not appear to be a formal record of oversight and active monitoring of risk assessments as per the requirements of the risk assessment compliance note. There also appears a lack of clarity within the organisation regarding the level of management at which the logs should be held.

Risk assessment review dates were observed and scheduled on some individual risk assessments, but this was not the case for all risk assessments. In addition, where reviews had been conducted, a minimal record of this was maintained. For example, one risk assessment, reviewed in January 2023, only provided the review date but gave no indication of whether or not any changes had been made as a result.

Agreed Action 1.1

Council Management Team will define corporate expectations for risks assessments that should be held at council premises. It will also define training requirements for managers with health and safety responsibilities at sites, and requirements for health and safety inductions for new staff / those take up site management responsibilities. The aim is to ensure clarity on what good health and safety practice looks like corporately.

Priority	2
Responsible Officer	Corporate Director of Place
Timescale	31 March 2024

Agreed Action 1.2

Directorate Management Teams and DCNCs will continue to have health and safety as a standing agenda item for discussion and take appropriate actions, including those relating to risk assessments.

Both groups will ensure that F3B risk assessment logs are in place for premises and activities within their area of responsibility. In addition, they will review and seek assurances that observational monitoring is undertaken to ensure risk assessments comply with the risk assessment compliance note and that controls are implemented (see Finding 3 for more detail).

Priority	2
Responsible Officer	Council Management Team
Timescale	31 March 2024

2. Health and safety training for responsible officers at sites

Issue/Control Weakness	Risk
Health and safety training requirements are unclear and there is variation in provision for officers with responsibility for health and safety at sites.	Officers do not receive suitable health and safety training, leading to an increased risk of incidents at sites.

Findings

While a range of health and safety courses are available on MyLO, the council's online learning platform, there is a wide variation in course attendance for officers responsible for health and safety at the five sites visited. For example, only three of the five officers had completed the 'CYC essential training: Introduction to Health and Safety' course and two of those officers had also attended the IOSH Managing Safely course (one in October 2017 and the other in January 2022). One officer had completed 13 courses, while another had only completed two (one in 2015 and the other in 2017). We also found that officers were unaware of the guidance and instructional videos on how to use B-Safe that are available on the intranet. Three officers had used B-Safe and had received support and advice from the health and safety team when doing so.

The health and safety policy states that it is the role of the shared health and safety service to advise on health and safety training for staff at all levels. It is the responsibility of heads of service to 'arrange for shortcomings in training and instruction to be rectified' and of directors to ensure that arrangements 'secure the competence and capability on health and safety matters of all employees'. However, interviews conducted with officers indicated that they had not received guidance and advice on the training they should attend. Two officers stated they had received informal advice from the health and safety team on completing risk assessments, but none could recall any recent, formal training on how to conduct the risk assessment process robustly.

Agreed Action 2.1		
Linked to action 1.1, officers with responsibility for health and safety at council premises will be provided with clarity on the health and safety training available to them and their staff and what they are required to complete, including training on preparing risk assessments and IOSH Managing Safely. Relevant officers will undertake this training.	**Priority**	2
	Responsible Officer	Corporate Director of Place / Head of Human Resources
	Timescale	31 March 2024

Agreed Action 2.2		
The shared Health and Safety team will deliver a one-hour micro masterclasses on risk assessments to officers with responsibility for health and safety at council premises.	**Priority**	2
	Responsible	Head of Health and

Officer	Safety
Timescale	31 March 2024

3. Non-compliance with the health and safety risk assessment compliance note

Issue/Control Weakness	Risk
Discrepancies were identified between the risk assessments at the sites visited and the risk assessment compliance note.	Risk assessments are not created following council guidance, meaning that hazards are not identified and adequately mitigated and there is an increased risk of an incident occurring.

Findings

There were disparities between the health and safety policy and risk assessment compliance note and actual practice observed at sites. From our site visits, and review of a sample of risk assesments at each site against the risk assessment compliance note, we identified issues within the following areas:

- The compliance note states that risk assessments are to be carried out by managers or relevant staff in consultation with employees who are familiar with the work activity. However, we found that only some risk assessments recorded evidence of consultation with employees.
- The compliance note outlines a number of strategies to undertake in the process of identifying hazards in the workplace, but we found some risk assessments did not identify certain hazards relevant to those risk assessments.
- Risk assessments should state the level of risk after control measures are implemented, but not all risks had been evaluated to provide a risk rating
- Controls identified in risk assessments were not always in place or were not specific about the control requirements.
- The compliance notes states that the action plan should be used to record who is responsible for additional control implementation, but action plans had not always been used to identify who was responsible.
- The compliance note states that risks and control measures should be communicated to appropriate people who may be affected by the hazard. However, there was a lack of evidence that the results of risk assessments had been communicated to employees and some were not available to employees, contractors and service users.

An appendix has been prepared providing details of the specific issues identified in each of the above areas.

Agreed Action 3.1

Site-specific issues identified in Appendix 1 have been provided to the relevant premises managers to address. They will:

- Ensure that hazards are identified that are relevant to the risk assessment created.
- Evaluate risks on an ongoing basis, including recording the level of risk, and ensure that any changes, additions, or amendments are recorded on the risk

Priority	2
Responsible Officer	Head of Human Resources
Timescale	31 March 2024

assessment.

- Ensure that risk assessments are written in collaboration with teams and ensure that final documents and actions are communicated.
- Ensure that responsibilities for additional controls are documented in action plans, assigned to responsible officers, and implemented.
- Ensure that risk assessments are accessible for employees, contractors, and others, to refer to and are a 'live' document.

Agreed Action 3.2		
Procedures will be established to ensure that risk assessments are completed by trained and competent people in consultation with (or by representatives of) those people undertaking the activities. Service managers/supervisors will address the risks identified or escalate any concerns where risk controls are not able to be controlled locally. Health & Safety team inspections will continue to sample risk assessments for appropriateness.	**Priority**	2
	Responsible Officer	Head of Human Resources
	Timescale	31 March 2024

Annex 1

Audit Opinions and Priorities for Actions

Audit Opinions

Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.

Our overall audit opinion is based on 4 grades of opinion, as set out below.

Opinion	Assessment of internal control
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Priorities for Actions

Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

Health and Safety Audit
Detailed Finding 3: Comparison of risk assessments to the risk assessment compliance note

Risk assessment compliance note statements.	Finding
Consultation with employees: The compliance note states that Risk assessments are to be carried out by managers or relevant staff in consultation with employees who are familiar with the work activity.	Risk assessments at four out of five sites showed evidence that they had been created in consultation with employees, but this was not the case for all those reviewed. • **Mansion House (MH):** Two risk assessments out of seven provided evidenced creation in consultation with employees. These were the risk assessments for lone working and school workshops. • **Marjorie Waite Court (MWC):** Three risk assessments out of six provided indicated creation in consultation with employees. These were: General premises (HHASC), Manual Handling (Housing Scheme managers), and Lone Working (Housing Scheme managers). • **The Beehive (BH):** Three risk assessments out of 25 provided indicated creation in consultation with employees. These were: All kitchens, Accessing Short Breaks at the Beehive, and Violence and aggression. • **Hob Moor Children's Centre (HMCC):** Only one risk assessment provided was completed by a council officer (the premises risk assessment). This did not evidence creation in consultation with employees. • **James House (JH):** One risk assessment was provided. This evidenced creation in consultation with employees. This was the risk assessment for the support team.
Activities/hazards identification: Strategies to undertake in the process of identifying hazards in the workplace	We found some risk assessments did not identify certain hazards relevant to those risk assessments. For example: • **MH:** The risk assessment for lone working did not refer to exposure to violence and agression. The events risk assessment did not refer to violence and agression or medical emergencies.

	• **MWC:** The risk assessment for lone working only refers to slips, trips and falls as the identified hazard. The risk assessment for manual handling, which covers the use of a Mangar machine and manual hoist, only refers to the hazard as 'manual handling', rather than detailing the possible impacts. • **BH:** The All Kitchens risk assessment and laundry room risk assessment do not consider the risk of slips, trips and falls. • **JH:** The risk assessment for support workers does not refer to slips, trips and falls.
Control implementation: The compliance note states that when conducting risk assessments officers should: • Identify what the existing control measures are for the hazards • Be specific with these control measures and define actual training courses, safe systems of work, levels of supervision, standard of personal protective equipment etc • Are the existing controls appropriate and in line with relevant CYC SMS Compliance Notes? If not, identify what additional control measures need to be put in place to reduce the risk • Use the Risk Matrix and Risk Rating table to identify the level of risk after existing (and any additional) control measures – combine the current Potential Harm and Likelihood of harm occurring eg Major & Unlikely = Medium	We found that not all risks had been evaluated to provide a risk rating on the risk assessment: • **MH:** Risks evaluated on all risk assessments seen. • **MWC:** No risk measurement observed on General Premises risk assessment. • **BH:** No risk measurement observed on the Accessing Short Breaks at the Beehive risk assessment. • **HMCC:** Risks had been evaluated on the premises risk assessment. • **JH:** No risk measurement observed on the premises risk assessment We found that controls identified in risk assessments were not always in place or were not specific. • **MWC**: a visitors book not being used, visiting workmen not accessing risk assessments and health and safety information, and contractors not always supervised on site. • **BH**: The trampoline safety instructions referred to in the risk assessment stated that trampoline should be on a soft surface, however the trampoline was placed on a hard surface. The medical room risk assessment referred to 'monthly manager checks' as a control but staff were unaware of this check. • **JH**: Whist a range of training has been identified as a control measure on the risk assessment provided, the specific courses to attend were not specified.
Action plan used to record who is responsible for implementing	A review of action plans for the sample selected showed they had not always been used to identify additional controls:

controls: The compliance notes states that the action plan should be used to record who is responsible for implementing what and when	• **MH:** For the seven risk assessments reviewed, action plans were not used to record who was responsible for implementing additional controls. • **MWC:** Five out of six action plans reviewed recorded some responsibilities and additional controls. • **BH:** Of four risk assessments that identified that additional controls were required (Violence and aggression, All kitchens, Medical room and Accessing Short Breaks), only the action plan for the Violence and Aggression risk assessment was completed. • **HMCC:** The action plan was used to identify responsibilities and additional control measures on the risk assessment. • **JH:** Additional controls were identified in the main risk assessment body and one action had been identified in the action plan section with a responsible officer having been identified.
Risks and control measures communicated to employees: The compliance note states that Risks and control measures are communicated to appropriate people who may be affected by the hazard.	There was a lack of evidence that the results of risk assessments had been communicated to employees, with just two sites, **HMCC** and **JH**, being able to provide evidence of communication to staff by means of a meeting agenda or copy of a communication. Induction checklists were obtained from three of the sites visited: • **BH**: Induction checklist includes reference to risk assessment • **HMCC**: Induction checklists includes reference to identified hazards. A 'Normal operating procedures document is shared with service users. • **JH**: Induction checklist includes reference to risk assessment. Induction checklists are not used at **MH**, although the site manager was able to explain the induction process. Introduction of a checklist was discussed during the site vist. **MWC** completes fire safety inductions, but it was not clear whether personal emergency evacuation plans are covered as part of this process.
Risk assessments accessible to staff: The compliance note states that copies of risk assessments must be accessible within the workplace and provided to employees (and others eg contractors, where required) on	Visits to sites and interviews with officers responsible for health and safety indicated the following: • **MH:** Risk assessments are accessible to employees electronically via access to a shared drive. Sharing of health and safety information with contractors/visitors was observed.

induction, on request, and as part of ongoing management.	• **MWC:** Risk assessments are stored electronically, but are not accessible to site staff or site users. Contractors sometimes go direct to residents flats without staff knowing that they have visited. • **BH:** Risk assessments are accessible to employees electronically via access to a shared drive. • **HMCC:** Risk assessments were not available to site users at time of visit. Discussion took place on how to ensure this going forwards. Sharing of health and safety information with contractors/visitors was observed. • **JH:** Risk assessments are accessible to employees electronically via access to a shared drive. Some hard copy risk assessments available.

Public Health Contract Management

City of York Council

Internal Audit Report

Business Unit: Public Health
Responsible Officer: Director of Public Health
Service Manager: Consultant in Public Health
Date Issued: 31/08/2023
Status: Final
Reference: A3680/001

	P1	P2	P3
Actions	**0**	**0**	**3**
Overall Audit Opinion	Reasonable Assurance		

Summary and Overall Conclusions

Introduction

Local authorities have a duty to take steps to improve the overall health of the people in their area. City of York Council's (CYC) Public Health team is responsible for managing three key areas of public health: health improvement, health protection and healthcare. This work is driven by the Joint Health and Wellbeing Strategy, which outlines the work, priorities and goals of Public Health alongside the wider Council Plan.

The Public Health service has responsibility for commissioning a wide range of health services in York, such as sexual health, recovery services and NHS health checks. The Council currently has a total of 15 active Public Health contracts, with a lifetime value of £20.5 million.

A robust contract management process is important in ensuring that Public Health contracts continue to provide value for money, that the council and its contractors meet their obligations to service users, and that risks are effectively managed.

Objectives and Scope of the Audit

The purpose of this audit was to provide assurance to management that procedures and controls within the system ensure that:

- Effective governance and reporting mechanisms are in place and enable oversight of contracts.
- Comprehensive performance measures, indicators or targets are used to monitor service delivery and are specified in contract agreements.
- There is effective financial monitoring of contracts.

Contract management arrangements were assessed by reviewing a sample of contracts selected during the audit through discussions with the service. The two contracts selected were the Integrated Sexual Health Service and the Alcohol and Illicit Drug Integrated Treatment and Recovery Service.

Key Findings

Governance and reporting mechanisms are in place for the Public Health contracts. Roles and responsibilities and reporting lines for contract management are clearly documented in contract managers' job descriptions. Public Health governance meetings take place regularly, and the relevant contract managers attend and report on the contracts. The policies and procedures for managing these contracts have been developed internally among officers but are not documented. Both contract managers have received relevant training on procurement, but no specific training on contract management. Procurement have recently developed a contract management checklist and associated contract management training provision to support staff within the Council, but these arrangements have not yet been rolled out to Public Health.

Monthly budget monitoring meetings are held where any financial issues are raised. Spend on the sampled contracts is not routinely monitored as both contracts are block contracts. However, financial concerns can be raised at contract monitoring meetings and escalated to address any issues such as additional funding requirements, as evidenced in meeting minutes. Procurement officers advised that when contract extensions are made the financial position of providers would be reviewed however there is no other established process in place for ongoing monitoring of the financial health of providers throughout the contract.

There are no dedicated risk registers for the contracts, and no ongoing risks relating directly to the contracts are listed on the general Public Health risk register, though some are listed under 'closed risks'. This risk register is not complete and does not follow the requirements of the Council's Risk Management Guide.

The contracts set out procedures for extensions and variations, in line with the Council's Contract Procedure Rules. Where contract variations were in place for changes to the contract price these had been documented in signed deeds of variation. Procurement advised that when making contract variations any impact on the category plan is considered. Nevertheless, this would only be formally reviewed in cases where variations would have an impact on the plan; for example, where a variation would change the nature of service delivery and therefore may be better approached by retenderting. This was not the case in any of the variations reviewed. A contract variation to increase the price of the Drug and Alcohol Service contract was above the maximum limit defined in the original contract and subsequent variation increasing the limit, therefore a corrigendum was agreed to increase the value of the contract. Evidence was available to demonstrate that variations had been completed in line with the Contract Procedure Rules, including consultation with Legal and appropriate delegated authorisation. The YORtender contract register has been updated following contract variations that have increased the contract price.

Key performance indicators (KPIs) are set out in the service specifications of the sampled contracts, and the specifications comprehensively outline arrangements for collecting and sharing information, requiring both parties to meet regularly to discuss performance as part of the performance management framework.

For the Integrated Sexual Health Service contract, KPIs are updated as required upon agreement of both the Council and the service, for example due to changes in standards such as the Public Health Outcomes Framework. This contract requires an annual report to be produced by the provider, outlining achievements and challenges from the year, including KPIs and forward planning for the year ahead.

Due to service capacity issues this has not always been provided. The Drug and Alcohol Service contract provided first year KPIs with the expectation these would be changed and co-developed through the contract term. For both contracts, there is evidence of updates to KPIs and discussion of possible KPI changes during quarterly contract monitoring meeting minutes. Testing found that monitoring meetings had been held at the required timescales, had been appropriately documented, attended by suitable officers, and performance had been discussed.

Any queries or concerns regarding KPIs are recorded on query log spreadsheets. Queries and actions are discussed at contract monitoring meetings and logs updated, as evidenced in meeting minutes. The quarter 2 query log for the Integrated Sexual Health contract contained no updates due to an error; however, minutes showed discussion of KPIs within the contract monitoring meeting. The usual process for log updates was followed for the quarter 3 query log which contained all required information.

Officers advised that should there be ongoing performance concerns these would be added to the Public Health risk register. The sampled contracts outline further steps that can be taken should there be issues with persistent underperformance from services. The Integrated Sexual Health contract provides detailed steps including an agreement management meeting, remedial action plan, joint investigation, exception reports, and withholding of payments. The Drug and Alcohol Service contract discusses the use of improvement plans; however, it does not provide detail of further steps, such as timescales for action. Officers advised that they are building in more detail to the new contract regarding improvement plans for the procurement for June 2024 to provide more clarity regarding actions and timescale expectations.

Overall Conclusions

There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. Our overall opinion of the controls within the system at the time of the audit was that they provided Reasonable Assurance.

1 Annual Report

Issue/Control Weakness	Risk
The Integrated Sexual Health Service provider has not complied with the contractual requirement to produce an annual report.	Gaps in compliance with the performance management framework may impede the council's ability to assess performance across the full suite of KPIs and to gain assurance on the appropriateness of future plans or developments.

Findings

For both contracts, compliance with the performance management framework is assessed each quarter via KPI monitoring spreadsheets. KPI spreadsheets are updated prior to the contract management meeting so that they can be reviewed by the contract manager prior to the meeting and any performance issues can be discussed. Some KPIs are monitored quarterly and some are monitored annually or biannually. KPIs have been agreed with reference to the Public Health Outcomes Framework (PHOF) and other relevant standards including the Faculty of Sexual and Reproductive Healthcare and British Association for Sexual Health and HIV.

In addition to monitoring spreadsheets, periodic performance reports are required. The Drug and Alcohol Service has provided quarterly progress reports.

Within the Integrated Sexual Health Service contract, there is a requirement for the provider to produce an annual report highlighting the achievements and challenges of the service that year and to include forward plans for the year ahead. Due to capacity issues the Integrated Sexual Health Service provider has not always provided the annual report as required; however, this has been regularly discussed in contract monitoring meetings with the provider. Officers are currently reviewing the annual reporting requirement to establish an alternative reporting mechanism that would meet the Council's needs whilst reducing resource demands on the provider.

Agreed Action 2.1

Officers to agree future reporting arrangements with the provider and annual report to be completed.	**Priority** 3
	Responsible Officer Public Health Specialist Practitioner Advanced
	Timescale Implemented

2 Risk Register

Issue/Control Weakness	Risk
Some areas of the Public Health risk register did not comply with the council's risk management policy.	Risks are not appropriately identified or managed.

Findings

The Public Health risk register is the central document for recording and managing risks facing the service, including risks facing Integrated Sexual Health Service and the Drug and Alcohol Service. Separate risk registers for managing these contracts are not completed.

The central risk register is maintained and regularly updated, but is not comprehensive or fully completed. While all risks on the register have been assessed for gross risk, one ongoing risk has not been assessed for net risk, and four risks have not been given a follow-up update. Most risks do not have specific target dates or closure dates. When compared to the Council's Risk Management Policy and Strategy and Risk Management Guide, it was noted that the service's risk register does not include the following expected fields: a clearly defined risk title; a risk category (set out in Appendix C of the Guide), a target risk score, a control owner (in addition to the risk owner), an action owner, and a priority given to each action (high, medium, or low).

There are currently no ongoing risks recorded relating directly to either contract sampled during the audit on the risk register. This is surprising because possible ongoing risks facing these services are likely to include risks relating to the ongoing re-procurement process for the Drug and Alcohol Service contract, and the associated risks of the financial status and capacity of providers within the market.

While the risk register does discuss underfunding of sexual health services (as a closed risk), funding for the Integrated Sexual Health contract ahead of the agreement of a Section 75 partnership agreement was said to remain a concern in the April 2023 Public Health governance meeting. Further risks to the sexual health service could include increased demand due to demographic or behavioral changes.

Agreed Action 2.1

Amendments to be made to the team Risk Register to be in line with corporate policies.	**Priority** 3
	Responsible Officer Senior Public Health Technical Systems Development Officer
	Timescale 30th September 2023

Agreed Action 2.2		
Training to be provided to the senior management team on the updated risk register and request new fields and backdated and completed going forwards.	**Priority**	3
	Responsible Officer	Senior Public Health Technical Systems Development Officer
	Timescale	30th September 2023

Agreed Action 2.3		
Training to be provided on risks by the Insurance Manager to the senior management team and a wider discussion around risk and how to raise with the wider Public Health Team.	**Priority**	3
	Responsible Officer	Senior Public Health Technical Systems Development Officer
	Timescale	30th September 2023

3 Monitoring of financial health of providers

Issue/Control Weakness	Risk
There is no formal process in place for monitoring the financial health of service providers.	Provider failure or decision to leave the market results in services being unable to achieve their objectives, leading to financial loss and reputational damage to the Council.

Findings

During the tendering process checks are undertaken by Procurement on the financial health of providers to inform the tendering decision. A Creditsafe check is undertaken and the most recent audit of accounts is reviewed by finance. Once the contract is in place, there is no established process for monitoring the ongoing financial health of providers other than at the time of a contract extension.

Procurement do not underter any annual checks on service provider financial status throughout the lifetime of the contract. As a result, officers complete brief annual check of services providers on Companies House; however, this is not a formal process and was developed without receiving guidance from Procurement or Finance.

Annual checks on the financial health of providers helps in the identification and mitigation of any financial risks, including failure of the provider to deliver the contracted service. For these reasons, the Government Commerical Function's guidance for Assessing and Monitoring the Economic and Financial Standing of Bidders and Suppliers recommends this is undertaken annually.

Agreed Action 3.1

To build into all contract monitoring yearly financial monitoring which will break down the contract value and how this is being spent.

Priority	3
Responsible Officer	Senior Public Health Technical Systems Development Officer
Timescale	30th September 2023

Audit Opinions and Priorities for Actions

Audit Opinions

Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.

Our overall audit opinion is based on 4 grades of opinion, as set out below.

Opinion	Assessment of internal control
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Priorities for Actions

Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.