INTERNAL AUDIT

Final Assurance Report 2015/16

Effectiveness of Internal Audit

9th June 2015

Overall IA Assurance Opinion:

REASONABLE

Recommendation Overview:

High Risk	0
Medium Risk	3
Low Risk	6
Notable Practice	0

Review Sponsor:

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Final Report Distribution:

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Ownership of all final Internal Audit assurance reports rests with the relevant Audit Sponsor. However, we will disclose final Internal Audit assurance reports to the Audit Committee upon their specific request.

1. Introduction

1.1 This risk based Internal Audit (IA) assurance review was identified as part of the 2015/16 annual IA plan presented to the Council's Corporate Management Team (CMT) and Audit Committee on 17th March 2015. **The purpose of this review is to provide assurance to management and to the Audit Committee over the following key risks surrounding the Effectiveness of IA:**

- If IA fails to deliver an effective service this will prevent independent, objective assurance to be provided to the Council, Audit Committee, Chief Executive, Directors and Heads of Service. Namely that the key risks associated with the achievement of the Council's vision and strategic priorities being managed effectively; and
- The Council's IA function does not perform an annual review over its conformity with the PSIAS leading to non-compliance with regulations and have reputational and financial consequences.

2. Background

2.1 IA provides an independent assurance and consultancy service that underpins good governance, which is essential in helping the Council achieve its strategic objectives and realise its vision for the borough of Hillingdon. It is also a requirement of the Accounts and Audit (England) Regulations 2011 that the Council undertakes an adequate and effective IA of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control.

2.2 The UK Public Sector IA Standards (PSIAS) came into force on 1st April 2013 and were introduced with the intention of promoting further improvement in the professionalism, quality, consistency and effectiveness of IA across the public sector. They stress the importance of robust, independent and objective IA arrangements to provide senior management with the key assurances they need to support them both in managing the organisation and in producing the Annual Governance Statement (AGS).

2.3 The effectiveness of IA is a key cornerstone of corporate governance. The Accounts and Audit (England) Regulations 2011 require relevant bodies 'to conduct an annual review of the effectiveness of its IA' and that IA should conform to 'proper practices'. If the effectiveness of IA is not measured then the IA service will not know where to improve or how efficient and effective the service is.

2.4 IA conducts an annual review which assesses the effectiveness of the IA function and provides assurance over IA's compliance with the PSIAS. The PSIAS outline the requirement for an 'Internal Assessment' which includes monitoring the performance of IA activity and performing periodic self-assessments by persons with sufficient knowledge of IA practices.

3. Executive Summary

3.1 Overall, the IA opinion is that we are able to give **REASONABLE** assurance over the key risks to the achievement of objectives for the Effectiveness of Internal Audit. Definitions of the IA assurance levels and IA risk ratings are included at **Appendix C**.

3.2 I found there to be a strong control environment and robust governance arrangements in place within the IA service with sufficient evidence to support compliance with the PSIAS. Since the appointment of the Head of Internal Audit (HIA) in July 2013 there have been a large number of significant strategic and operational improvements within the IA service. This has included two significant staffing restructures which have generated financial savings for the Council whilst at the same time improving the overall effectiveness of the IA service.

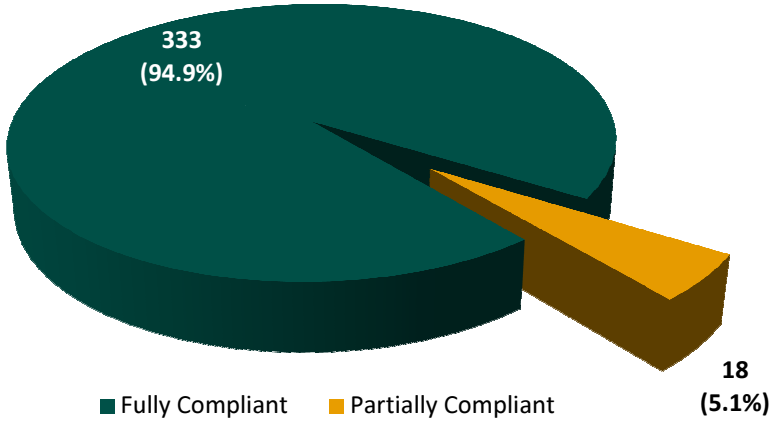
3.3 The key priority for 2014/15 has been the completion of the 2014/15 IA plan to enable the HIA to provide a full and complete Annual Assurance Statement to those charged with governance. This is on track to be achieved, following a significant improvement in the delivery of IA reports, with 96% of audit engagements within the 2014/15 IA Plan delivered to draft report status by the 31st March 2015. This is a significant achievement when compared to prior years. Furthermore, there is evidence that the IA staff have bought into the strategic and operational improvements that have been introduced. This has resulted in the team working together more effectively and collaborating with management in a more approachable manner.

3.4 There is a clear increase in the level of consultancy work that IA has undertaken within the 2014/15 year and this, in addition to the enhanced role that IA have in the improvement of Council services, is a sign of the success of the collaborative approach that IA strive to deliver to help services to succeed. However, during the course of this review it was noted that the approach to consultancy reviews could be further enhanced and formalised. Further, through review of the 2013/14 Annual HIA Report (in addition to the IA Plan for 2015/16) it is clear that the HIA has considered sources of assurance as part of the production of these documents. However, no formal assurance mapping exercise has been undertaken across the Council to enable reliance to be placed on other forms of assurance and thus focus IA resource on assurance gaps across the Council.

3.5 The implementation of IA software (TeamMate) from 1st April 2014 has brought considerable benefits to the IA service and the Council, including the risk based IA approach whilst improving consistency of quality across the team. However, I found that TeamMate is sometimes being used inconsistently within the IA Service therefore in order to provide greater assurance that the IA processes are being consistently followed, I have recommended that a suitably experienced staff member, independent from the audit under review, conducts quarterly sample based reviews of finalised audits. This, in addition to implementing a more formalised management review process, should help ensure that the full benefits from the TeamMate software are realised and embedded.

3.6 As part of this review I have scored the performance of the Council's IA Service against CIPFA's Local Government application note and checklist for assessing conformance with the PSIAS. This best practice checklist builds upon the Institute of Internal Auditor's (IIA) mandatory guidance, as documented within the IIA's International Professional Practices Framework (IPPF) and PSIAS. The checklist contains 351 best practice questions and we are pleased to report that, of the 351 best practice lines within the checklist, IA are **fully compliant with** 333 (**94.9%**) of the requirements. In my opinion IA were partially compliant with 18 (5.1%) of requirements within the checklist. Recommendations have been raised to address areas of partial or non-compliance, with these detailed at **Appendix A** and **Appendix B** respectively. A detailed breakdown of compliance against the checklist is provided at **Appendix D**, whilst the results are depicted below:

Graphical representation of Conformance:



3.7 Due to the dynamic changes that have taken place in IA this year, it is clear that the service has made great strides and continues to move forward in a positive direction. The recommendations raised in this report are designed to help the IA service further build on its strategic plan and service priorities. The detailed findings and conclusions of my testing which underpin the above IA opinion have been discussed at the exit meeting and are set out in section four of this report. The key IA recommendations raised in respect of the risk and control issues identified are set out in the Management Action Plan included at **Appendix A**. Good practice suggestions and notable practices are set out in **Appendix B** of the report.

4. Detailed Findings and Conclusions

4.1 Overall conformity to the PSIAS as per the definition of Internal Auditing and the Code of Ethics

4.1.1 The IIA's IPPF is the conceptual framework that organises authoritative guidance promulgated by the IIA. The IPPF consists of three mandatory elements and three strongly recommended elements. The three mandatory elements of the IPPF are:

- Definition of Internal Auditing;
- Code of Ethics; and
- International Standards for the Professional Practice of Internal Auditing (Standards).

Conformance with the principles set forth in mandatory guidance is required and essential for the professional practice of internal auditing. Mandatory guidance is developed following an established due diligence process, which includes a period of public exposure for stakeholder input.

4.1.2 The IIA Standards (which provide authoritative guidance for the IA profession) consist of Attribute, Performance and Implementation Standards. Attribute Standards address the attributes of organisations and individuals performing IA services. The Performance Standards describe the nature of IA services and provide quality criteria against which the performance of these services can be measured. The Attribute and Performance Standards apply to all IA services. The UK PSIAS, which came into force on 1st April 2013, build upon the IIA's IPPF but provide tailored requirements and guidance to the Internal Audit Activity (IAA) within the Public Sector. Hereafter, where I have referred to "the Standards" within this report we are referring to compliance with the UK PSIAS, and the specific public sector requirements, unless otherwise explicitly stated.

4.1.3 The Standards provide a definition of Internal Auditing as follows:

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

4.1.4 Through my assessment of performance against the Attribute and Performance Standards, discussed under paragraphs 4.2 and 4.3 below, I am pleased to report that **the IA function is meeting the IIA's definition of Internal Auditing and was found to comply with the IIA's Code of Ethics**. We have raised no recommendations in relation to the overall conformance with the Standards.

4.2 Conformity to the Attribute Standards of the PSIAS

4.2.1 Attribute Standards address the attributes of organisations and individuals performing IA services. My assessment of the Council's IAA against Section 3 of CIPFA's PSIAS conformance checklist established that 91.2% (104 of the 114 elements in this section) were adjudged as fully compliant with 8.8% (10 of the 114 elements in this section) deemed

partially compliant when assessed against the Attribute Standard criteria detailed within the CIPFA conformance checklist. Areas with partial compliance are discussed in further detail below.

4.2.2 There have been no reports that the Bribery Act has not been followed by the IA Service and no related issues have been raised over the past year, however, the Bribery Act is not covered in the Council's Anti-fraud and Anti-corruption training. It is known that the IA Team do cover aspects of fraud as part of their professional training; however, it may prove beneficial to further enhance and develop a greater knowledge and understanding of Council processes through the completion of the Council's Anti-Fraud and Anti-corruption training in addition to greater alignment and working arrangements with the Council's Corporate Fraud Investigations Team (CFIT). As this training is not currently mandatory, I have raised a best practice recommendation in this area (refer to **Recommendation 4** in the Management Action Plan at **Appendix B**).

4.2.3 Attribute Standard 1000 states that the purpose, authority and responsibility of the IAA be formally defined in an IA Charter. The IA Charter establishes the IAA's position within the organisation, including the nature of the HIA's functional reporting relationship with the board (Audit Committee); authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of IA activities. My review of the Council's IA Charter highlighted that whilst the term 'the board' was clearly defined, the term 'senior management' for the purposes of IAA was not explicitly defined as required by the Standards. The CIPFA checklist also requires that IA reporting lines and relationships are clearly defined within the IA Charter and, in my opinion, this aspect requires greater clarity. I have raised a recommendation in this area aimed at strengthening compliance with this Standard (refer to **Recommendation 5** in the Management Action Plan at **Appendix B**).

4.2.4 Attribute Standard 1000-C.1 requires that the nature of consulting services must be clearly defined in the IA Charter, which I found to be the case. Attribute Standard 1200 - Due Professional Care states Internal Auditors need to exercise due professional care during a consulting engagement by considering the requirements and expectations of clients, including the nature, timing and communication of engagement results. We established that whilst a formal consultancy engagement process is in place, this process is not formalised when compared to the detailed and documented approach for undertaking assurance reviews.

4.2.5 As part of my review I sample tested 15 audit engagements (12 assurance and 3 consultancy), primarily to assess compliance against the Performance Standards. As part of this testing it was established that, in two of the consultancy reviews sampled, a terms of reference (ToR) had not been produced to formally document the scope of the consultancy activity. In contrast each of the 12 assurance reviews sampled had a ToR produced which sought approval of the objectives of the review. I have raised a recommendation in this area aimed at strengthening compliance with the Attribute Standard 1200-C1 (refer to **Recommendation 1** in the Management Action Plan at **Appendix A**).

4.2.6 The HIA, in accordance with Attribute Standard 1300, is to develop and maintain a Quality Assurance and Improvement Programme (QAIP) that covers all aspects of the IAA. Results of the ongoing assessment are captured within a Quality Assurance and Improvement Programme (QAIP). A QAIP is designed to enable an evaluation of the IAA's conformance with the *Definition of Internal Auditing* and the *Standards* and an evaluation of whether internal auditors apply the *Code of Ethics.* The QAIP also assesses the efficiency and effectiveness of the IAA and identifies opportunities for improvement.

4.2.7 My testing confirmed that a QAIP has been developed and includes tasks, including recommendations arising from the 2013/14 Effectiveness of IA review, to facilitate full conformance with the PSIAS. The IIA's Attribute Standard 1320 states that the HIA must communicate the results of the QAIP to senior management and the board. I established that work carried out throughout the year on the QAIP is communicated to stakeholders.

4.2.8 However, upon review I was unable to fully confirm compliance with the public sector requirement of this Standard to *"report results of the QAIP and progress against any improvement plans within the annual report"*. As a result, a best practice recommendation has been raised aimed at strengthening alignment of the QAIP to the PSIAS (refer to **Recommendation 6** in the Management Action Plan at **Appendix B**).

4.3 Conformity to the Performance Standards of the PSIAS

4.3.1 The Performance Standards describe the nature of IA services and provide quality criteria against which the performance of these services can be measured. My assessment of the Council's IAA against Section 4 of CIPFA's PSIAS Conformance Checklist established that 96.4% (213 of the 221 elements in this section) were adjudged as fully compliant, with 3.6% (8 of the 221 elements in this section) deemed partially compliant. when assessed against the Performance Standard's criteria. Areas with partial or non compliance are discussed in further detail below.

4.3.2 An area identified with partial compliance relates to Performance Standard 2010, whereby the public sector requirement states that the risk-based plan must take into account the requirement to produce an annual IA opinion and the assurance framework. Through review of the 2013/14 Annual HIA Report as well as the IA Plan for 2015/16 it is clear that the HIA has considered other sources of assurance as part of the production of these documents. However, I noted that no formal assurance mapping exercise has been undertaken across the Council. This would help enable formal reliance to be placed on the other forms of assurance and focus IA resource on any assurance gaps across the Council. I have therefore raised a recommendation in this area (refer to **Recommendation 2** in the Management Action Plan at **Appendix A**).

4.3.3 In accordance with Performance Standard 2500.A1, the HIA has established a follow-up process to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action. This method was reported to have achieved extremely positive results for the Council's overall control environment in the last 12 months, with the vast majority of high and medium risk IA recommendations raised now promptly implemented by management. In fact, the quarterly IA progress report to the Audit Committee in March 2015 reported that only 3% of high and medium risk IA recommendations were outstanding. By comparison, in June 2013 this figure was 47% and in the last 3 years this figure has been as high as 69%.

4.3.4 The implementation of recommendations raised by IA continues to be monitored by the IA team whilst TeamCentral (a module of the IA software TeamMate), is embedded across the Council. TeamCentral was confirmed to have been rolled out to four of the five Groups (Directorates) within the Council. Training for the final Group, Residents Services, is scheduled for Q1 of 2015/16. Verification of management's assertion of implemented action is conducted through selected follow up audits. It was noted that not all follow up audits were carried out as anticipated during 2013/14. This was as a result of changing priorities and a revised risk focus within the 2013/14 IA plan. This has been remediated within 2014/15 with numerous detailed follow-up reviews undertaken. However, a more formal process for the selection of follow up audits could aid consistency in this area and therefore a recommendation has been raised in respect of this (refer to **Recommendation 7** in the Management Action Plan at **Appendix B**).

4.3.5 In accordance with Performance Standard 2340 IA engagements must be properly supervised to ensure objectives are achieved, quality is assured and staff are properly developed. We found that established and effective management review and supervision is in place and undertaken throughout the audit process for all IA engagements. Typically this includes management providing direction and advice to team members during the course of the engagement. The scope of this supervision is dependent on the proficiency and experience of the auditor as well as the complexity and nature of the IA engagement being undertaken.

4.3.6 We established that formal feedback is provided to staff via the Council's performance management cycle. Further, audit reports are reviewed utilising tracked changed to provide staff with coaching and development on their report writing skills. There is, however, an inconsistent approach undertaken to the review of IA working papers to seek to continually drive up quality as well as satisfy all the requirements of Performance Standard 2300 - Performing the Engagement. A recommendation has been raised in respect of this aimed at evidencing compliance with this Performance Standard (refer to **Recommendation 3** in the Management Action Plan at **Appendix A**).

4.3.7 In addition to testing compliance with the Standards, I sample tested 15 IA engagements (as discussed in para. 4.2.5) to confirm adherence to the processes documented within the IA Manual with the objective to highlight specific areas where processes could be further enhanced.

4.3.8 As part of my testing I reviewed the usage of the Electronic Working Papers (EWP) module of TeamMate for each of the 15 engagements sampled, with the EWP module found to have been used during the course of the engagement in 8 of the 15 engagements sampled. In the six of the exception cases it was identified that whilst the EWP module had been completed in full, this was undertaken following the issue of the draft report/consultancy memo. The one remaining case sampled related to an audit completed under the contract for the provision of IA services to the West London Waste Authority (WLWA); it has been agreed that due to limited access to TeamMate whilst working offsite, TeamMate update could be completed following the fieldwork and therefore I deemed this case satisfactory.

4.3.9 Examination of the detail within the TeamMate EWP files identified that the documentation of risk, control and testing methodologies was inconsistent. Further, functionality within the risk and control evaluation is not being fully utilised with the ability to link controls to testing activities not effectively embedded, resulting in manual input and the potentially for duplication of effort.

4.3.10 I further tested TeamMate EWP for compliance with Performance Standard 2330, to ensure that relevant information is in place to support the conclusions and engagement results. My testing identified that 3 of the 15 engagement working papers sampled required further explanation of tests conducted to enable another auditor to re-perform the audit testing, as per best practice guidelines. I have raised a recommendation in this area aimed at strengthening controls in this area (refer to **Recommendation 3** in the Management Action Plan at **Appendix A**).

4.3.11 In accordance with Performance Standard 2440, the HIA must communicate results to the appropriate parties. We confirmed that appropriate and effective communication methods are in operation within the Service. It was established, via discussion with the HIA, that IA does not directly release engagement results (IA reports) to parties outside of the organisation. If they did, a disclaimer on the limitations on the distribution and use of the results (within the IA report) would be included. However, it was noted that the quarterly progress reports to Audit Committee are made available to the public. Therefore, in order to satisfy Performance Standard 2440.A, a disclaimer should be included on these reports and I have raised a recommendation to strengthen compliance with the Performance Standards (refer to **Recommendation 8** in the Management Action Plan at **Appendix B**).

4.4 Follow up recommendations made in the 2013/14 Effectiveness of IA review

4.4.1 The 2013/14 review Effectiveness of IA review provided a **REASONABLE** assurance opinion, with **3 MEDIUM** and **7 LOW** risk recommendations raised. As part of this review we have verified the implementation of the medium risk recommendations confirming that two have been fully implemented and one has been deemed as partly implemented. This relates to the HIA performing quality checks on IA files on a quarterly basis. I confirmed that a formal process has been set up, but so far this has been performed annually rather than quarterly. I have therefore raised this as a good practice suggestion (refer to **Recommendation 9** in the Management Action Plan at **Appendix B**).

5. Acknowledgement

5.1 I would like to formally thank all of the officers contacted during the course of this review for their co-operation and assistance.

6. Internal Audit Contact Details

This audit was led by: Elaine Portess
Principal Internal Auditor

This audit was reviewed by: Martyn White, CIA
Senior Internal Audit Manager

Thank you,

Elaine Portess
Principal Internal Auditor

APPENDIX A

Management Action Plan

No.	Recommendation	Risk	Risk Rating	Risk Response	Management Action to Mitigate Risk	Risk Owner & Implementation date
1	Management should review and formalise the process for the undertaking of consultancy work. This should include the requirement for a terms of reference, to agree the objectives and scope of each review, with the IA Manual/Process documents updated accordingly (para ref 4.2.5).	*Where procedures are not clearly documented, there is the risk that work is undertaken in an ad hoc fashion, resulting in inconsistent working practices and standards, which may in turn impact upon the reputation of the IA service.*	MEDIUM ●	**TREAT**	The process for undertaking consultancy reviews has been the subject of a great deal of discussion within the IAMT over the last few months. The process will be reviewed and updated and ToRs will be produced where the updated process requires it. However, some advisory work (i.e. verbal advice, a quick document review, etc) will likely be carried out without the need for a formal ToR to be issued.	**Muir Laurie**, Head of Internal Audit 31st October 2015
2	A formal assurance mapping exercise should be undertaken across the Council to enable reliance to be placed on other forms of assurance and focus IA resource on assurance gaps across the Council (para ref 4.3.2).	*There is an increased likelihood that sources of assurance are not identified resulting in gaps in assurance arising with increased potential for risks materialising. Further, there is an increased likelihood that duplication of effort arises, reducing the efficiency of the Council's sources of assurance.*	MEDIUM ●	**TREAT**	The idea of conducting a formal assurance mapping exercise already features in the IA Quality Assurance and Improvement Programme and is something the IAMT have discussed. It is also something that the HIA is very keen to see carried out, but in the longer term as part of a wider LBH move to Control Risk Self Assessment and an Enterprise Risk Management Framework.	**Muir Laurie**, Head of Internal Audit 1st July 2016

APPENDIX A (cont'd)

No.	Recommendation	Risk	Risk Rating	Risk Response	Management Action to Mitigate Risk	Risk Owner & Implementation date
3	The use of TeamMate should be further embedded within the IA Team to become business as usual and to utilise the full benefits of the system. This should include the use of the risk and control evaluation to focus audit time and resource on risks and mitigating key controls. A file review sheet should be formally implemented to provide formal and constructive development to IA staff whilst enhancing quality across the service. A plan document should also be developed and utilised for each engagement which assists in time allocation and management (para ref 4.3.6 and 4.3.10).	*Where audit working paper software is not used as intended, working papers reviews are not formally documented and planning documents are not utilised there is an increased likelihood that the quality and efficiency of Internal Auditor's work is negatively affected or further team efficiencies are not achieved.*	MEDIUM ●	**TREAT**	Improving the use of TeamMate has been the subject of a great deal of discussion within the IAMT over the last few months. IA processes in this area will be updated and improved and communicated effectively to all of the IA team. The IAMT will ensure they and the rest of the IA service fully comply with the updated procedures in relation to the use of TeamMate, subject to potential ICT restrictions i.e. where IA staff are unable to access TeamMate due to a lack of internet connection.	**Muir Laurie**, Head of Internal Audit 31st March 2016

APPENDIX B

Good Practice Suggestions & Notable Practices Identified

No.	Observation/ Suggestion	Rationale	Risk Rating
4	The IA team should undertake training on the UK Anti Bribery Act in addition to the Council's Anti Fraud and Anti Corruption Training to enhance their understanding of the Council's anti-fraud arrangements (para ref 4.2.2).	*Where staff are not up to date with latest guidance, there is an increased likelihood that staff do not perform their duties to the standard that is required, potentially lacking conformance with the PSIAS in relation to having sufficient knowledge to evaluate the risk of fraud and anti-fraud arrangements in the organisation.*	LOW ●
5	At the next review of the Internal Audit (IA) Charter, management should further define 'senior management' in addition to providing greater clarity on IA's reporting lines and relationships with management, the board and other areas of the organisation (para ref 4.2.3).	*Where the IA Charter is not explicit in its description of senior management, reporting lines and relationships, there may be confusion over the level of independence that IA operates, which may impact negatively upon the reputation of IA.*	LOW ●
6	The Quality Assurance and Improvement Programme (QAIP) should include direct links to the Public Sector Internal Audit Standards (PSIAS) and thus be used to demonstrate the conformance with PSIAS. Progress against the QAIP should be explicitly referred to in the Annual Report, with consideration of appending the QAIP to quarterly progress reports to the Audit Committee (para ref 4.2.8).	*Where the QAIP is not clearly and directly linked to the PSIAS there is an increased likelihood that the Council do not fully conform to the requirements of the PSIAS. Where the progress made against the QAIP is not clearly communicated to the Audit Committee, within the Annual Report, the board (Audit Committee) may not be fully aware of areas of non conformance and unable to challenge and monitor areas for improvement.*	LOW ●
7	To further enhance the follow up of recommendations, a consistent process should be applied such as detailed follow up of all limited or no assurance audits in the subsequent year and full verification of all high risk recommendations. (para ref 4.3.4).	*Where a consistent and formal process is not applied to the follow up of recommendations, there is a risk that not all recommendations are followed up by the time they fall due. Further, where recommendations have been implemented but not verified, there is an increased likelihood that incorrect implementation of recommendations goes undetected and the risk remains unmitigated.*	LOW ●

Good Practice Suggestions & Notable Practices Identified

No.	Observation/ Suggestion	Rationale	Risk Rating
8	In order to satisfy Performance Standard 2440.A, IA should seek advice from Legal Services regarding the inclusion and wording of a disclaimer on IA reports within the public domain such as those presented to the Council's Audit Committee. This should include detail around the limitations of the report, its distribution and content within the report (para ref 4.3.11).	*Where disclaimers are not included on reports within the public domain, there is an increased likelihood that IA results are used for unintended purposes. This may incur reputational damage on both the Council, and the IA Service.*	**LOW** ●
9	Quarterly quality checks of TeamMate EWP files should be undertaken by the HIA to ensure high standards are continually achieved. The results of these checks should feed into the Quality Assurance and Improvement Programme (QAIP) (para ref 4.4.2).	*Where quality checks do not take place throughout the year, there is an increased risk that standards may not be achieved and are unidentified, preventing continued improvement of the audit process and a negative impact upon the IA team's effectiveness and reputation.*	**LOW** ●

APPENDIX C

INTERNAL AUDIT ASSURANCE LEVELS AND DEFINITIONS

ASSURANCE LEVEL	DEFINITION
SUBSTANTIAL	There is a **good level of assurance** over the management of the key risks to the Council objectives. The control environment is robust with no major weaknesses in design or operation. There is **positive assurance** that objectives will be achieved.
REASONABLE	There is a **reasonable level of assurance** over the management of the key risks to the Council objectives. The control environment is in need of some improvement in either design or operation. There is a misalignment of the level of residual risk to the objectives and the designated risk appetite. There remains **some risk** that objectives will not be achieved.
LIMITED	There is a **limited level of assurance** over the management of the key risks to the Council objectives. The control environment has significant weaknesses in either design and/or operation. The level of residual risk to the objectives is not aligned to the relevant risk appetite. There is a **significant risk** that objectives will not be achieved.
NO	There is **no assurance** to be derived from the management of key risks to the Council objectives. There is an absence of several key elements of the control environment in design and/or operation. There are extensive improvements to be made. There is a substantial variance between the risk appetite and the residual risk to objectives. There is a **high risk** that objectives will not be achieved.

1. **Control Environment:** The control environment comprises the systems of governance, risk management and internal control. The key elements of the control environment include:
   - establishing and monitoring the achievement of the authority's objectives;
   - the facilitation of policy and decision-making;
   - ensuring compliance with established policies, procedures, laws and regulations – including how risk management is embedded in the activity of the authority, how leadership is given to the risk management process, and how staff are trained or equipped to manage risk in a way appropriate to their authority and duties;
   - ensuring the economical, effective and efficient use of resources, and for securing continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness;
   - the financial management of the authority and the reporting of financial management; and
   - the performance management of the authority and the reporting of performance management.

2. **Risk Appetite:** The amount of risk that the Council is prepared to accept, tolerate, or be exposed to at any point in time.

3. **Residual Risk:** The risk remaining after management takes action to reduce the impact and likelihood of an adverse event, including control activities in responding to a risk.

APPENDIX C (cont'd)

RISK RESPONSE DEFINITIONS

RISK RESPONSE	DEFINITION
TREAT	The probability and / or impact of the risk are reduced to an acceptable level through the proposal of positive management action.
TOLERATE	The risk is accepted by management and no further action is proposed.
TRANSFER	Moving the impact and responsibility (but not the accountability) of the risk to a third party.
TERMINATE	The activity / project from which the risk originates from are no longer undertaken.

INTERNAL AUDIT RECOMMENDATION RISK RATINGS AND DEFINITIONS

RISK	DEFINITION
HIGH ●	The recommendation relates to **a significant threat** or opportunity that impacts the Council's corporate objectives. The action required is to mitigate a substantial risk to the Council. In particular it has an impact on the Council's reputation, statutory compliance, finances or key corporate objectives. **The risk requires senior management attention**.
MEDIUM ●	The recommendation relates to **a potentially significant threat** or opportunity that impacts on either corporate or operational objectives. The action required is to mitigate a moderate level of risk to the Council. In particular an adverse impact on the Department's reputation, adherence to Council policy, the departmental budget or service plan objectives. **The risk requires management attention**.
LOW ●	The recommendation relates to **a minor threat or opportunity** that impacts on operational objectives. The action required is to mitigate a minor risk to the Council as a whole. This may be compliance with best practice or minimal impacts on the Service's reputation, adherence to local procedures, local budget or Section objectives. **The risk may be tolerable in the medium term**.
NOTABLE PRACTICE ●	The activity **reflects current best management practice** or is an innovative response to the management of risk within the Council. **The practice should be shared with others**.

APPENDIX D

Summary of conformance with CIPFA's Public Sector Internal Audit Standards (PSIAS) checklist:

PSIAS Conformance Area	Compliant	Partially Compliant	Non Complaint	Total
1 Definition of Internal Auditing The Definition of Internal Auditing is the statement of fundamental purpose, nature and scope of internal auditing.	3	0	0	**3**
2 Code of Ethics The Code of Ethics is a statement of principles and expectations governing behaviour of individuals and organisations in the conduct of internal auditing.	13	0	0	**13**
3 Attribute Standards				
3.1 1000 Purpose, Authority and Responsibility The purpose, authority and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Definition of Internal Auditing, the Code of Ethics and the Standards. The chief audit executive must periodically review the internal audit charter and present it to senior management and the board for approval.	20	3 (para ref 4.2.3)	0	**23**
3.2 1100 Independence and Objectivity The internal audit activity must be independent and internal auditors must be objective in performing their work.	34	1 (para ref 4.2.2)	0	**35**
3.3 1200 Proficiency and Due Professional Care Engagements must be performed with proficiency and due professional care.	19	2 (para refs 4.2.2 and 4.2.5)	0	**21**
3.4 1300 Quality Assurance and Improvement Programme The chief audit executive must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity.	31	4 (para ref 4.2.8)	0	**35**
Attribute Standard Sub Total	***104***	***10***	***0***	***114***
4 Performance Standards				
4.1 2000 Managing the Internal Audit Activity The chief audit executive must effectively manage the internal audit activity to ensure it adds value to the organisation.	46	1 (para ref 4.3.2)	0	**47**
4.2 2100 Nature of Work The internal audit activity must evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach.	31	0	0	**31**

APPENDIX D (cont'd)

PSIAS Conformance Area	Compliant	Partially Compliant	Non Complaint	Total
4.3 2200 Engagement Planning Internal auditors must develop and document a plan for each engagement, including the engagement's objectives, scope, timing and resource allocations.	56	2 (para ref 4.2.5)	0	**58**
4.4 2300 Performing the Engagement Internal auditors must identify, analyse, evaluate and document sufficient information to achieve the engagement's objectives.	21	1 (para ref 4.3.6)	0	**22**
4.5 2400 Communicating Results Internal auditors must communicate the results of engagement.	54	3 (para refs 4.2.8, and 4.3.11)	0	**57**
4.6 2500 Monitoring Progress The chief audit executive must establish and maintain a system to monitor the disposition of results communicated to management.	3	1 (para ref 4.3.4)	0	**4**
4.7 2600 Communicating the Acceptance of Risks When the chief audit executive concludes that senior management has accepted a level of residual risk that may be unacceptable to the organisation, the chief audit executive must discuss the matter with senior management.	2	0	0	**2**
Performance Standard Sub Total	***213***	***8***	***0***	***221***
Total	**333**	**18**	**0**	**351**
Percentage	**94.9%**	**5.1%**	**0.0%**	**100%**

Graphical representation of Conformance: