APPENDIX 1
Tees Valley Audit & Assurance Services

Annual Internal Audit Report

Middlesbrough Council
Internal Audit Annual Report 2017/18

Report issued by: Helen Fowler, Audit and Assurance Manager

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Distributed to:

Members of the Corporate Affairs and Audit Committee

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Tees Valley Audit & Assurance Services

Annual Report of the Audit and Assurance Manager

2017/18

1. Introduction

1.1 The objectives of this report are to:

a) Provide a summary of the internal audit and assurance work performed in the year 2017/18 and to express an opinion on Middlesbrough Council's overall internal control environment, based on the work carried out.

b) To consider the internal audit performance outturn for 2017/18 for Tees Valley Audit & Assurance Services and to provide an assessment of the internal audit service against the Public Sector Internal Auditing Standards (PSIAS).

2. Background

2.1 Since 1 January 2011, the Council's internal audit service has been provided by Tees Valley Audit & Assurance Services (TVAAS), a shared service arrangement between Redcar & Cleveland and Middlesbrough Councils. On 1 April 2014, TVAAS services to Redcar and Cleveland expanded and now incorporates health and safety, risk management and insurance and business continuity.

2.2 The work of TVAAS is governed by the Accounts and Audit Regulations 2015 and Public Sector Internal Audit Standards (PSIAS). In accordance with the PSIAS, the Audit and Assurance Manager is required to report to those charged with governance on the findings of audit work, provide an annual opinion on the Council's internal control environment and identify any issues relevant to the preparation of the Annual Governance Statement. Audit work was undertaken across the Council's services and activities in accordance with an Internal Audit Plan, which was approved by the Corporate Affairs and Audit Committee at its meeting on 29 June 2017.

2.3 Internal Audit assists management in delivering the objectives of the Council by working to an annual programme of work that includes assignments linked to corporate risks and priorities, and which seeks to add value by assessing the quality of controls in place to assure delivery, ensure value for money and achieve better outcomes for local people.

2.4 The Corporate Affairs and Audit Committee has responsibility for reviewing the adequacy of the Council's corporate governance arrangements. Reports issued by TVAAS are a key source of assurance providing the Committee with some evidence that the internal control environment is operating as intended. On behalf of the Corporate Affairs and Audit Committee and the Strategic Director Finance, Governance & Support (Section 151) Officer, TVAAS acts as an assurance function providing an independent, objective assurance 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.

3. Annual Internal Audit Opinion

3.1 TVAAS undertakes its programme of work in accordance with the standards set out in the PSIAS. Standard 2450 states that the Council's chief audit executive should provide an annual internal audit opinion and report on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The annual opinion should be supported by sufficient, reliable, relevant and useful information. The annual report should cover:

(a) the scope of the work undertaken and the time period to which that opinion refers;
(b) a summary of the audit work used to form an opinion;
(c) the opinion on the overall adequacy and effectiveness of the Council's governance, risk and control framework;
(d) any qualifications to be made to the overall opinion and reasons for them,
(e) any issues of relevance to the Council's Annual Governance Statement;
(f) a statement on conformance with the PSIAS and the results of the internal audit service's quality assurance and improvement programme.

3.2 The overall opinion of the Audit and Assurance Manager on the controls operating in the Council during 2017/18 is that they provide **Good Assurance**. This opinion is based on the work performed by the internal audit team during the year 2017/18 **(Appendices A-E).** If reliance has been placed on another assurance body in reaching this opinion, this will be noted against the relevant assignment.

3.3 The higher number of reports that have been issued during the year with a moderate or cause for concern opinion meant that consideration was given to whether the annual opinion for 2017/18 should have been reduced to a moderate opinion. When making this assessment, consideration has been given to the areas where issues were identified, the responsiveness of management action to those issues and whether the issues relate to one service area or are more widespread across the Council.

3.4 The opinion of Good for 2017/18 therefore takes into account that assurance can be obtained by the number of reports where the overall opinion is Strong or Good and the action taken to implement recommendations where cause for concern or moderate opinions have been given. Three priority one actions have been raised during the year but that all have since been implemented and there are no P1s outstanding from previous years. During 2017/18, Internal Audit issued four reports (one of which was an investigation) with a cause for concern opinion: street lighting contract; laboratories, trading limits breach investigation and Data Protection Reforms.

3.5 Based on the audit work carried out during 2017/18, Internal Audit identified many areas where controls and governance were assessed as being strong or good and the financial control audits continue to consistently receive a high level of assurance. The number of management actions that pass their due date but remain outstanding is lower than in previous years. The main areas where control was found to be weaker are outlined below.

3.6 One area related to compliance with processes, the need for greater management monitoring and oversight in some areas and the scope for more effective monitoring of service or contract performance. Although these issues may not be Council wide, they did emerge in a number of audits throughout the year. Whilst many of the recommended actions have since been implemented, the need for management scrutiny and monitoring needs to be maintained in accordance with the Middlesbrough Manager framework.

3.7 Another area that was highlighted for governance attention during the year was the process for declarations of interest, gifts and hospitality. This area had been subject to an internal audit two years ago resulting in a cause for concern opinion. When this year's audit commenced, it was apparent that many of the actions recommended and agreed in the original audit regarding a consistent approach to the recording and management of declarations had not been fully implemented. However, steps have since been taken to improve the control environment and all recommendations have since been confirmed by the Auditor as implemented. LMT has now requested that it is briefed on any Internal Audit findings that are moderate or below so they are aware of the issues, mitigating actions and timescales to deliver these, and receive regular updates on progress.

3.8 Data Protection Reforms – at the request of the Council, this area was reviewed in preparation for the new regulations and was a cause for concern report at the time of its issue in January 2018. Although the Council has specialist knowledge and awareness of the Data Protection reforms and their impact and had identified some strategic actions that need to be undertaken, testing at the time of the audit identified the need for improvements in the strategic governance, planning, documenting, and resourcing the Council's approach and response to meeting the reforms. The report included one P1 action which has since been implemented. The Council has also appointed its Data Protection Officer which is a statutory role.

3.9 During 2017/18 Internal Audit tested further progress made by the Council to address the implementation and embedding of its land and property disposal framework. This has been the subject of previous internal audit concern and was also the remaining issue upon which the External Auditor qualified its value for money opinion for the 2016/17 Statement of Accounts. Testing identified the progress that has been made to embed the process but highlighted some further areas for development which were accepted by management. This work was carried out in December 2017 and therefore it is expected that further progress will have been made since then. External audit testing is currently underway

3.10 For the previous year 2016/17, approximately 112 internal audit recommendations were made of which 97 have been closed as implemented and one has been closed as the risk has been accepted by management. Only 12 actions remain outstanding (10 P2 and 2 P3) of which only one has passed its due date. For 2017/18, 134 actions have been recommended, of which 61 have been implemented to date. Of the 73 that have yet to be implemented, only 11 (7 P2 and 4 P3) have passed their agreed target date (as at 30 June 2018).

3.11 Many audits undertaken during the previous year 2016/17 confirmed that suitable policy and procedural frameworks had been established as a result of the Council Improvement Plan. At that time, it was too early to conclude on the extent to which such frameworks had become embedded within the Council's overall culture. The overall internal audit opinion of Good for 2016/17 was therefore an assessment of the policy and procedural framework and not an

assessment of the extent to which that framework had been embedded or was being complied with. Embedding and compliance has therefore been a main focus for audit work undertaken during 2017/18. The higher number of Moderate opinions given would suggest that compliance with contract and performance management requires improvement in some service areas (as discussed in 3.6) however many of the key governance areas such as project management, risk management, medium term financial plan, decision making, capital programme etc. have received strong or good assurance.

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3.12 2017/18 provided sufficient flexibility and contingency to enable a number of variations to the agreed audit plan to take place. **Appendix G** details the main variations to the version of the plan originally agreed in June 2017. It should be noted that not all of the assignments in **Appendix G** replaced planned audits as each annual audit programme includes a contingency allocation of time for dealing with issues as they arise.

4. Internal Audit Resources

4.1 TVAAS is hosted by Redcar & Cleveland Council and the internal audit provision is delivered through a joint arrangement with a service level agreement setting out the terms of the service to be provided to Middlesbrough Council.

4.2 TVAAS now comprises officers from internal audit, health and safety, risk management, insurance and business continuity. TVAAS currently has a staffing resource of 15 staff (with two vacancies). Officers across the combined Audit and Assurance Team can share information and assist the timely communication and resolution of risk and areas of non compliance. There have been some resourcing issues encountered during the year due to a long term absence that has now been resolved. In addition, the Team has been carrying some vacancies and there is currently a recruitment exercise underway to recruit two auditors. One new auditor is due to start with the Team at the end of July 2018.

5. Value Added

5.1 From the outset, one of the objectives of the shared service was to add value in the work that it performs. As Middlesbrough Council faces significant and challenging financial pressures in the years ahead, it is vital that TVAAS' work supports the Council in achieving its objectives.

5.2 To ensure that TVAAS delivers an effective internal audit service, the Audit and Assurance Manager completes an annual assessment of the internal audit service against the criteria as set out in the Public Sector Internal Audit Standards. **Appendix H** includes the summary assessment but the full assessment has been subject to independent review by Hartlepool Borough Council who reported in May 2018 satisfactory assurance that TVAAS is compliant with the PSIAS with only minor suggestions for development. Those areas and others identified by the Audit and Assurance Manager are reflected in the proposed actions in **Appendix H**.

6. Appendices

Appendix A - Summary of final and draft audit reports issued 2017/18
Appendix B - Type of recommendations made during 2017/18
Appendix C - Final reports with a Moderate Opinion (or less) 2017/18
Appendix D – Priority 1 Recommendations
Appendix E – Basis of Opinion

Appendix F - TVAAS performance outturn 2017/18
Appendix G - Variations to the 2017/18 audit plan
Appendix H – Self assessment of TVAAS against the Public Sector Internal Audit Standards

APPENDIX A – COMPLETED AUDITS/FINAL REPORTS ISSUED 2017/18

Audited System /Service			Priority				
	Directorate	Assurance Opinion	P1	P2	P3	Draft Date	Final Date
Purchasing Cards	Finance, Governance & Support	Moderate	0	3	1	30/10/2017	22/11/2017
Youth Offending Service	Children's Services	Moderate	0	4	1	10/11/2017	01/12/2017
Declarations of Interests	Finance, Governance & Support	Moderate	0	4	1	14/11/2017	07/12/2017
Town Hall Project Management	Growth and Place	Strong	0	1	2	16/11/2017	15/12/2017
Planning Enforcement	Growth and Place	Moderate	0	4	1	30/10/2017	20/12/2017
Data Protection Reforms	Finance, Governance & Support	Cause for Concern	1	7	1	28/11/2017	10/01/2018
Highways and Winter Maintenance	Growth and Place	Moderate	0	3	3	22/12/2017	10/01/2018
Compliance with Contract Procedure Rules	Finance, Governance & Support	Strong	0	1	0	17/10/2017	09/02/2018
Capital Accounting	Finance, Governance & Support	Strong	0	0	0	31/01/2018	21/02/2018
Income Targets	Finance, Governance & Support	Strong	0	0	1	12/02/2018	26/02/2018

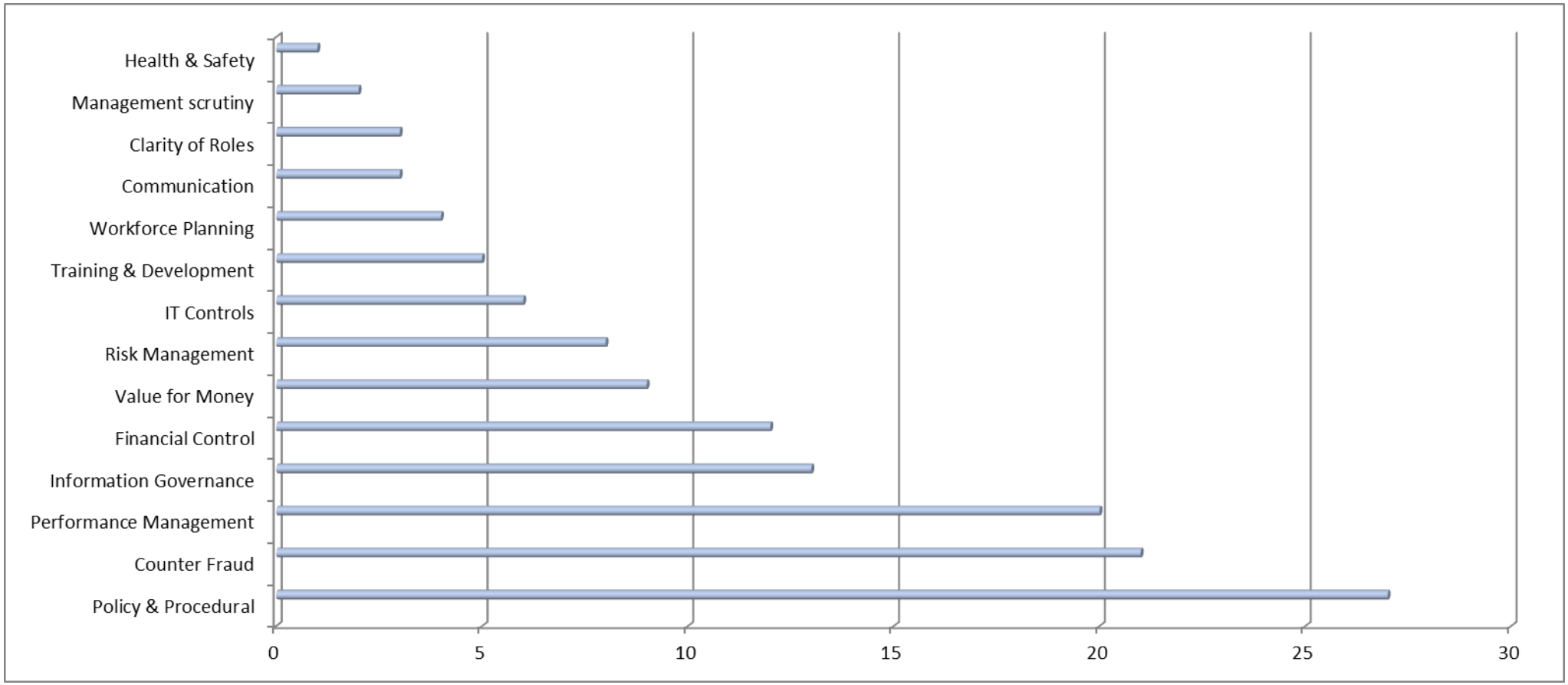
Audited System /Service			Priority				
	Directorate	Assurance Opinion	P1	P2	P3	Draft Date	Final Date
Property and Commercial Services	Growth and Place	Strong	0	1	1	12/02/2018	01/03/2018
LED Street Lighting Contract	Growth and Place	Cause for Concern	0	7	0	13/02/2018	15/03/2018
Trading Breach	Finance, Governance & Support	Cause for Concern	2	2	6	23/11/2017	16/03/2018
Social Care Payments	Social Care	Moderate	0	6	1	07/02/2018	04/04/2018
Newport Primary School	Children's Services	Strong	0	0	3	12/03/2018	12/04/2018
HR Policies Compliance	Finance, Governance & Support	Good	0	3	6	29/03/2018	10/05/2018
Capital Programme	Finance, Governance & Support	Strong	0	0	0	26/02/2018	14/05/2018
Laboratories	Growth and Place	Cause for Concern	0	8	0	29/04/2018	14/05/2018
Volunteer Controls	Growth and Place	Good	0	3	1	24/04/2018	21/05/2018
Pension Fund Investments	Finance, Governance & Support	Strong	0	0	0	02/05/2018	22/05/2018
Medium Term Financial Plan	Finance, Governance & Support	Strong	0	0	0	03/05/2018	23/05/2018
Complaints Management	Finance, Governance &	Moderate	0	3	3	11/04/2018	06/06/2018

Audited System /Service	Directorate	Assurance Opinion	Priority			Draft Date	Final Date
			P1	P2	P3		
	Support						
Decision Making	Finance, Governance & Support	Good	0	3	2	29/04/2018	08/06/2018
Road Safety	Growth and Place	Strong	0	1	0	11/05/2018	11/06/2018
Project Management	Finance, Governance & Support	Good	0	2	0	24/05/2018	13/06/2018
Risk Management	Finance, Governance & Support	Good	0	5	4	04/05/2018	20/06/2018
St Pius Primary	Children's Services	Strong	0	0	0	14/06/2018	26/06/2018
Beech Grove Primary School	Children's Services	Strong	0	1	0	14/06/2018	27/06/2018
Breckon Hill Primary School	Children's Services	Strong	0	1	1	15/06/2018	27/06/2018
Financial Planning, Monitoring And Control	Finance, Governance & Support	Strong	0	0	2	13/06/2018	28/06/2018
Ayresome Primary School	Children's Services	Good	0	2	0	15/06/2018	29/06/2018
Housing & Council Tax Benefits	Finance, Governance & Support	Strong	0	0	0	25/06/2018	29/06/2018
Council Tax and Business Rates	Finance, Governance &	Strong	0	0	0	15/06/2018	02/07/2018

Audited System /Service			Priority				
	Directorate	Assurance Opinion	P1	P2	P3	Draft Date	Final Date
	Support						
Payroll	Finance, Governance & Support	Good	0	2	2	01/06/2018	04/07/2018
Travel & Expenses	Finance, Governance & Support	Good	0	4	1	01/06/2018	04/07/2018
Pension Fund Admin	Finance, Governance & Support	Strong	0	0	0	21/06/2018	09/07/2018
Main Accounting/Bank Reconciliation	Finance, Governance & Support	Strong	0	0	2	14/06/2018	13/07/2018
Debtors	Finance, Governance & Support	Strong	0	0	2	18/04/2018	13/07/2018
Creditors	Finance, Governance & Support	Strong	0	0	1	18/05/2018	13/07/2018
Total		**133**	**3**	**81**	**49**		

Of the 133 recommendations detailed above, three were ranked as Priority 1 and more detail on these actions is provided in Appendix D. A further one P2 action was recommended and implemented (making 134 in total) as a result of a special investigation into a suspected fraud incident (investigation is ongoing and therefore no further information is provided at this point).

APPENDIX B - The table below highlights the type of issues being found during 2017/18 (based on 134 recommendations from 2017/18 year (final reports only)



APPENDIX C – FINAL INTERNAL AUDIT REPORTS 2017/18 WITH AN OPINION OF MODERATE OR LESS

Audit Title	Overall Assurance Level	Summary
Purchasing Cards 22/11/2017	Moderate	Sample testing identified control weaknesses in relation to the use of purchasing cards which need to be addressed in order to strengthen the anti-fraud environment and ensure that cards are used in accordance with procedures. Although there were only four recommendations included in the audit report, the issues with VAT recovery and the fact that 31% of card users tested were not performing any checks on the validity of their card expenditure meant that the overall assurance level could not be higher. Four actions were recommended of which all have since been confirmed as implemented.
Youth Offending Service 01/12/2017	Moderate	The main issues identified during the audit related to the weaknesses in anti-fraud controls in two main areas: • The accurate completion of travel/visit related documentation, the retention of all supporting documentation, and the proper authorisation of travel expense claims; • The extent to which expenditure incurred by purchasing cards is monitored and controlled. Testing demonstrated that only three of the six recommendations contained in the previous audit report issued in 2015, had continued to be complied with. Recommendations were therefore made again in these areas. Whilst, all key procedural documents were found to have been updated, there were some non-key procedure documents that still required review. Five actions were recommended of which all have been confirmed as implemented.
Declarations of Interest/Gifts & Hospitality 07/12/2017	Moderate	Clear guidance was available for officers and Members for declaring interests, gifts and hospitality under the current arrangements but the corporate process for managing declarations, once received, remained weak as highlighted in the 2016 audit. Improvements were still required to the control environment to ensure that any declarations are recorded, and responded to in a consistent and appropriate manner by management across all directorates. Overall, audit testing identified that several recommendations made during the previous audit in 2016, had not been fully

Audit Title	Overall Assurance Level	Summary
		implemented meaning that some issues remained. The management of declarations has since transferred to the Members and Statutory Services Manager and discussions during this audit proved positive in terms of the new manager's recognition of the weaknesses highlighted by the Principal Auditor and the steps that have already been taken to improve the control environment. For that reason, an assurance rating of moderate (rather than cause for concern) was given in the report. Five actions were recommended of which all have been confirmed as implemented.
Planning Enforcement 20/12/2017	Moderate	Whilst a revised enforcement manual has been under development since April 2017, the existing version had not been updated since 2008 meaning that the manual had not captured legislative changes in the intervening period. Audit testing of a sample of alleged breaches reported to the Service identified that none had been dealt with in accordance with required timescales or had been adequately resolved. Performance monitoring in relation to enforcement action was found to require improvement and whilst the lack of an enforcement officer between June and October 2017 had contributed to these issues, audit testing confirmed that many of the issues pre-dated that period. It was anticipated that the new enforcement officer will address the control weaknesses raised in the report. Five actions were recommended and all have now been confirmed as implemented.
Highways/Winter Maintenance 10/01/2018	Moderate	The main issues identified by the audit related to the lack of evidence to provide assurance that the Service is actively assessing its performance. This was due to an absence of performance monitoring information for both highways and winter maintenance, despite the winter maintenance plan stating that such data is collated. It was also identified that a number of highways related policy documents required updating to reflect current working arrangements. There is the potential to increase service resilience via the digital mapping of current gritting routes. Six actions were recommended of which all but two (due date 30 June and 30 September) have been implemented.
Data Protection Reforms 10/01/2018	Cause for Concern	The Council requested this review to be included in the annual audit plan. The audit identified that the Council has specialist knowledge and awareness of the Data Protection reforms and their impact and had identified some strategic actions that need to be undertaken, and had begun to communicate these changes and the impacts on services. Testing at the time of the audit identified the need for

Audit Title	Overall Assurance Level	Summary
		improvements in the strategic governance, planning, documenting, and resourcing the Council's approach and response to meeting the reforms by the legislative deadline of 25 May 2018. The report included one P1 action which has been implemented as detailed in Table 6 below. Nine actions were recommended of which all have been confirmed as implemented.
LED Street Lighting Contract Management 15 March 2018	Cause for Concern	The main issues highlighted during the audit were that key performance indicators were not being recorded and monitored; meeting minutes were not clear regarding items discussed, decisions taken or actions and timescales agreed. The audit identified that contract performance was not reported to senior management or other stakeholders and that outcomes were not being appropriately recorded or reported in relation to the contract. Financial control was not structured and monitoring processes were unclear. The audit also highlighted that a dispute resolution process had not been developed. Seven P2 actions were agreed. The Director's responsiveness to the issues raised has resulted in all actions being addressed.
Trading Breach 16 March 2018	Cause for Concern	At the request of the Strategic Director Finance Governance & Support, an investigation was carried out following a breach of trading limits which resulted in an over purchase of shares. There was no indication that the action was deliberate and retrospective authorisation of the transaction was carried out in a reasonable manner. However, the fact that the transaction had been able to occur (and given the sums involved) was a cause for concern. Improvements were required to: • the timeliness and completeness of documentation passed to Investment Managers; • the manner in which Investment Managers communicate their investment decisions; • the way in which those investment instructions are communicated by the Front to the Back Office before being entered into the automated system. Managers at all levels were aware of the potential for conflicts of interest, and there was no evidence of conflicts (or insider trading) in this case however, continuing oversight and improved recording methods were recommended. Ten recommendations were made including two P1s (as detailed in Appendix D). Four of these actions, including both of the P1s, have been confirmed as

Audit Title	Overall Assurance Level	Summary
		implemented.
Social Care Payments 04 April 2018	Moderate	Audit testing concluded that the controls surrounding the management of adult social care payments required improvement. As was the case during the previous audit testing raised similar concerns over the payment of supplier invoices in advance. Five of the twenty invoices tested totalling £26,020 had been paid at least one month in advance of the Council's agreed payment terms. The Strategic Procurement & Commissioning Manager has taken immediate action to ensure that no further payments are made in advance and has implemented controls to identify occurrences of invoices where there has been an attempt to seek payment in advance followed by liaison with the relevant providers to prevent advance payments being actioned. Audit testing on a random basis of direct, residential care, home care and deferred payments identified that the information recorded in the LAS system (relating to the social worker provision of hours and financial rate per hour) was out of date for 37 out of the 40 care plans. This could result in the contracted company being over or under paid by the Council. Seven recommendations were agreed of which three have been confirmed as implemented. The remaining four actions have a target date of September 2018.
Laboratories 14 May 2018	Cause for Concern	The main issues highlighted by the audit were due to an absence of: • Regular review and update of policies and procedures; • Proper authorisation and anti-fraud measures for the ordering and receipt of goods and of the use of purchasing cards; • Regular review and update of inventory items; • Robust monitoring of vehicle and fuel usage; • Regular review of the agreement; and • Performance measures and a robust performance management regime. Eight P2 actions were agreed with management; all are still outstanding but none have passed their agreed target date.
Complaints Management 06 June 2018	Moderate	The audit noted that improvements were required to the process for recording and tracking complaints and that there needed to be processes for ensuring robust monitoring and reporting of performance to senior management/stakeholders and to indicate poor/under performance. Other issues identified included the need for up to

Audit Title	Overall Assurance Level	Summary
		date corporate complaints procedures, the lack of recent training provided to staff and the absence of a formal process for dealing with early resolutions. Although the audit identified a number of issues, it was noted that a review of the complaints service had recently been undertaken at the time of the audit and which had already identified a number of potential changes to be made to the corporate policy that could reduce the number of complaints and improve the overall responsiveness and fairness of the process. Management advised that the recommendations contained in the audit report would be included within any future improvement plan. Six actions were recommended and agreed with management of which all are still outstanding but none have passed their target date as the final version of the report has only recently been issued.

APPENDIX D – Priority 1 Recommendations During 2017/18

Audit Area	Audit recommendation	Target Date	Implemented	Comments
Data Protection Reforms	A programme management methodology should be implemented to include appointment of a sponsor, project management, definition of scope, designation of work streams, and production of a single comprehensive project plan to set out detailed action, expected outcomes, outputs, interdependencies, and timescales.	31/01/18	Yes	The project brief has been provided to Internal Audit and has been assessed by the Programme Management Office (PMO) that a level 2 project management approach is sufficient for the project. The project brief will operate as a programme and will have milestones added the work streams develop individual plans. The brief has been approved by the Head of Performance and Partnerships. The Corporate Strategy Manager has reported that the PMO are satisfied with the level of content and that a separate risk register has been developed with the Information Governance Team and the Head of Performance and Partnerships and was due to be reviewed at project board meetings. As the implementation plans are developed, additional resources may be identified as required.
Trading Breach	Systems should ensure that for any corporate actions where a voluntary announcement is issued (i.e. an investment decision is to be made), the corresponding mandatory announcement should be provided to the responsible Investment Manager by the Back Office at the same time as the first voluntary document and the response form. Where an Investment Manager is uncertain about the effects of a corporate action's investment options, they should ensure all appropriate checks are made (including escalation to the Fund Manager or Head of Investments	31/07/18	Yes	The Head of Investments and Treasury Management has advised that actions have been taken as per the recommendations made. Evidence has been provided to the Auditor. The Investment Managers now include in their checking process evidence of checks and a system for peer checking has been developed and implemented for corporate actions.

Audit Area	Audit recommendation	Target Date	Implemented	Comments
	and Treasury Management and, if prudent to do so, take the default option. A system of checking should be introduced, to provide assurance that the process is fully embedded and is being complied with by all key staff. An assessment should also be carried out to establish whether any further training is necessary.			
Trading Breach	The Head of Investments and Treasury Management should assess for how long, and to what degree the stock should be held. If there is a decision to sell there are a number of considerations to take into account (as detailed in the final report).	22/02/18	Yes	The HITM engaged with the stock source very early after the transaction and has maintained contact with them and their stockbroker to assess options and identify possible sales opportunities. An assessment of the optimal shareholding has been completed.

APPENDIX E – BASIS FOR ANNUAL OPINION

	2017/18	2016/17
Strong reports – Final (excluding individual schools)	20 (4)	16 (3)
Strong reports – Draft	0	0
Good reports – Final (excluding individual schools)	8 (1)	12 (2)
Good reports - Draft	0	1
Moderate reports – Final (excluding individual schools)	7	3
Moderate reports - Draft	0	2
Cause for Concern reports – Final (excluding schools)	4	0
Cause for Concern reports - Draft	0	0
Cause for Significant Concern reports - Final	0	0
Cause for Significant Concern reports - Draft	0	0
Total Recommendations made (not including schools)	134 (8) for schools = 126	112 (15) for schools = 97
Number of Priority 1 Recommendations	3	0
Number of reports (final and draft)	39 of which 5 were schools. 34 exc schools	34 of which 5 were schools 29 exc schools
% Strong (figures in brackets include schools)	47% (51%)	45% (47%)
% Good	20% (21%)	38% (38%)
% Moderate	21% (18%)	17% (15%)
% Cause for Concern	12% (10%)	0%
% Cause for Significant Concern	0%	0%
Annual Opinion	Good	Good

APPENDIX F - Performance Target Outturn for 2017/18

Indicator	***Target***	***Measurement***	***Status (figures will be updated prior to LMT)***
1) Percentage completion of the agreed annual audit plan	100% - by 30 April 2017 .	Complete = draft report or other deliverable issued by 30 April 2018.	89% (2016/17:94%)
2) To achieve an average customer satisfaction survey score	3.8	4 is the highest possible score.	3.77 (2016/17: 3.46) An increase in performance although not too many surveys are now returned.
3) % of draft reports issued within 15 days of the end of fieldwork	100%	Target increased in 2015/16 due to 2014/15 performance exceeding target.	95% (2016/17: 88%) of drafts issued within 15 working days of the end of fieldwork but only 64% (2016/17:71%) finals issued within 20 days of the draft date. Action – information on significant response delays to be shared with LMT.
4) % Auditor productivity	100% of expected productivity	The number of available productive days is calculated for each member of the team, taking into account estimated absences. This results in an expected number of productive days per officer. The target is for 100% of the Team to meet their expected productivity.	Audit and Assurance Officers average 93% (2016/17 96%) – lower due to one of the H&S Assurance Officers training course. Compliance Auditors average 96% (2016/17: 96%) although it would be 74% if taking long term absence into account. Situation has since been resolved. Please also see table below.
5) Number of assignments completed by target dates set	To meet target dates set at outset of audit (or earlier)	Target will be set by each audit lead and agreed with auditor at the start of each assignment.	Only 29% of audits are being delivered by the original target dates set. This is a combination of auditor staff absences during the year but also the time taken to obtain responses to requests for information and responses to

			reports from auditees. This should be assisted during 2018/19 by a combination of flagging up late responses to LMT and also closer supervision against auditor deadlines.
6) Number of audits completed within the budgeted time allocation	100%	Each assignment has a set number of days which should be adhered to. If an officer requires additional time then a case has to be approved by one of the Team's managers.	81% (2016/17:80%) assignments are currently being delivered either within budget or only a day in excess.

Audit and Assurance Individual Productivity

	31/03/2012	31/03/2013	31/03/2014	31/03/2015	31/03/2016	31/03/2017	31/03/2018
Average number of productive days per member of audit team	157	176	189	189	202	216	201
% Productivity (based on working days available after annual leave and public holidays)	72%	80%	81%	84%	87%	91%	87%
% Productivity (based on working days available after annual leave, public holidays, sickness and authorised absence)	75%	82%	83%	87%	89%	94%	93%

APPENDIX G – SIGNIFICANT VARIATIONS TO THE 2017/18 INTERNAL AUDIT PLAN AND APPLICATION OF CONTINGENCY TIME

The following table details areas examined during 2017/18 that were not included on the original internal audit plan (or where significant additional time was required).

Audit area	Estimated days	Time taken from	Reason
Section 17 Payment Investigation	25	Safeguarding contingency allocation and Children's Homes audit	Investigation required into suspected misuse of funds. Investigation is ongoing and therefore no further detail can be given.
Trading Limits Breach	28	Financial controls contingency and counter fraud contingency	Investigation requested by the Strategic Director of Finance Governance and Support.

The following audits were not completed from the 2017/18 audit plan:

Audit Title	Comments
Contract Management	The programme and process for obtaining funding has delayed original timescales and the Council was still organising the procurement of a contract management system with the aim of implementation and training during February and March with a go live in April. The audit would be of more benefit after this time and so has been included in the 2018/19 audit plan. Reported to Corporate Affairs and Audit Committee at 08 March 2018 meeting.
Liquid Logic	Audit deferred as no longer considered to be a priority area for audit review and strong assurance had been given on IT controls in 2016/17.
Agresso	This audit was deferred to allow for planned improvements and changes to be made to the system. Previous audit recommendations have still been followed up as usual. Reported to Corporate Affairs and Audit Committee at 08 March 2018 meeting.
IT Governance	Due to the commitments of the Head of ICT Services, it has been proposed that this audit will be deferred until early 2018/19. Other (non internal audit) reviews will be undertaken into aspects of cyber security. Reported to Corporate Affairs and Audit Committee at 08 March 2018 meeting.
Youth Employment Initiative	It was agreed to move this audit into early 2018/19 and carry out at the same time as the Redcar and Cleveland audit of the same area. Reported to Corporate Affairs and Audit Committee at 08 March 2018 meeting.
Performance Data Quality	Audit deferred into 2018/19 due to timing of action plan. The audit is ongoing but will be reported on in 2018/19
Partnership Governance	The audit is ongoing but will be reported on in 2018/19
Children's Homes	Allocation used for suspected misuse of funds investigation

Audit Title	Comments
Treasury Management	Audit rolled forward into 2018/19 and will be carried out early in the financial year
Special Educational Needs - Schools	Although a sample of school audits was undertaken, the audits were carried out as a joint financial controls/SEN exercise and the audit reports delayed until the SEN information could be provided. Due to other commitments, the SEN information was not provided in time for this report and therefore the school audit reports were issued as financial control related only.
Better Care Fund	This audit was not started.
Prevention and Access	This audit was not started.
Waste Management and Recycling	This audit was commenced but was not completed. Time was allocated to the street lighting contract audit which required more time due to issues identified.
Adult Social Care	This audit was not started.

APPENDIX H – Assessment of TVAAS against Public Sector Internal Audit Standards (PSIAS) 2017/18

Key:

MC - Mostly Conforms with PSIAS. The relevant structures, policies and procedures of the activity, as well as the processes by which they are applied, comply with the requirements of individual Standard or element of the Code of Ethics in all material respects. Mostly conforms does not require complete or perfect conformance.

PC - Partially Conforms with PSIAS. The activity is making good-faith efforts to comply with the requirements of the individual Standard or element of the Code of Ethics, section or major category, but falls short of achieving some major objectives. These will usually represent significant opportunities for improvement in effectively applying the Standards or Code of Ethics and / or achieving their objectives.

DNC - Does Not Conform with PSIAS. The activity is not aware of, is not making good-faith efforts to comply with, or is failing to achieve many / all of the objectives of the individual Standard or element of the Code of Ethics, section, or major category. These deficiencies will usually have a significant negative impact on the activity's effectiveness and its potential to add value to the organisation. These may also represent significant opportunities for improvement, including actions by senior management or the audit committee.

N/A - Not Applicable.

CAE - Chief Audit Executive is a generic title used in the Standards to describe the person responsible for managing the internal audit activity. For Redcar and Cleveland Borough and Middlesbrough Councils, the chief audit executive is the Audit and Assurance Manager of Tees Valley Audit and Assurance Service which is a shared internal audit service established between the two councils in 2011. Throughout this document, the Audit & Assurance Manager is referred to as AAM.

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
Attribute Standards				
1000 Purpose , Authority and Responsibility	MC	The internal audit charter was first approved by the Audit and Governance Committee in Dec 2013 and has been updated annually, the most recent update being presented to the Corporate Affairs and Audit Committee at the meeting on 26 July 2018. The Charter sets out the reporting relationships, position and accountability of internal audit. It recognises the mandatory nature of the PSIAS. The Audit & Assurance Manager (AAM) reports functionally to the Corporate Affairs and Audit Committee and administratively to the Strategic Director Finance, Governance and Support who is also the Council's S151 Officer.	n/a	n/a
1100 – Independence and Objectivity	MC	The Service is independent and staff declare any potential conflicts of interest as and when they arise although all staff are specifically asked to complete a declaration form on an annual basis. Staff do not work on those areas where there could be a potential conflict of interests. Audit assignments are periodically rotated although auditors may be assigned to the same assignment for up to three years. The Audit and Assurance Manager has a direct reporting route to the Strategic Director Finance Governance & Support as S151 Officer and to the Chair of the Corporate Affairs and Audit Committee. Any threats or potential threats to objectivity are and have been raised by the AAM with the relevant S151 if and as and when they arise.	The AAM does not currently meet on a regular basis with the chief executive at Middlesbrough Council but does have unfettered access to the chair of the audit committee and the S151 and would raise any issues with the Chief Executive if required.	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
1110 – Organisational Independence	MC	The AAM has regular meetings with the S151 Officer Strategic Director Finance, Governance and Support and the Deputy S151 Officer (Head of Financial Governance and Revenues). The Corporate Affairs and Audit Committee receives the updated audit charter once a year and approves it. Independence is regularly referred to in most reports to committees. Members of the Corporate Affairs and Audit Committee approve the number of days audit resource and have the opportunity to contribute to the content of the annual audit plan. The AAM can report that there is currently no threat to her independence and that any concerns will be discussed with the Chair of the Corporate Affairs and Audit Committee. The professional standards with which internal auditors must abide by are regularly communicated via reports submitted to the Corporate Affairs and Audit Committee.	The terms of reference for the Corporate Affairs and Audit Committee do not include the Committee's role in relation to approving the internal audit budget, confirming internal audit's removal/appointment and commenting on chief audit executive performance. However, CIPFA guidance reports that governance requirements in the UK public sector would not generally involve the board (audit committee) approving the CAE's remuneration specifically. The underlying principle is that the independence of the CAE is safeguarded by ensuring that his or her remuneration or performance assessment is not inappropriately influenced by those subject to audit.	Ensure the S151 Officer and chair of the Corporate Affairs and Audit Committee contributes feedback to or reviews the performance appraisal of the AAM.
1111 – Direct Interaction with the Board	MC	The AAM attends meetings of the Corporate Affairs and Audit Committee to present internal audit and other assurance related progress reports. Minutes of those meetings record attendance and presentation of reports.	n/a	n/a
1120 – Individual Objectivity	MC	The Service is independent and staff declare any potential conflicts of interest as and when they arise although all staff are specifically asked to complete a declaration form on an annual basis. Staff do not work on those areas where there could be a potential or perceived conflict of interests.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
1130 – Impairment to Independence or Objectivity	MC	There are no instances where auditors are assessing operations where they have had responsibility for that operation within the previous year. Assignments are rotated when it is considered that an auditor has been involved for too long in auditing the same area although the Service is restricted to some extent by resources. Staff are reminded of ethical responsibilities at team meetings, 121s and other group meetings. All staff complete an annual declaration of interests form and sign up to the ethics as set out in the PSIAS.	n/a	n/a
Proficiency and Due Professional Care				
1210 – Proficiency	PC	The AAM is a qualified Chartered Certified Accountant (FCCA) and a chartered Internal Auditor (CMIIA) with the qualification in internal audit leadership (QIAL) and has both private sector and local government experience. Overall customer feedback is mostly positive and quality checks have been implemented for the end of each audit to ensure that requirements are met. The Principal Auditor and a compliance auditor have embarked upon the Institute of Internal Auditor's Certified Internal Auditor qualification programme.	Data analysis techniques still have to be sourced. There remain some individual examples of auditors needing to take extra care with the quality of their work. This continues to be managed by 121 and appraisal processes with improvement targets set as appropriate.	Data analytical skills to be investigated. Individual performance to continue to be addressed via 121s/appraisal and performance framework. Audit leads to ensure that all quality checks have been completed prior to the issue of a final report.

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
1220 – Due Professional Care	MC	Prior to the start of each audit, the lead auditor will contact the client and agree a mutually convenient start date. Each audit involves an initial introductory meeting at which the objectives of the assignment are discussed and agreed. Auditors do their research prior to this meeting and consider legislative requirements; risks; previous issues; savings targets; restructures; objectives of the service/system under review. Auditors will therefore have their own ideas as to where the audit should focus but the client must and does have their input. A draft terms of reference is then issued to the client for the audit which gives the client the opportunity to agree the scope and suggest any amendments. The terms of reference document is retained on the audit management system (MKI) as is the evidence of agreement (wherever possible). The test plan is then formulated according to that terms of reference and the auditor will commence the fieldwork. The terms of reference is always attached to a copy of the draft and final report.	n/a	n/a
1230 – Continuing Professional Development	PC	A competency framework is in existence and is based on the Council's corporate framework. The AAM has to complete CPD as part of her professional membership – FCCA and CMIIA.	The Team does not have any other qualified staff above AAT although there are currently three members of staff pursuing IIA certified internal auditor status.	Exams to be completed as agreed during the recent appraisals.
Quality Assurance and Improvement Programme				
1310 - Requirements of the Quality Assurance and Improvement Programme	MC	There is a QAIP in place which is maintained by the AAM. Each audit assignment is subject to review by another member of the Team. The AAM reviews all internal audit draft reports prior to their issue. The effectiveness of the Team is monitored via the regular progress reports to the Corporate Affairs and Audit Committee. An annual self-assessment is submitted to the Corporate Affairs and Audit Committee.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
1311 – Internal Assessments	MC	Audits are allocated at the start of the year according to skills, experience, knowledge, previous involvement with an issue/area. Allocations change throughout the year to accommodate changes in resources and priorities but competence to do an audit is always taken into account. All audits are subject to a detailed review process. The internal audit service has always had various performance measures both for the team and individually. Some of those measures have been defined by the service level agreement with Redcar and Cleveland Borough Council; others have been added in response to areas where improvement is required. The QAIP has been updated where required and feedback provided to staff as part of the ongoing 121 and appraisal process.	n/a	n/a
1312- External Assessments	MC	Peer review by Hartlepool Borough Council has been undertaken in May 2018. Provided assurance on the Service's compliance with the PSIAS with only minor suggestions made.	n/a	n/a
1320 - Reporting on the Quality Assurance and Improvement Programme	MC	Results of external peer review by Hartlepool Borough Council's Chief Internal Auditor has reported satisfactory assurance on TVAAS' compliance with the PSIAS.	n/a	n/a
1321 - Use of "Conforms with the International Standards for the Professional Practice of Internal Auditing"	MC	The annual self-assessment of the Service is reported to the Corporate Affairs and Audit Committee. It highlights any areas for further development and how the Service conforms to the PSIAS.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
1322 - Disclosure of Non Conformance	MC	Improvement actions included in annual self-assessment. No significant deviations reported and this has been confirmed by external peer review.	n/a	n/a
Performance Standards				
2000 – Managing the internal audit activity	MC	The internal audit staff perform assignments in accordance with the audit and assurance manual and in accordance with the PSIAS. The Audit and Assurance Manual updated during the year to reflect changes in process.		
2010- Planning	MC	The audit plan is based on the key risks as set out in the Council's risk registers. The audit plan is consulted on with the S151 Officer, all senior managers, Corporate Affairs and Audit Committee Members and External Audit. Audit plans allow flexibility and include contingency time. Variations are reported to the Corporate Affairs and Audit Committee.	Whilst a full formal risk assessment exercise has not been completed recently, all areas included in the audit plans are based on the content of the risk registers and the key priorities of each Council. It is therefore not considered that a detailed risk assessment exercise would add sufficient value to justify the resource. It is considered that the current consultative approach of compiling the Plan and basing the content on risk registers ensures that both plans are directed towards key risks and priorities.	n/a
2020- Communication and Approval	MC	LMT approves audit plan content prior to plans being submitted to the Corporate Affairs and Audit Committee. Resources are managed within the Team but are reported within the progress reports where there are resource issues.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2030 – Resource Management	MC	Audits are allocated initially but usually have to be reallocated throughout the year to cater for absences, management requests to re-schedule audits etc. Reductions in audit budgets have resulted in less coverage but the plans and the method of providing assurance has been re-defined in order to still be able to provide sufficient work to enable annual opinions at both councils.	n/a	n/a
2040 – Policies and Procedures	MC	The Audit and Assurance Manual is reviewed and updated periodically. There are other team processes for staff reference e.g. escalation processes and standard wording for emails etc.	n/a	n/a
2050 – Co-ordination	PC	Sometimes the scope of an audit may include a requirement to review other sources of assurance. There are no formal arrangements defined as these will be performed on an individual case basis. The assurance map is still to be compiled for MBC. Periodic meetings take place with the external auditors.	Assurance mapping exercise requires completion.	Complete assurance map during 2018/19.
2060 - Reporting to Senior Management and the Board	MC	Regular progress reports to LMT and to the Corporate Affairs and Audit Committee throughout the year. An annual report on counter fraud is submitted including a summary of the key fraud risks. Frequency tends to be determined by committee cycles as the Council's reporting process requires that any reports going to Members must have been reviewed by LMT first. Additional reports may be presented if an issue has emerged that requires reporting outside of that cycle.	n/a	n/a
2070 - External Service Provider and Organisational Responsibility for Internal Auditing	MC	MBC is aware that the responsibility for maintaining an adequate internal audit activity rests with the S151 Officer.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2100 – Nature of Work	MC	All internal audit work is aimed at improving the governance and control environments of both councils. Audit work contributes via feeding into the Annual Governance Statement.	n/a	n/a
2110 - Governance	PC	The Service works to high standards of objectivity and independence even if that requires a difficult message to be delivered. Staff sign annually to confirm their understanding of ethics. Standards are regularly referred to in documents. Performance measures and progress against them is reported in the progress reports to the Corporate Affairs and Audit Committee. Recommendations are made according to the perceived risk and are rated 1 to 3 in terms of priority.	The Service currently does not have IT audit expertise therefore technical IT auditing skills would not be applied in audits.	Review skills mix of Team with a view to recruiting/training IT auditor.
2120 – Risk Management	MC	The audit plan for MBC is designed with strategic risks in mind. The most recent audit of MBC's risk management framework was completed in June 2018.	n/a	n/a
2130 - Control	MC	The annual audit plan is designed to cover the key areas of risk relating to the organisation's achievement of objectives and effective management of risks to those objectives. The Annual Audit Plan always include time to review the key financial controls and governance processes. With reduced resources, it is inevitable that the coverage of the Plans is less than in previous years but this has required a new approach to auditing with shorter audits focussed on key controls and risks and avoidance of areas that have been subject to other assurance.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2200-Engagement Planning	MC	A Terms of Reference is agreed for each assignment and includes scope, timing, resource and objectives. When planning an audit, auditors consider the area's significant risks, resources, operations, objectives and performance. Relevant managers are asked for their input into each terms of reference. Resources are agreed at the outset for each audit and additional resources required should be approved in advance. A guide to internal audit is available on the Intranet.	Target dates were set for audits last year although there is still scope for audits to be delivered more quickly. A different approach was taken during the second half of 2017/18 with the focus being on a deadline for drafts to have been issued (as opposed to a focus on time taken in days to complete an audit).	n/a
2210 – Engagement Objectives	PC	Terms of references are agreed prior to the audit's commencement. A final version of the terms of reference is held on the audit management system MKI and evidence of client agreement if this has been provided by email. Audit scopes and objectives differ for each audit but cover key risks and objectives for the service or system under review. A testing programme is then drawn up and agreed by the audit lead within the Team.	Although internal auditors refer to the strategic risk register for risks relating to an audit area, they do not carry out a preliminary risk assessment of the activity under review.	Audit & Assurance Manual to be revised to include the need to carry out a preliminary risk assessment of the activity under review.
2220 – Engagement Scope	MC	The scope would be selected so as to achieve sufficient coverage to be able to offer an assurance opinion. The scope would take into account those areas that are both within the organisations and which are outside and where Internal Audit may have no rights of access.	n/a	n/a
2230 - Engagement Resource Allocation	MC	Lead auditor's judgement at the outset of the audit (possibly in conjunction with the AAM and the client) would agree on sufficient level of resources for an assignment. Terms of reference would detail what had been agreed.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2240 - Engagement Work Programme	MC	Testing programme developed, based on the agreed terms of reference. The test programme has to be reviewed by another member of the Team before being approved on the system and attached to the relevant audit. Tests may sometimes be added during the audit following discussion between auditor and the audit reviewer/lead.	n/a	n/a
2300 Performing the Engagement				
2310 – Identifying Information	MC	All auditors understand the need to identify, analyse, document and evaluate sufficient information. They should all be alert to the possibility of poor value for money, intentional wrongdoing, errors and omissions, failure to comply with policy and conflicts of interest. Most assignments are supervised by a senior member of the team. The completed test programme is reviewed by the audit lead/reviewer. Extra testing will be requested where the audit lead/reviewer considers that insufficient evidence has been obtained.	n/a	n/a
2320 – Analysis and Evaluation	MC	The review process for each audit would identify any gaps in testing or evidence.	n/a	n/a
2330 – Documenting Information	MC	The review process for each audit would identify any gaps in testing or evidence. Further testing or information is carried out/requested as appropriate. Engagement records are held on the audit and risk management system – only TVAAS staff have access to this. The shared drive also records various information; again only TVAAS (and IT) staff have access to this. Information is only shared once the appropriate permissions have been sought, usually from the relevant S151 or other director.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2340 – Engagement Supervision	MC	All audits have a reviewer who is responsible for monitoring the progress of that audit and for ensuring that the work is of an acceptable quality and that the terms of reference are delivered. The audit and risk management system MKI has a review process to be undertaken for each assignment and the system shows the identity of the reviewer and extent of the review process completion. Quality checklists should be completed at the conclusion of each assignment.	n/a	n/a
2400 – Communicating Results	MC	Exit meetings are held at the end of most audits. All audit clients have the opportunity to discuss the audit findings and to highlight any factual errors or misunderstandings and to present an alternative view as to the overall assurance opinion given. Ultimately, it has to be the auditor's view but clients always have an opportunity to discuss/debate the audit findings. A final report is issued.	n/a	n/a
2410 - Criteria for Communicating	MC	Each audit results in a draft report that includes the original terms of reference, the overall audit opinion, the main findings and conclusions and the recommendations schedule. Management have the opportunity to comment on the draft report before the final version is agreed and issued. The final version will include the target dates and owners for agreed actions. The actions will then be followed up via the outstanding actions process. If a recommendation has not been accepted by management but the auditor does not feel can be removed (due to the risk) then the issue would remain in the report but would show as not agreed. The issue would be flagged with the relevant S151 or director. Summary of all internal audit outcomes are reported throughout the year to the Corporate Affairs and Audit Committee.	Some audit reports have exceeded the target turn around dates. This is often due to delays in obtaining responses from management.	Escalation procedure to be revisited and communicated to LMT. It will be suggested that significant delays in receiving responses to audit reports or other significant delays in being able to carry out an audit will be highlighted with LMT.

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2420 - Quality of Communications	MC	Audit reports are the Team's main product and therefore are always reviewed by the audit lead and then the draft report is reviewed by the AAM. Customer satisfaction survey issued following assignments.	n/a	n/a
2421 – Errors and Omissions	MC	The AAM would communicate any corrected information in a report to all parties who had received the original communication.	n/a	n/a
2430/31 – Conducted in Accordance Statement or Disclosure of Non-conformance	DNC	Previously, internal audit reports have not stated specifically that assignments are carried out in accordance with the PSIAS but this will be added to the template now that the external review has been completed.	Internal audit reports do not currently state explicitly that engagements are 'conducted in conformance with the PSIAS.	Report template to be amended.
2440 – Disseminating Results	MC	The front cover of each audit report details the distribution list. The distribution list is agreed at the time of the exit meeting and according to the Council's reporting protocols. External audit also receive copies of all relevant reports once final. The Risk Business Partner is copied into the final version of all MBC reports. If one Council wishes to view another Council's report, this has to be agreed with the relevant assistant director or director. The Audit and Assurance Manual sets out the reporting protocols for each Council.	n/a	n/a
2450 – Overall Opinion	MC	The annual opinion is an independent opinion given by the AAM and is based upon the work carried out, the number of recommendations made, the number of P1 recommendations made, the number of cause for concern reports. The annual report includes all the areas required by the PSIAS. Reasons would be stated if there was an adverse opinion issued.	n/a	n/a

Standard	Assessment	Summary	Areas of Non Compliance	Update and further action
2500 – Monitoring Progress	MC	Outstanding actions have been monitored throughout the year with requests for progress made to the action owners. All auditors/audit and assurance officers actively follow up on progress made to implement any recommendations that they have made. This information is recorded in the audit management system. Actions that have passed their agreed target date but which are still outstanding are reported (with the internal audit progress reports) to the Corporate Affairs and Audit Committee. LMT has requested that all outstanding actions be reported to LMT and this will be carried out during 2018/19.	n/a	n/a
2600 – Communicating the Acceptance of Risks	MC	Accepted risks for recommendations remain in the relevant audit report. Any risks accepted which were considered to put the Council at risk would be escalated and/or discussed with the Monitoring Officer and the S151 Officer. Accepted risks remain on the audit management system for reference.	n/a	n/a