Corporate Director (Law and Governance) and Monitoring Officer, T W Mortimer LLB Solicitor AU

AUDIT COMMITTEE

ASHFORD BOROUGH COUNCIL

Notice of a Meeting, to be held in the Committee Room 2 (Bad Münstereifel Room) - Ashford Borough Council on **Tuesday, 1st February, 2022 at 5.00 pm.**

The Members of the Audit Committee are:-

Councillor Krause (Chairman)
Councillor Buchanan (Vice-Chairman)

Cllrs. Hayward, Mulholland, Shorter, Smith, C Suddards, Walder

IMPORTANT INFORMATION FOR THE PUBLIC ABOUT THIS MEETING

Subject to Coronavirus risk assessments and procedures, a very small number of members of the Press and public can register to attend and observe the Meeting in person on a first-come, first served basis. To register to attend and observe the Meeting on this basis, please email membersservices@ashford.gov.uk You will be sent details of the procedures established by the Council in order to manage the risk of COVID-19 at the Meeting, which may include requirements such as to wear face coverings, and to not attend the Meeting if you are affected by any relevant circumstances relating to COVID-19. You will be expected to confirm your agreement to these requirements prior to attendance. However, instead of attending and observing in person, the Council encourages everyone to take advantage of the opportunity to watch and listen to the proceedings at the Meeting via a weblink, which will be publicised on the Council's website at www.ashford.gov.uk no later than 24 hours before the Meeting.

Agenda

Page Nos..

1. **Apologies/Substitutes**

   To receive Notification of Substitutes in accordance with Procedure Rule 1.2(c)

2. **Declarations of Interest** 1 - 2

   To declare any interests which fall under the following categories, as explained on the attached document:

   a) Disclosable Pecuniary Interests (DPI)
   b) Other Significant Interests (OSI)
   c) Voluntary Announcements of Other Interests

   See Agenda Item 2 for further details

20 January 2022

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Declarations of Interest (see also "Advice to Members" below)

(a) **Disclosable Pecuniary Interests (DPI)** under the Localism Act 2011, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares a DPI in relation to any item will need to leave the meeting for that item (unless a relevant Dispensation has been granted).

(b) **Other Significant Interests (OSI)** under the Kent Code of Conduct relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares an OSI in relation to any item will need to leave the meeting before the debate and vote on that item (unless a relevant Dispensation has been granted). However, prior to leaving, the Member may address the Committee in the same way that a member of the public may do so.

(c) **Voluntary Announcements of Other Interests** not required to be disclosed under (a) and (b), i.e. announcements made for transparency alone, such as:

- Membership of amenity societies, Town/Community/Parish Councils, residents' groups or other outside bodies that have expressed views or made representations, but the Member was not involved in compiling or making those views/representations, or
- Where a Member knows a person involved, but does not have a close association with that person, or
- Where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position.

[Note: Where an item would be likely to affect the financial position of a Member, relative, close associate, employer, etc.; OR where an item is an application made by a Member, relative, close associate, employer, etc., there is likely to be an OSI or in some cases a DPI. ALSO, holding a committee position/office within an amenity society or other outside body, or having any involvement in compiling/making views/representations by such a body, may give rise to a perception of bias and require the Member to take no part in any motion or vote.]

Advice to Members on Declarations of Interest:

(a) Government Guidance on DPI is available in DCLG's Guide for Councillors, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/5962/2193362.pdf

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, and a copy can be found in the Constitution alongside the Council's Good Practice Protocol for Councillors dealing with Planning Matters. See https://www.ashford.gov.uk/media/2098/z-word5-democratic-services-constitution-2019-constitution-of-abc-may-2019-part-5.pdf

(c) Where a Member declares a committee position or office within, or membership of, an outside body that has expressed views or made representations, this will be taken as a statement that the Member was not involved in compiling or making them and has retained an open mind on the item(s) in question. If this is not the case, the situation must be explained.

If any Member has any doubt about any interest which he/she may have in any item on this agenda, he/she should seek advice from the Director of Law and Governance and Monitoring Officer, or from other Solicitors in Legal and Democracy as early as possible, and in advance of the Meeting.

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Ashford Borough Council: Audit Committee

Minutes of a Meeting of the Audit Committee held in Committee Room 2, Civic Centre, Tannery Lane, Ashford on the **5th October 2021.**

Present:

Cllr. Krause (Chairman);

Cllrs. Hayward, Shorter, C. Suddards.

Apologies:

Cllrs. Buchanan, Walder.

Investigations and Enforcement Support Manager.

Also in Attendance (virtually):

Cllrs. Burgess, Mulholland, Ovenden.

In attendance:

Deputy Chief Executive, Compliance and Data Protection Manager, Head of Service Port Health, Port Health Manager, Head of Finance and IT, Accountancy Manager, Audit Manager, Head of the Audit Partnership, Member Services and Ombudsman Complaints Officer.

134 Minutes

Resolved:

That the Minutes of the Meeting of this Committee held on the 20th July 2021 be approved and confirmed as a correct record.

135 Strategic Risk Management

The Compliance and Data Protection Manager introduced this item and drew Members' attention to the key points within the report. She explained that this was a six monthly update report on the risk register, which highlighted risks that were outside the Council's risk appetite. The Compliance and Data Protection Manager and the Head of Service Port Health gave a presentation which covered:

- Introduction to risk in relation to Ashford Port Health.
- Overarching risk of failure to deliver Port Health Service, broken down into areas of concern, with examples of controls in place:

    - BCP designation and legal duties
    - Completion of site and occupation date
    - Deficit recovery
    - Consignment data
    - Relationship with Dover District Council

- Dependence failure with DEFRA
- Recruitment and retention
- Relationship with DEFRA

The presentation concluded with the following points:

- Delivering the Ashford Health Port Authority is a huge undertaking, not without risk
- Strong project governance in place and regular consideration of individual risks at project level
- Member oversight at a strategic level through Audit Committee
- On track to deliver in accordance with timescales.

The Chairman opened up the item for discussion and the following comments were made:

- A Member commented that during the presentation it was stated that most of the risk sat with DEFRA. However, he wished it to be noted that the consequences of any failed delivery would also have significant impacts on the Council.

- In response to a question about fee recovery and staff resources, the Head of Service Port Health said that the main problem was the staffing issue because it may be hard to upscale quickly. The Government had provided assurance that they would adjust the checking regime, but there was still a possibility that if there was more freight than had been calculated, there would be a need to find appropriate staff quickly, and this would be difficult. The Deputy Chief Executive added that DEFRA had provided Letters of Undertaking for the first year, and it may be necessary for the Council to request an extension of this period. The Head of Service Port Health advised that recruitment had currently been frozen until there was a better understand of the volume of service required. He also explained that the fees were based on the 'rest of the world' model, which he considered was the best current model, although it might be argued that the fees within this model were too high for local requirements. The Deputy Chief Executive confirmed that this staffing risk was included in the risk register.

- A Member asked whether there had been any human trafficking incidents to date. The Head of Service Port Health replied that the responsibility for this issue lay with the Border Force, although Port Health staff were appropriately trained to ensure their safeguarding was in place. A protocol was currently being developed and it was hoped that this would be in place shortly.

- In response to a question about veterinary support for the facility, the Head of Service Port Health confirmed that there was a shortage of appropriately trained veterinary staff as most trained vets preferred to work with live animals. Many of the staff currently employed had previously been working as meat inspectors in the UK.

- A Member noted that the Audit Committee had been asked to provide an oversight of the risks relating to the Port Health Service. He requested that

the Audit Committee be provided with an update on this item prior to going live in July 2022. This could either be in the form of a report to a meeting prior to that date or a Member briefing session.

- A Member noted the risk relating to cyber security and considered that it was appropriate for the Audit Committee to be briefed on this issue at a future meeting via a report from IT. The Compliance and Data Protection Manager confirmed that this matter was high on the national risk register.

- In response to a question about the £1.5m reserve, the Deputy Chief Executive confirmed that the funds would be provided through Government funding, but any delay in operation would impact on the funds. The Council's strategy was to reach a position of having 1 year's worth of funds in reserve over a 3-5 year period, and fees would be set accordingly and adjusted if necessary to avoid accruing a bigger reserve.

- A Member noted that the Ashford Border Post was based around freight from the Channel tunnel. He questioned how the service would be affected if the tunnel were to be closed, for example due to a fire. He asked whether the risk for Ashford Border Post was greater than for other border posts. The Head of Service Port Health replied that much of the work was undertaken digitally and that it was likely that the Ashford Border Post would be asked to assist others, such as Dover, at times when the volume of traffic was high due to freight switch. National central hubs were also under discussion at present and Ashford would be a prime location for such a facility.

- The Members of the Committee considered the remainder of the report and it was agreed that there should be a focus on the Council's cyber security risk the next time the corporate risk register report was presented.

Resolved

That the Audit Committee

a) Agrees the assessments and the adequacy of key controls to manage the risks.

b) Has considered the area of focus of this report on the risks associated with the Ashford Port Health Service

c) Would benefit from a more detailed report on cyber security to a future meeting in order for the adequacy of the controls to be assessed.

136 Annual Governance Statement - Progress on Remedying Exceptions

The Compliance and Data Protection Manager introduced this item and highlighted the key points within the report and tables. She explained that this was a mid-year review which outlined progress in implementing the recommendations highlighted in the Annual Governance Statement. All actions were in hand and within timescales.

Resolved

That the report be received and noted.

137 Corporate Enforcement Support & Investigations Team Annual Report 2020/21

The Head of Finance and IT introduced this item and drew Members' attention to the key points within the report. She said that the overall financial value identified from the Investigations Team's work was almost £616,000 of public funds. This equated to almost £220,000 of Ashford Borough Council funds. The team were now undertaking commercial work, and were working with two East Kent authorities. They were considering working with housing associations moving forward and would shortly embark on a trial project. There would also be a communications campaign to highlight what the team had achieved to deter fraud, and also to encourage members of the public to come forward and report cases of fraud.

The Chairman opened up the item for discussion and the following points were made:

- A Member noted the savings in public funds made by the Investigations team, and questioned whether the Council was recompensed for this work. The Head of Finance and IT explained that the figures related to fraud detected, rather than money actually made, and these two issues were not necessarily linked. She said that although other bodies did not recompense the Council formally, they did fund administration grants for Council Tax. The Deputy Chief Executive added that the work of the Investigations team protected the public purse, not just the Borough Council, and that it was a flexible boundary. He confirmed that there was reciprocal benefit through shared intelligence with other organisations.

- Members remarked that they were in favour of the communications campaign, which would not only help protect against fraud, but act as a deterrent for future fraud.

- In response to a question about benchmarking against other authorities, the Head of Finance and IT said that this had not been undertaken due to the relative sizes of fraud and investigations teams elsewhere and the level of fraud work undertaken. She said this could be done as there were a handful of other authorities nationally who would provide useful comparisons. The Deputy Chief Executive suggested that it was useful to consider the underlying level of fraud and error in the system against the effectiveness of the team. He said that some years ago an exercise had been undertaken to develop a risk appetite statement for the Council, and the Investigations and Enforcement Support Manager was asked to provide further details on this at a future meeting.

- A Member suggested that an item should be put in the Council's magazine highlighting the work of the Investigations Team, both to act as a deterrent and to encourage members of the public to come forward and report suspected fraud.

- Members agreed that a presentation would be given to Audit Committee at a future stage, including details on the risk appetite statement.

Resolved

That the report be received and noted.

138 Annual Report of the Audit Committee

The Audit Manager introduced this item and explained that the contributions Members had made at a recent workshop had been captured in the report. The report advised that the Committee had successfully undertaken its duties in the year 2020/21. She drew attention to the Value for Money presentation which was due to take place on 14th October. She said that the report provided reassurance that the important internal controls, governance and risk management issues were being addressed by the Committee.

- A Member remarked on the quality of the consultation training, which had been well attended. Another Member was pleased to see the views of Committee Members included within the report.

Resolved

a) **That the annual report of the Audit Committee for 2020/21 is agreed.**

b) **That the Chairman of the Audit Committee presents the report to a future meeting of the Full Council to demonstrate how the Committee has discharged its duties.**

139 Audit Fee Letter 2021/22

The Accountancy Manager introduced this item and explained the fees and additional charges.

In response to a question from a Member, the Accountancy Manager confirmed that the deadline for agreement of the audit fee was February 2022. He advised that a report would be submitted to the Committee towards the end of current year on the procurement process and confirmation of interest in remaining with the PSAA.

Resolved

That the Audit Committee notes the proposed Fee for the 2021/22 Final Accounts Audit.

140 Date of Next Meeting

30th November 2021 at 5pm.

Agenda Item No: 4

Report To: Audit Committee

Date of Meeting: 1 February 2022

Report Title: Invitation to become an opted-in authority

Report Author &
Job Title: William Mackay – Accountant
Lee Foreman - Accountancy Manager

Portfolio Holder Neil Shorter
Portfolio Holder for: Finance and IT

Summary: Public Sector Audit Appointments (PSAA) procure and tender contracts between Local Authorities and Audit firms whilst acting as a regulator to confirm that any fee variations raised by external auditors are fair and appropriate and in line with regulation.

The Council previously appointed the PSAA in 2016 and the Council now needs to decide if it wants to become an opted-in authority for the 5 year appointing period covering the 2023/24 to 2027/28 accounts.

This report considers the options available to the Council and proposes giving notice to PSAA of the authority's intention to become opted in authority.

Key Decision: No

Significantly Affected Wards: None

Recommendations: **The Committee is recommended to:-**

I. **Propose to Council that the Authority gives its intention to become an opted-in authority to the Public Sector Audit Appointments for the 5 year appointing period commencing 2023/24.**

Financial Implications: The Audit fee and budget figure will need to be monitored and amended accordingly as per the outcome of any tender review, any amendment will be reported accordingly.

The Redmond Review has indicated that external fees are too low and therefore are likely to increase over the coming years, being part of a wider framework will enable economies of scale and help keep increases to a minimum.

If the national scheme is not used some additional resource may be needed to establish an auditor panel and conduct a local procurement. Until a procurement exercise is completed it is not possible to state what, if any, additional resource may be required for audit fees from 2023/24.

Legal Implications:

Section 7 of the Local Audit and Accountability Act 2014 requires a relevant Council/Authority to appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding year.

Section 8 governs the procedure for appointment including that the Council/Authority must consult and take account of the advice of its auditor panel on the selection and appointment of a local auditor. Section 8 provides that where a relevant Council/Authority is a local Council/Authority operating executive arrangements, the function of appointing a local auditor to audit its accounts is not the responsibility of an executive of the Council/Authority under those arrangements.

Section 12 makes provision for the failure to appoint a local auditor. The Council/Authority must immediately inform the Secretary of State, who may direct the Council/Authority to appoint the auditor named in the direction or appoint a local auditor on behalf of the Council/Authority.

Section 17 gives the Secretary of State the power to make regulations in relation to an 'appointing person' specified by the Secretary of State. This power has been exercised in the Local Audit (Appointing Person) Regulations 2015 (SI 192) and this gives the Secretary of State the ability to enable a sector-led body to become the appointing person. In July 2016 the Secretary of State specified PSAA as the appointing person.

Contact:

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Introduction and Background

1. The current auditor appointment arrangements cover the period up to and including the audit of the 2022/23 accounts. The Council previously opted into the Public Sector Audit Appointments (PSAA) national auditor appointment scheme for the period covering the accounts for 2018/19 to 2022/23.
2. The Council now needs to make a decision about our external audit arrangements from 2023/24.
3. Under the Local Government Audit & Accountability Act 2014 ("the Act"), the council is required to appoint an auditor to audit its accounts for each financial year. The council has three options available to the Council ;
    - To appoint its own auditor, which requires it to follow the procedure set out in the Act.
    - To act jointly with other authorities to procure an auditor following the procedures in the Act.
    - To opt in to the national auditor appointment scheme administered by a body designated by the Secretary of State as the 'appointing person'. The body currently designated for this role is Public Sector Audit Appointments Limited (PSAA).
4. In order to opt in to the national scheme, a council must make a decision at a meeting of the Full Council.

Pressures in the current local audit market and delays in issuing opinions

5. Much has changed in the local audit market since audit contracts were last awarded in 2017. At that time the audit market was relatively stable, there had been few changes in audit requirements, and local audit fees had been reducing over a long period. 98% of those bodies eligible opted into the national scheme and attracted very competitive bids from audit firms (Only one District Council remained outside the framework). The resulting audit contracts took effect from 1 April 2018.
6. During 2018 a series of financial crises and failures in the private sector year led to questioning about the role of auditors and the focus and value of their work. Four independent reviews were commissioned by Government:
    - Sir John Kingman's review of the Financial Reporting Council (FRC),
    - the audit regulator; the Competition and Markets Authority review of the audit market;
    - Sir Donald Brydon's review of the quality and effectiveness of audit; and
    - Sir Tony Redmond's review of local authority financial reporting and external audit. The recommendations are now under consideration by Government, with the clear implication that significant reforms will follow. A new audit regulator (ARGA) is to be established, and arrangements for system leadership in local audit are to be introduced. Further change will follow as other recommendations are implemented.
7. The Kingman review has led to an urgent drive for the FRC to deliver rapid, measurable improvements in audit quality. This has created a major pressure for audit firms to ensure full compliance with regulatory requirements and

expectations in every audit they undertake. By the time firms were conducting 2018/19 local audits during 2019, the measures they were putting in place to respond to a more focused regulator were clearly visible. To deliver the necessary improvements in audit quality, firms were requiring their audit teams to undertake additional work to gain deeper levels of assurance. In reality this means that the auditor has to review high value items on our balance sheet regardless of any amendments to accounting practice that apply to Local Authorities, a good example of this would be understanding the value of a school or a heritage asset, if its recorded at £1 or £1m it makes very little difference to the assets use or the taxpayer. However, additional work requires more time, posing a threat to the firms' ability to complete all their audits by the target date for publication of audited accounts.

8. Delayed opinions are not the only consequence of the FRC's drive to improve audit quality. Additional audit work must also be paid for. As a result, many more fee variation claims have been needed than in prior years.

9. This situation has been accentuated by growing auditor recruitment and retention challenges, the complexity of local government financial statements and increasing levels of technical challenges as bodies explore innovative ways of developing new or enhanced income streams to help fund services for local people. These challenges have increased in subsequent audit years, with Covid-19 creating further significant pressure for finance and audit teams.

10. None of these problems is unique to local government audit. Similar challenges have played out in other sectors, where increased fees and disappointing responses to tender invitations have been experienced during the past two years.

Options

Appointment by the Authority itself or jointly

11. The Council may elect to appoint its own external auditor under the Act, which would require the council to:

    - Establish an independent auditor panel to make a stand-alone appointment. The auditor panel would need to be set up by the Authority itself, and the members of the panel must be wholly or a majority of independent members as defined by the Act. Independent members for this purpose are independent appointees, excluding current and former elected members (or officers) and their close families and friends. This means that elected members will not have a majority input to assessing bids and choosing to which audit firm to award a contract for the Authority's external audit.

    - Manage the contract for its duration, overseen by the Auditor Panel.

The national auditor appointment scheme

12. This is in effect a re-run of the current arrangement with PSAA as specified as the 'appointing person' for principal local government.

13. The PSAA is now undertaking the work needed to invite eligible bodies to opt in for the next appointing period, from the 2023/24 audit onwards, and to complete a procurement for audit services. PSAA is a not-for-profit organisation whose costs are around 4% of the scheme with any surplus distributed back to scheme members.

14. In summary the national opt-in scheme provides the following:

    - the PSAA manage the appointment of a suitably qualified audit firm to conduct audits for each of the five financial years commencing 1 April 2023;
    - appointing the same auditor to other opted-in bodies that are involved in formal collaboration or joint working initiatives to the extent this is possible with other constraints;
    - managing the procurement process to ensure both quality and price criteria are satisfied. PSAA has sought views from the sector to help inform its detailed procurement strategy;
    - ensuring suitable independence of the auditors from the bodies they audit and managing any potential conflicts as they arise during the appointment period;
    - minimising the scheme management costs and returning any surpluses to scheme members;
    - consulting with authorities on auditor appointments, giving the Council/Authority the opportunity to influence which auditor is appointed;
    - consulting with authorities on the scale of audit fees and ensuring these reflect scale, complexity, and audit risk; and
    - ongoing contract and performance management of the contracts once these have been let.

Assessment of options and officer recommendation

15. If the Council does not opt in to the national auditor appointment scheme there would be a need to establish an independent auditor panel to make a stand-alone appointment, although this could be done jointly with other Council.
16. The auditor panel would need to be set up by the Council itself, and the members of the panel must be wholly or a majority of independent members as defined by the Act.
17. This means that elected members will not have a majority input to assessing bids and choosing to which audit firm to award a contract for the Council/Authority's external audit.
18. This would be a resource-intensive processes to implement for the council, and without the bulk buying power of the sector-led procurement would be likely to result in a more costly service. It would also be more difficult to manage quality and independence requirements through a local appointment process.
19. The Council and the auditor panel would need to maintain ongoing oversight of the contract.
20. In weighing up the options we must be mindful of the issues that there have been with the current arrangements, and the PSAA must take some responsibility for the issues caused, accepting bids that are unviable resulting in fee increases, concentrating work in too few firms, and not penalising auditors within the contract framework for poor performance. However it is considered that working within the system to improve standards will be more effective than opting out.

21. The national auditor appointment scheme provides appointment of an independent auditor with limited administrative cost to the council. By joining the scheme, better outcomes would be expected and be less burdensome for the Council than a procurement undertaken locally because:

    - collective procurement will reduce costs for the sector and for the Council compared to a multiplicity of smaller local procurements;
    - it does not require the Council to establish its own auditor panel with an independent chair and independent members to oversee a local auditor procurement and ongoing management of an audit contract;
    - it is the best opportunity to secure the appointment of a qualified, registered auditor - there are only nine accredited local audit firms, and a local procurement would be drawing from the same limited supply of auditor resources as PSAA's national procurement; and
    - supporting the sector-led body offers the best way of to ensuring there is a continuing and sustainable public audit market into the medium and long term.

Recommendation

22. This report concludes that the sector-wide procurement conducted by PSAA will produce better outcomes and will be less burdensome for the Council than a procurement undertaken locally.
23. This route also minimises risks to the authority if we failed to appoint an auditor in accordance with the requirements and timing specified in local audit legislation, and not achieving best value for money.
24. It is therefore **recommended that the Audit Committee propose to Council that the Authority gives its intention to become an opted-in authority to the Public Sector Audit Appointments for the 5 year appointing period commencing 2023/24.**
25. Regulation 19 of the Local Audit (Appointing Person) Regulations 2015 requires that a decision to opt in must be made by a meeting of the Council.
26. The Council then needs to respond formally to PSAA's invitation in the form specified by PSAA by the close of the opt-in period which is the 11 March 2022.

The next audit procurement

27. The PSAA will commence the formal procurement process in early February 2022. It expects to award contracts in August 2022 and will then consult with authorities on the appointment of auditors so that it can make appointments by the statutory deadline of 31 December 2022.
28. The prices submitted by bidders through the procurement will be the key determinant of the value of audit fees paid by opted-in bodies. PSAA will:

    - seek to encourage realistic fee levels and to benefit from the economies of scale associated with procuring on behalf of a significant number of bodies;
    - continue to pool scheme costs and charge fees to opted-in bodies in accordance with the published fee scale as amended following consultations with scheme members and other interested parties (pooling means that everyone within the scheme will benefit

from the prices secured via a competitive procurement process – a key tenet of the national collective scheme);

- continue to minimise its own costs, around 4% of scheme costs, and as a not-for-profit company will return any surplus funds to scheme members. In 2019 it returned a total £3.5million to relevant bodies and in 2021 a further £5.6million was returned.

29. PSAA will seek to encourage market sustainability in its procurement. Firms will be able to bid for a variety of differently sized contracts so that they can match their available resources and risk appetite to the contract for which they bid. They will be required to meet appropriate quality standards and to reflect realistic market prices in their tenders, informed by the scale fees and the supporting information provided about each audit. Where regulatory changes are in train which affect the amount of audit work suppliers must undertake, firms will be informed as to which developments should be priced into their bids.

30. The scope of a local audit is fixed. It is determined by the Code of Audit Practice (currently published by the National Audit Office), the format of the financial statements (specified by CIPFA/LASAAC) and the application of auditing standards regulated by the FRC. These factors apply to all local audits irrespective of whether an eligible body decides to opt into PSAA's national scheme or chooses to make its own separate arrangements. The requirements are mandatory; they shape the work auditors undertake and have a bearing on the actual fees required.

31. There are currently nine audit providers eligible to audit local authorities and other relevant bodies under local audit legislation. This means that a local procurement exercise would seek tenders from the same firms as the national procurement exercise, subject to the need to manage any local independence issues. Local firms cannot be invited to bid. Local procurements must deliver the same audit scope and requirements as a national procurement, reflecting the auditor's statutory responsibilities.

Portfolio Holder's Views

32. This report brings forward a number of options and I support the recommendation to procure future external audit services through the PSAA framework. However, the learning points identified in Paragraph 20 need to be taken forward in the procurement process and this should be advocated to the PSAA procurement team. Council's will also need to be more robust in holding the PSAA to account if improved performance is not delivered.

Contact and Email

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ASHFORD
BOROUGH COUNCIL

Agenda Item No. 5

Report to: Audit Committee

Date of Meeting: 1st February 2022

Report Title: Homes England – Compliance Audit Annual Report 2021-22 for Ashford Borough Council

Report Author & Job title: Mark James, Development Partnership Manager
Portfolio Holder: Cllr Paul Clokie, Portfolio Holder for Housing

Key

Summary:

The Council is fortunate to be supported in its affordable homes programme delivery by Homes England. Their grant awards have seen the Council deliver numerous affordable housing schemes, and notably their grant funding has helped provide Farrow Court, Danemore, the New Quarter buildings (Somerset Heights and Stour Heights) and a range of infill sites.

Latterly, we have two projects on site that are receiving grant – one of which, at Halstow Way, is at a high enough grant level to enable the housing service to set a social rent, a genuinely affordable rent at about 60% of the open market rent value, meaning the homes are at an attainable and accessible rent level for those who will be placed there once the scheme completes in June 2022.

The attached report from Homes England advises Members of the outcome of the Compliance Audit carried out on a sample of the Homes England funded housing schemes. The purpose of the Compliance Audit is to confirm that the provider (the Council) has complied with Homes England's policies, procedures and funding conditions.

Decision: No

Recommendations: The Audit Committee is recommended to note the contents of the report. The Chair is asked to confirm that he has signed the report.

Policy Overview: N/A

Finance Risk Assessment: N/A

Contact: mark.james@ashford.gov.uk – Tel: 01233 330687

Report Title: **Homes England – Compliance Audit Annual Report 2021-22 for Ashford Borough Council**

Introduction and Background

1. Each year Homes England (formerly known as the Homes and Communities Agency) carries out Compliance Audits on housing providers who are in receipt of Homes England funding under the Affordable Housing Programme (2016-21) or other funding programmes (they have recently launched the 2021-26 programme). Sample schemes are selected and checks are made to ensure that the provider (the Council in this instance) has complied with Homes England's policies, procedures and funding conditions on all contracts and agreements entered into.

2. Providers are required to appoint an independent auditor to carry out these checks. The auditor then reports their findings to Homes England, who assess this and then issue a report of their own to the provider, advising them of the grade they have been given. These are:

    - Green, if they meet requirements
    - Amber, if there is some failure to meet requirements
    - Red, if there is a serious failure to meet requirements

3. It is vitally important, given the scale of the council's affordable homes delivery programme and the need to be seen as an efficient deliverer of projects that Ashford Borough Council continues to meet the requirements set out by Homes England. Reputationally this has considerable merit for the authority as well and stands the authority in good stead as we seek to obtain further grant awards to help accelerate the affordable homes programme.

4. Failure to comply will not only jeopardise the Council's reputation but put at risk future schemes and tarnish the positive perception that the council has worked hard to build with central government and its many agencies. Given the scale of the pipeline the Council is putting together, which was detailed to Cabinet in December 2021, being seen as a reliable trustworthy deliverer, but also an ambitious partner through the Continuous Market Engagement process is paramount.

2021-22 Compliance Audit

1. After a period in which Homes England's spot checks had not picked any of Ashford Borough Council's schemes for further attention, in 2021-22 the Council was once again selected for a Compliance Audit. The scheme selected was the new build scheme at East Stour Court, in Mabledon Avenue, Ashford. The scheme is part of the Council's DAHLIA brand of independent living accommodation for older people (DAHLIA standing for Desirable Affordable Housing Linking Independence and Age). It consists of 24 x 1-bedroom flats and 5 x 2-bedroom flats, which were being completed as the audit was being carried out.

2. Ashford Borough Council received £39.177 per unit for East Stour Court, a total of £1,136,140. This was through the 2016-21 Affordable Housing Programme to assist it in delivering this scheme. Some members may recall that previously the grant awards for independent living schemes had a different acronym (CASSH – the Care and Support Specialised Housing Fund) but all awards now are made from the one funding 'pot'.

3. The independently appointed auditor appointed was Greg Trimmer of Trimmer CS Ltd. He undertook the audit between 11th and 20th August 2021. Following his audit, Ashford Borough Council was advised of the outcome in August 2021 and his report was submitted to Homes England accordingly.

4. The attached report (Appendix A) from Homes England confirms that the council was pleasingly awarded a Green Grade with no breaches of funding conditions or recommendations for improvement. Ashford Borough Council has had four Compliance Audits now since 2014 and in each audit has been awarded a Green Grade.

5. As stated, this is pleasing as we seek to extend our strong rapport with Homes England and to be seen by them as a trusted deliverer of affordable housing and also that we go about that with strong and robust processes that ensure we comply with the conditions that the funding awards carry.

Recommendations

I. Members are asked to note the contents of the Homes England Compliance Report for the 2021-22 financial year.

II. The Chair is asked to confirm that he has signed the report.

Contact and E-Mail

Mark James, Development Partnership Manager, Housing Services

mark.james@ashford.gov.uk

Compliance Audit Report – 2021/22

29UB – Ashford Borough Council

Final Grade	Green - Meets requirements
Independent Auditor Organisation	Trimmer CS Limited
Independent Auditor Name	Greg Trimmer

Report Objectives and Purpose

Compliance Audits check Provider compliance with Homes England's policies, procedures and funding conditions. Standardised checks are made by Independent Auditors on an agreed sample of Homes England schemes funded under affordable housing programmes. Any findings, which may be a result of checks not being applicable to the scheme or an indication of procedural deficiency, are reported by the Independent Auditor to both the Provider and Homes England concurrently. The Homes England Lead Auditor reviews the findings and records those determined to be 'breaches' in this report. Breaches are used as the basis for recommendations and final grades for Providers. Grades of green, amber or red are awarded; definitions are provided on page 2 of this document.

Further information is available at: https://www.gov.uk/guidance/compliance-audit.

Provider's Acknowledgement of Report

The contents of this report should be acknowledged by your Board's Chair or equivalent. Confirmation of this acknowledgement should be recorded in the IMS Compliance Audit System by your Compliance Audit Lead on behalf of your Board's Chair or equivalent. Online acknowledgement should be completed within three calendar months of the report email notification being sent.

Confidentiality

The information contained within this report has been compiled purely to assist Homes England in its statutory duty relating to the payment of grant to the Provider. Homes England accepts no liability for the accuracy or completeness of any information contained within this report. This report is confidential between Homes England and the Provider and no third party can place any reliance upon it.

Compliance Audit Grade Definitions

Green Grade	No high or medium severity breaches identified, although there may be low breaches identified. The Homes England audit report will show that the provider has a satisfactory overall performance but may identify areas where minor improvements are required.
Amber Grade	One or more medium severity breaches identified. The Homes England audit report will show that the provider has failed to meet some requirements but has not misapplied public money. The provider will be expected to correct identified problem(s) in future schemes and current developments.
Red Grade	One or more high level severity breaches identified, the Homes England audit report will show that the provider has failed to meet some requirements and there has been a risk of misapplication of public funds.

Compliance Audit Grade and Judgement

Final Grade	Green - Meets requirements
Judgement Summary	On review of the evidence provided, the outcome of the audit has shown the provider has complied with all the programme requirements and guidance. A GREEN grade has been assigned and no breaches were identified.

Scheme/Completions details

Scheme ID/ Completion ID	**Address/Site ID**	**Scheme type**
975805	East Stour Court- Ashford- 16/21Ashford,TN24 8BG	Rent

Audit Results

Number of Schemes/Completions Audited	1
Number of Breaches Assigned	0
Number of High Severity Breaches	0
Number of Medium Severity Breaches	0
Number of Low Severity Breaches	0

Agenda Item No:	6
Report To:	Audit Committee
Date of Meeting:	1st February 2022
Report Title:	Instruction and administrative processes of Legal Services: Internal Audit Report
Report Author & Job Title:	Alison Blake: Deputy Head of Audit Partnership

Summary:	On 7 September Mid Kent Audit published the final report on work examining controls which govern the instruction and administrative processes of the Council's Legal Service. While noting that the Service faces significant pressures resulting from increased demand and several long-standing senior lawyer vacancies, further magnified by the Pandemic, the report gave a "weak" assurance rating, an adverse conclusion holding that the majority of controls do not work consistently at keeping risks to an acceptable level. The Legal Service has agreed to a series of remedial actions to address the findings. In line with settled practice, this report brings the findings to Members' attention to allow an understanding of the issues raised and to support and track improvements.

Key Decision:	No
Significantly Affected Wards:	N/A
Recommendations:	**The Committee is recommended to:** I. **Note** the findings raised in Mid Kent Audit's report on the instruction and administrative processes of the Council's Legal Service, and **II.** **Consider** whether receipt of a future report from the Solicitor to the Council and Monitoring Officer on progress towards completing agreed remedial actions is needed.
Policy Overview:	N/A
Financial Implications:	No new implications.

Legal Implications	No specific implications. The Audit did not test the quality of the legal advice being provided, documents negotiated, or the court work carried out, and its conclusion did not extend to or seek to make judgements on those matters.
Equalities Impact Assessment	Not required.
Other Material Implications:	N/A
Exempt from Publication:	**NO**
Background Papers:	The Final audit report - attached.
Contact:	Alison.blake@midkent.gov.uk – Tel: 01622 602080

Report Title: Legal Services Internal Audit Report

Introduction and Background

Planning and Reporting the Audit Engagement

1. Each year, working in conformance with Public Sector Internal Audit Standards, Mid Kent Audit draws up a risk-based audit plan for approval by Members. Before 2019/20, the Council's legal service had never been subject to internal audit review. Although the legal service did appear on the 2019/20 audit plan we agreed to defer the engagement in discussion with officers to allow a review to take place.

2. The Council's legal service next appeared on the 2020/21 Audit Plan agreed by this Committee in **March 2020**. In operational planning discussions with officers we agreed to schedule the work late in the year. Also, recognising that we lack expertise to comment on the quality of legal advice provided, we agreed to focus our work only on the legal service's instruction and administrative processes.

3. We began the work as scheduled on 31 March 2021 working to a brief agreed with the Service. We finished fieldwork on 11 June 2021, slightly later than planned owing to a need for fully looking into the emerging findings. We published a draft report to the service on 23 June and, after much discussion to decide the most effective remedial actions, published the final report on 7 September.

4. This timeline meant the final report appeared some time after the Deputy Head of Audit reported his annual opinion to Members on 15 June. However, the work was substantially complete at that stage and its conclusions featured fully within the delivered opinion.

Audit Engagement Findings

5. We include the full published report as an appendix. In summary, while recognising the significant and sustained resource pressures on the service, due to several long-standing senior lawyer vacancies, and further magnified by the Pandemic, our work found that eight of ten examined controls were not working effectively. Based on those findings we identified two risks operating beyond the Council's agreed risk appetite:

    - [the risk that] the Legal Service is not sufficiently integrated by Officers into the Council's processes, leading to Legal Services having no or poor awareness of issues/projects where legal advice is or may be required or may result in poor advice given.

    - [the risk that] Legal advice/support to clients is hindered by inadequate instruction and administrative processes.

6. Driving these conclusions were eleven separately listed audit findings. Two stand out as 'high priority', labelling them as having the deepest impact in reducing control effectiveness:

   - Only two of ten cases sampled used the standard instruction forms intended for use by instructing departments/officers. This meant the legal service could have missed prompt receipt of important information relevant to the advice needed, such as urgency.

   - None of the ten cases we sampled had been closed, although all had concluded. As well as providing a misleading impression of the number of open cases, not closing a case promptly leaves a risk of further documents being erroneously added to the case.

7. Following our standard practice in audit, we discussed and agreed remedial actions for each finding with the service. These actions fall due for completion between January and June 2022. We will follow up progress in line with our usual approach and, first, report to Management Team.

8. We in audit thank officers from the Legal Service for their help throughout the engagement, recognising that the Audit took place at a time of numerous staff vacancies in the Service, and also when staff were working at home in a wide variety of situations, instead of together as a team in the usual way. In particular the Service's management's positive engagement with our findings has resulted in a broad set of agreed actions which we believe will lead to real improvements.

Legal Service Response (this section completed by the Solicitor to the Council and Monitoring Officer)

9. I am grateful to the audit team for their work with Legal Services to identify a range of recommended improvements to our instruction and administrative processes. Those improvements will assist the Legal Service to provide more proactive and timely legal advice and support to the Council, and I regard their implementation as important to the development of the Service. Therefore, I have taken personal responsibility for their implementation, and I have appointed one of our senior lawyers to act as a legal practice manager and work closely with me to ensure that the recommended actions are undertaken within realistic timelines. Indeed a number of the actions have already been completed, and most of the remaining actions are due for completion by April 2022.

Proposal

10. We recommend the Committee note the attached final audit report. We further recommend the Committee consider amending its work programme to schedule a future update (or updates) on progress towards fulfilling agreed actions.

Implications and Risk Assessment

11. The audit report sets out the possible risks arising from the findings, but these are accompanied by short-term remedial actions which have been agreed by the Service's management for implementation.

Next Steps in Process

12. Mid Kent Audit will continue to monitor progress and this will form part of interim and annual reporting to Members as part of overall summaries.

MID KENT AUDIT

Instruction and administrative processes of Legal Services

(Financial year 2020/2021)

FINAL AUDIT REPORT

SEPTEMBER 2021

FINAL Assurance Rating:

Weak

Audit Code	A21-AR08	**Service**	ABC Legal & Democracy
Lead Auditor	Andy Billingham	**Sponsor**	Terry Mortimer
Audit Reviewer	Ali Blake	**Director**	Tracey Kerly

Summary Report

Our opinion based on our audit work is that the internal controls in place over the ***instruction and administrative processes of Legal Services*** are:

WEAK[1]

We note that the Service continues to face significant pressures resulting from increased demand and a lack of resources (due to several long-standing senior lawyer vacancies in the service). These pressures have been further magnified over the last year during the Pandemic, and this has impacted on both the design and operation of their internal controls, specifically, those designed to effectively manage the flow and administration of legal services requests. The majority of controls that we tested were either ineffective or partially effective and so are not helping to effectively manage the Service's risks.

The scope of our work has been to look at processes and case management controls, this is in effect, the first stage in the legal service process. We have not tested the quality of the legal advice being provided, documents negotiated, or the court work carried out, therefore our conclusion does not extend to or seek to make judgements on those matters.

Our testing confirmed that some of the corporate processes to request, instruct and engage with Legal Services are not adequately integrated into Council processes. These inconsistencies extend the full breadth of the processes including legal considerations in Council decision making and major projects. The Service needs to work with its client services/officers (including the Council corporately) to secure their cooperation to make improvements to ensure there is a consistent instruction process in place. This process should then be used by clients and administered by Legal Services in a clear, effective, and suitably prioritised way. Work needs to be undertaken with service users to increase awareness, engagement and to make sure that instruction processes can be easily accessed and monitored.

Internally, administrative processes of Legal Services are hampered by a lack of resources and some non-compliance with agreed administrative procedures and approaches. In part, this is due to some officers/locums not being signposted and trained to follow up to date procedures, or, simply not being aware that procedures exist in the first place. Some risks are increased further as the service does not formally document a risk-based prioritisation or allocation process nor formally document a case review process for open files.

[1] We provide the definitions of our assurance ratings at **appendix II**

Next Steps

In this report we describe the **11** priority findings where actions will require future follow-up. We are pleased to report that all of the findings have been agreed, and that the service has set out a series of actions and set target dates for completion. As such, we will follow up these actions as they fall due in line with our usual approach.

We have prioritised these as below:

Critical (Priority 1)	0
High (Priority 2)	2
Medium (Priority 3)	5
Low (Priority 4)	4
Advisory	0

We provide the definition of our priority ratings at appendix II.

Independence

We are required by Public Sector Internal Audit Standard 1100 to act at all times with independence and objectivity. Where there are any threats, in fact or appearance, to that independence we must disclose the nature of the threat and set out how it has been managed in completing our work.

We have no matters to report in connection with this audit project.

Acknowledgements

We would like to express our thanks to all those officers who helped completion of this work, in particular:

- Terry Mortimer, Solicitor to the Council & Monitoring Officer
- Jeremy Baker, Principal Solicitor
- Rhonda Mickelborough, Legal Support Officer
- Tina Young, Legal Assistant
- Rosie Reid, Member Services & Ombudsman Complaints Officer

Distribution

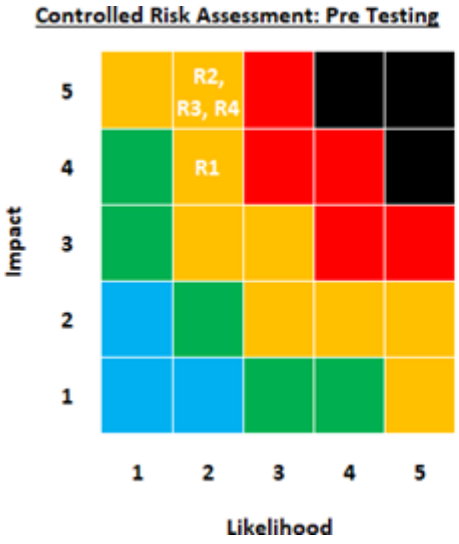
Audit team and contact details	Report distribution list
Deputy Head of Audit Partnership Russell Heppleston (russell.heppleston@midkent.gov.uk) **Audit Manager** Ali Blake (alison.blake@midkent.gov.uk) **Senior Auditor** Andy Billingham (andy.billingham@midkent.gov.uk)	**Draft and Final Report** Terry Mortimer, Solicitor to the Council and Monitoring Officer Jeremy Baker, Principal Solicitor **Final Report** Ben Lockwood, Deputy Chief Executive (s151) Tracey Kerly, Chief Executive

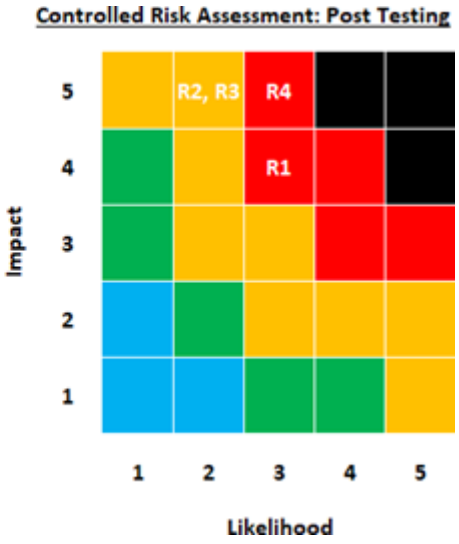
Detailed Findings

Our work considers the objectives, risks and controls agreed with the service as in the review's scope. We assessed each risk during planning as either **Critical**, **High**, **Medium**, **Low** or **Minimal** based on the controls reported and the service's understanding of how well the controls work. We base our assessments on controlled risk and score using the Council's Risk Framework.

This detailed report sets out our results and findings from testing each agreed objective, risk and control. We also describe the effect of our findings on the assessed risk.

The post-testing risk assessment takes into consideration the adequacy and effectiveness of the controls. We have increased the exposures for **2 (R1 and R4)** risks following our testing of the controls. Where these risks have increased it has taken them above the Council's risk appetite and tolerance, because the Council's Risk Framework sets the tolerance for "Compliance", which includes legal risks, as VERY LOW.





The table below summarises our assessment of **control effectiveness** following our testing and how each control links to the risks:

Control	Post-Testing Control Assessment			
	Risk 1	Risk 2	Risk 3	Risk 4
Awareness of instruction process	Ineffective			
Legal representation at meetings	Effective		Effective	
Draft Cabinet reports	Partly Effective		Partly Effective	
Project Initiation Documents (PID)	Partly Effective		Partly Effective	
Instruction of new cases	Ineffective			Ineffective
Allocation of new cases	Partly Effective			Partly Effective
Review of ongoing cases	Ineffective			Ineffective
Case records	Partly Effective			Partly Effective
Standing instructions		Partly Effective		
Ombudsman complaints		Effective		

Of the 10 controls tested, 2 were working as intended. The remainder of the report sets out in greater detail the evidence to support our conclusions along with our findings and action plan, including our recommendations.

Objective 1: To provide timely, relevant and comprehensible legal advice to the Council, its Members and Officers

RISK 1:

The Legal Service is not sufficiently integrated by Officers/Members into the processes of the Council, leading to Legal Services having no or poor awareness of issues/projects where legal advice is or may be required or may result in poor advice given.

Control 1: Awareness of instruction process

Besides some standing instructions, discussed later in the report, the Service hasn't provided any recent training or awareness sessions to internal service users regarding how to interact with Legal Services.

The Councils intranet has recently been replaced with a Smarthub. Although officers can still access information on the intranet, the information relating to Legal Services on the intranet is out of date and information on Smarthub has not been fully updated. To avoid confusion and provide better clarification, officers should remove out of date information and transfer all remaining relevant information to the Smarthub. (**see R01**)

Control 2: Legal representation at meetings

We examined and reviewed information from 3 meetings over the last 6 months to determine the representation of Legal Services and their contributions:

1. Management Team.
2. Statutory Officer Meetings.
3. Programme Management Board.

We found officers didn't keep minutes for all the meetings, however we confirmed a Legal representative attended 7/12 Management Teams, 9/9 Statutory Officer meetings and 1/3 Programme Management Board meetings. It appears that every effort is made to have legal support and representation where it is required but note that the demands on existing resources and current limitations on those resources, mean that consistent representation could be harder to maintain. This will likely be compounded if the service does increase engagement, and therefore this will need to be carefully balanced with priorities / risks going forward. i.e. agreeing to have representation at certain meetings and not others.

Control 3: Draft Cabinet reports

The Council requires officers to consult with Legal Services on draft Cabinet reports prior to Management Team circulation. The requirement is controlled using a prompt within the Cabinet report template and Cabinet report writing guidance to authors. We tested a random sample of 5 Cabinet reports for 20/21 and found the following:

- 5/5 completed the legal implications section.
- 5/5 were presented to Management Team where there was a Legal Services representative present.

However, based on the details and guidance of the legal implications section, it is unclear what information was sought, the legal advice given, and by whom. During our interviews, Legal Service officers also stated that they too were often unclear what information was obtained when the draft report was presented to Management Team. (**See R02**)

Control 4: Project Initiation Documents (PID)

We examined the PID template and there is no prompt to detail discussions held with Legal Services despite prompts for Finance, Procurement and Planning. PID's are presented at the Programme Management Board for consideration and this acts as a compensating control to ensure Legal Services are kept up to date about new projects and any potential legal implications. However, we could only verify a Legal representative attended 1/3 of the meetings we reviewed. Similarly, during our interviews with Legal Services officers they expressed concerns that they were unaware of all upcoming projects. (**See R03**)

Control 5: Instruction of new cases

The Council's Smarthub includes 2 forms to instruct Legal Services, a "request for legal advice" and "instruction form for s106 agreements". The first, "request for legal advice" includes an instruction to check the intranet first for general advice. As noted above, the information on the intranet is out of date, and includes links which are no longer active. The form currently requires the instruction to be sent straight to the Principal Solicitor, which contradicts the advice on the Smarthub, which states it should be sent to Legal Support. (**See R07**)

We found there are no issues with the second form, 'instruction form for s106 agreements.

There were no tailored instruction forms for other services who regularly use Legal Services such as Housing (Property). (**See R01**), however the general form is

available to them.

We tested a random sample of 10 instructions in 2020/21 to establish if they were received using the instruction template in accordance with the agreed instruction process. We found that out of the 10 tested, only 2 were received using the correct instruction forms (2/10 cases). (**See R01**)

We tested all 10 cases further to determine if they were processed, once instructed, in accordance with agreed procedures and found:

- We found 1 case where client instructions weren't received prior to the arrival of external solicitor's correspondence. (**See R01**)
- 10/10 cases were allocated a unique reference number
- 10/10 allocated a fee earner
- Acknowledgements were sent for 6/10 cases. These acknowledgements did not follow a consistent process despite a standard acknowledgement template being available to all staff. (**See R08**)
- 9/10 files were set up correctly by Legal Support. The remaining case was set up and completed by a Locum. (**See R09**)

Control 6: Review/risk assessment/allocation of new cases

During our interviews with Officers, there was a consistent view that a risk assessment process exists for new Planning instructions to determine urgency and how the matter should progress. However, the risk assessment methodology and its application are not documented, and we were unable to evidence how the process operates in practice. There is no risk assessment or prioritisation process for Property cases, due to resource constraints and vacancies within the service. (**See R10**)

We also found that officers within the Property team receive their cases directly, as such, it is not possible to determine their current workload, urgency of the case or whether there is sufficient resilience during periods of officer leave. (**See R11**)

Control 7: Review of ongoing cases

There are currently 1455 open cases on the Iken system, the oldest date back to April 2000. We tested a sample of 10 open cases to establish whether they should be closed. Our testing comprised detailed walkthrough and review of each case and discussion with officers. We found:

- All 10 cases should have been closed.
- The oldest case last worked on dated back to February 2004.

- 3 cases were initially closed but re-opened so additional time could be charged to them. These cases were subsequently not re-closed. (**See R04 and R09)**

Some team leaders review open cases in 1-2-1's with officers. However, there is no process to periodically look at all open cases to ensure they have adequately progressed or have been closed. While a case remains open it can be edited. This may create a risk of documentation changing after the case is concluded.

Control 8: Case records

The Service uses Iken as their legal case management system. Access to the system is controlled through usernames and passwords. We found that officers in post since Iken was introduced haven't had their password controls enabled, this includes one superuser. Officers who do use passwords do not regularly update them. While Iken can only be accessed by logging onto the Council's network, the Council's IT Security Policies should be reviewed and any necessary further IT access controls put in place to ensure the protection and safeguarding of legally sensitive information and to ensure clear accountabilities over case data. (**See R05**)

We tested a random sample of 5 leavers, all had their access to Iken disabled. However, officers confirmed they had reviewed this during the audit and disabled missed accounts. No routine process exists to ensure the timely removal of leavers. (**See R06**)

Conclusion

Total controls tested	Controls operating effectively	Controls partially effective	Controls not operating effectively
8	1	4	3

Our conclusion, based on the results of testing, are that improvements should be made to the legal instruction processes, including raising awareness, user engagement and support. Open cases need to be reviewed, to ensure historic cases have adequately progressed, and PID/Cabinet report templates updated, to prompt early Legal discussion about potential issues. Our assessment of the controlled risk has increased in likelihood based on the number of controls not operating as intended to manage the risk to acceptable levels (i.e. VERY LOW, in line with the Council's Risk Framework).

Objective 2: To conduct, on behalf of the Council, actual or threatened legal proceedings, and Ombudsman complaints that raise legal issues

RISK 2:

Legal Services is not notified promptly of actual or threatened legal proceedings, and Ombudsman complaints that raise legal issues.

Control 1: Standing instructions

Standing instructions are detailed on the Council's Smarthub and include generic instructions on how to instruct new work and legal matters as well as specific instructions for the s106 process. There are no further specific instructions for individual services who frequently instruct Legal Services for example, the process, what form to complete, and the information required. (**See R01**)

Control 2: Ombudsman complaints

The administration of Ombudsman complaints is overseen by experienced officers who report progress annually to the Standards Committee. There were 4 ombudsman complaints with legal issues received since 1 April 2020. We tested all of these and found 3/4 were promptly passed to Legal Services. We haven't raised a finding about the 1 delayed complaint as, upon detailed review, we are satisfied that this was an isolated incident and does not represent a systemic issue or risk.

Conclusion

Total controls tested	Controls operating effectively	Controls partially effective	Controls not operating effectively
2	1	1	-

Our conclusion based on our testing is that the process for administering and processing Ombudsman complaints are generally effective. Improvements could be made to tailor standing instructions to individual services who frequently instruct Legal Services, this would provide better guidance and ensure consistency in the application of the controls.

RISK 3:
Legal Services not being given comprehensive instructions in good time by Officers

The controls in place to mitigate this risk are the same as some of the controls previously mentioned under Risk 1. These controls are listed below but further information is included above.

- Control 1: Legal representation at meetings
- Control 2: Draft Cabinet reports
- Control 3: Project Initiation Documents

Conclusion

Total controls tested	Controls operating effectively	Controls partially effective	Controls not operating effectively
3	1	2	-

The results of our testing conclude that PID and Cabinet report templates should be amended to ensure prompt discussion between report authors and Legal officers of Legal issues. (**See R02 and R03**) The controls reported as partially effective do increase the likelihood that Legal Officers aren't given comprehensive instructions in good time, however, given the results of our testing we don't feel that this has significantly increased the level of overall risk exposure.

RISK 4:

Legal advice/support to clients is hindered by inadequate instruction and administrative processes

This risk focusses on the procedures that are in place to facilitate and enable the goal of providing legal advice/support to clients. The controls in place to mitigate this risk are the same as some of the controls previously mentioned under Risk 1. These controls are listed below but further information is included above.

- Control 1: Instruction of new cases
- Control 2: Review/risk assessment/allocation of new cases
- Control 3: Review of ongoing cases
- Control 4: Case records

Conclusion

Total controls tested	Controls operating effectively	Controls partially effective	Controls not operating effectively
4	0	2	2

Our conclusion, based on the results of testing, is that the controls in place to effectively administer and manage the workload of the service need to be improved. This includes the need to strengthen the controls over the review and management of open cases, and to improve the controls over the prioritisation and allocation of work. As none of the controls tested were operating effectively, our risk assessment has been revised to reflect the increased exposure that the service faces. This new assessment is above the tolerance of compliance/legal risk that the Council sets within its risk framework.

Recommendations and Action Plan

01 - Awareness of instruction process	High (Priority 2)

Finding Description: Legal Services haven't provided recent training/awareness sessions to users regarding how to interact with Legal Services.

There are generic standing instructions in place however these could be further tailored to individual services such as Property to provide additional guidance. Our testing found that 2 out of a sample of 10 cases used the standard instruction forms. Our testing also found 1 case of an instruction coming from an external solicitor as the internal instructing department had failed to complete an instruction.

The information available on the intranet is out of date. Information available on the intranet hasn't been transferred to the Smarthub.

Cause: Lack of resources within Legal Services

Effect: Service users aren't fully aware of the process they should follow when interacting with Legal Services.

The instruction process is inconsistent. Important information such as urgency of the work isn't obtained at the first point of contact to help inform the risk assessment / allocation process.

Recommendation:

1. Provide regular updates to service users on how to engage with and instruct Legal Services
2. Increase standing instructions for individual service areas
3. Update and transfer available guidance on the intranet to the Smarthub

Management Response & Actions

Response Type: Agreed

Recommendation 01/Action 01 – Information about Legal Services, its staff and their legal expertise, and how to instruct Legal Services (including existing instruction forms), is published on the SmartHub and is up to date. The SmartHub is the corporate method of communication to staff and will contain all further tailored instruction forms that are made available. When new Legal staff have been recruited, we will brief Corporate Management Team in general on how and when to instruct Legal Services, including signposting the relevant SmartHub pages.

Recommendation 01/Action 02 – (i) We intend to make available tailored instruction forms to other client services that regularly use Legal Services. (ii) We intend to brief each relevant client service on how and when to use the tailored instruction forms. N.B. (a) There will be cases where standard instruction forms may not be completed, for example in cases of urgency. N.B. (b) The absence of a standard instruction form (as opposed to informal and/or undocumented instructions) from the client service has not of itself prevented or delayed the carrying out of any necessary legal work. However, the use of standard instruction forms will assist Legal Services in carrying out its work efficiently. **Recommendation 01/Action 03** – This has been implemented.

Responsible officer: Terry Mortimer	**Implementation date**: **Action 01:** 01 January 2022 **Action 02(i):** 30 April 2022 **Action 02(ii):** 31 May 2022 **Action 03:** Implemented & Closed

04 - Review of open cases	High (Priority 2)

Finding Description: There isn't a process in place to periodically review all open cases to ensure cases have adequately progressed or are closed following completion.

Reports from the system show that there are currently 1455 open legal cases. Our testing of a random sample of 10 open cases found they all should have been closed.

Cause: Lack of officer resources both for operation and oversight of controls

Effect: Officers are unaware if all open cases have sufficiently progressed or the overall number of genuinely open cases.

Open cases can still be edited following completion.

Recommendation:

1. Introduce a regular process to check that open cases have been adequately progressed
2. Review historic open cases to ensure they've been adequately progressed
3. Embed a process for closing cases

Management Response & Actions

Response Type: Agreed

Recommendation 04/Action 01 – A number of processes already exist to review the progress of open cases, for example fee-earners can request file lists of cases not progressed for x days; team leaders have regular 1 to 1 meetings with fee-earners in order to monitor case progression; meetings take place between Legal and client officers to review progress. It is however accepted that:

(i) there should be more regular internal reviews of case progression, and to that end, a procedure will be created by Legal Management Team, and included in the Procedure Manual referred to in the response to ***recommendation 09***;

(ii) more regular timetabled case monitoring with some client officers should be explored and if necessary incorporated within an agreed protocol with those client services.

Recommendation 04/Action 02 - Over 250 historic files were closed during a review of the Legal Service's open cases during May and June 2021. Many of those files are currently awaiting post-closure processes, such as scanning and indexing of scanned documents for long-term record purposes. It is accepted that there should be a review of historic open cases, and the review of case progression referred to above will seek to identify the historic open cases in order that they can be subject to the file closure

process.

Recommendation 04/Action 03 - See response to ***recommendation 09***

Responsible officer: Terry Mortimer	**Implementation date**: **Action 01 (i):** 01 April 2022 **Action 01 (ii):** 31 May 2022 **Action 02:** 01 April 2022 **Action 03:** 01 April 2022

02 - Cabinet reports	Medium (Priority 3)

Finding Description: The Cabinet report template doesn't detail enough information to confirm whether legal issues have been adequately considered and discussed with Legal Services prior to presentation at Management Team.

While not specifically tested we also note that other Member reports also don't include sufficient detail around legal implications.

Cause: The design of the Cabinet report template doesn't prompt officers to discuss legal issues with Legal Services or detail the discussion held and with whom.

Effect: When the draft Cabinet report is presented at Management Team the Legal representative is unclear as to whether legal issues have been fully considered.

Recommendation:

1. Re-design the Cabinet report template to include the following information.

    - Confirmation legal implications have been discussed with Legal Services
    - The name of the officer who provided the advice
    - Details of the advice given

2. Consider re-designing all report templates to incorporate:

    - Confirmation legal implications have been discussed with Legal Services
    - The name of the officer who provided the advice
    - Details of the advice given

Management Response & Actions

Response Type: Agreed

Recommendation 02/Action 01 – This is accepted and will need to be implemented corporately, and will require the introduction across the Council of a new process for the identification and advice of legal implications for all Cabinet reports, involving the instruction of a Legal officer in time to provide the necessary input to draft reports. To that end, we will work with Member Services and Management Team to update the Cabinet report template and report-writing guidance to improve the "Legal implications" section.

N.B. *We consider that this is a high priority recommendation because it is directly related to the control of Risk 1 (i.e. that the Legal Service is not sufficiently integrated etc.) which is identified in the "Detailed Findings" in this report as being above the council's risk tolerance.*

Recommendation 02/Action 02 – Although this recommendation is not applicable to all reports for various reasons, it is accepted that it should be considered for reports to internal bodies whose decisions will be implemented without a Cabinet/Full Council report being written, such as ERIB and TEB. To that end, we will work with Member Services and Management Team to update relevant report templates and report-writing guidance to provide/improve the "Legal implications" section and introduce the procedure referred to above.

Responsible officer:	**Implementation date**:
Terry Mortimer	**Action 01:** 01 January 2022 **Action 02:** 01 January 2022

03 - Project Initiation Document (PID) Template	Medium (Priority 3)

Finding Description: The PID template includes prompts for discussions with Finance, Procurement and Planning but there is no prompt for discussions with Legal.

Legal Services officers stated they were unaware of all upcoming projects.

Cause: Inadequate design of the PID template

Effect: Legal issues might not be fully considered or discussed with Legal Services.

Recommendation: Include a "legal discussion" prompt in the PID to confirm the following:

- Confirmation legal implications have been discussed with Legal Services.
- The name of the officer who provided the advice.
- Details of the advice given.

Management Response & Action

Response Type: Agreed

Response Comments: This is accepted and will need to be implemented corporately, and will require the introduction across the Council of a new process for the identification of potential legal implications/need for legal resources for all PIDs, involving the instruction of a Legal officer in time to provide the necessary input to draft PIDs.

To that end, we have commenced work with the Corporate Policy team to update the PID template, flowchart, and guidance to include a “Legal implications” section.

N.B. We consider that this is a high priority recommendation because it is directly related to the control of Risk 1 (i.e. that the Legal Service is not sufficiently integrated etc.) which is identified in the “Detailed Findings” in this report as being above the council’s risk tolerance.

Agreed Action

Responsible officer:	Implementation date:
Terry Mortimer	01 December 2021

09 - Procedures	Medium (Priority 3)

Finding Description: There is evidence that Locums may not know where to find up to date file opening and closing procedures. We were informed during the wash-up of the audit that procedures are available in Iken, however these were not supplied, and officers did not direct us to them during our interviews or testing.

Our testing found one case out of ten where a Locum had opened and closed their own Iken file. This should have been done by Legal Support.

Cause: Lack of resources & internal training / support

Effect: The service employs Locums who work from home and rarely visit the office. The service is also looking to recruit new starters. If officers don't know where to find and don't follow up to date procedures, they are less likely to follow a consistent process.

Recommendation:

1. Ensure all procedures are up to date including:

    - Responding to instructions (acknowledgements).
    - Agreeing timescales for progressing the instruction
    - Setting up a file
    - Closing a file

2. Ensure officers are aware of how to access all procedures

Management Response & Actions

Response Type: Agreed

Recommendation 09/Action 01 There are up-to-date procedures already in place in Iken to deal with the above matters (Acknowledgments; File Opening; File Closing). These will be collated into a short Procedure Manual for all staff and Locums to make them aware of where they are located within Iken and when to use them.

However, acknowledgments do not and will not include a likely timescale for completion of the work instructed, as this will be discussed separately with the client officers when the matter/papers are reviewed with the client officers. Agreed timescales will be documented within the file when agreed with the client. Instead, acknowledgments will be amended to include a likely timescale for the fee-earner to make contact with the client officer(s) to progress the instruction, supported by an internal process to ensure that realistic response times are set and normally adhered to, such process to be in the Procedure Manual.

Recommendation 09/Action 02 - The Procedure Manual will be issued to all staff and Locums, and new starters.

The Procedure Manual will also include the procedures for:

- internal reviews of case progression, referred to in the response to ***recommendation 04***;
- risk assessment of new cases, referred to in the Response to ***recommendation 10***;
- staff leaving, referred to in the response to ***recommendation 06***; and
- acknowledgments, referred to in the response to ***recommendation 08***.

Responsible officer:	**Implementation date**:
Terry Mortimer	**Action 01:** 01 April 2022 **Action 02:** 01 April 2022

10 - Risk assessments	**Medium (Priority 3)**

Finding Description: There is no documented risk assessment methodology for prioritising cases prior to allocation.

Officers dealing with Planning cases verbally confirmed they conduct a risk assessment prior to allocation, however there isn't a similar process for Property cases.

Cause: Lack of resources and turnover of supervising staff

Effect: Urgent or important cases may be missed or delayed. Officers may be issued with work without the capacity to complete it.

Recommendation: Introduce a formal risk assessment framework and process for prioritising new legal cases received.

Management Response

Response Type: Agreed

Response Comments: As the report acknowledges risk assessments are carried out by team leaders prior to allocation but it is accepted that this process should be documented. To that end, a framework and process will be created by Legal Management Team and included in the Procedure Manual referred to in the response to ***recommendation 09.***

Responsible officer:	**Implementation date**:
Terry Mortimer	01 April 2022

11 - Allocations (property)	Medium (Priority 3)

Finding Description: Our testing established there is no allocations process for cases relating to Property.

Cause: Lack of resources and turnover of supervising staff.

Effect: Urgent or important cases may be missed or delayed. Officers may be issued with work without the capacity to complete it.

Recommendation: Introduce an allocations process for Property cases

Management Response & Action

Response Type: Agreed

Response Comments: It is possible to determine the current workloads of the Property team when allocating work during the vacancy in the team leader's post. Iken produces current case lists, and in addition a Principal Solicitor and/or the Solicitor to the Council personally allocates significant new cases in the Property team. The documented risk assessment process referred to in the response to ***recommendation 10*** will apply equally to Property cases.

Agreed Action

Responsible officer:	Implementation date:
Terry Mortimer	01 April 2022

05 - IKEN Access Controls	Low (Priority 4)

Finding Description: Some officers don't have a password to access Iken and only use their username. Existing passwords for officers may not fully comply with the Council's IT security policies, but this needs to be checked in more detail by Legal Services.

Cause: Officers who were employed by the authority when Iken was introduced weren't asked to set up passwords.

Effect: Weak Iken access controls mean officers can potentially access Iken inappropriately through superuser access.

Recommendation: Legal services should explore whether any further access security is required to comply with the council's IT policy

Management Response
Response Type: Agreed **Response Comments:** It is not correct to assume non-super-users can access the system as super-users. All access to Iken by all users is via their personal IT log in. Further, every action within Iken is auditable, thus each access is logged and all activity recorded. The Council's IT security policy allows some relaxation of password control for systems already protected by the main network password and which are only available once logged on using the main network password. We will: (i) liaise with IT to ensure that access to Iken complies with the Council's IT security policy, and (ii) if improved access arrangements are required, liaise with Iken to implement appropriate and technically feasible solutions.

Responsible officer:	Implementation date:
Terry Mortimer	**(i):** 01 December 2021 **(ii):** 01 March 2022

06 - Leavers	Low (Priority 4)

Finding Description: Officers confirmed they reviewed Iken user accounts during the audit and disabled accounts of officers who had left and had previously been missed.

There isn't a process in place to ensure officer accounts are timeously disabled when they leave. Although some protection is in place as access to Iken can only be gained by accessing the ABC network.

Cause: Officer oversight

Effect: Access controls are weakened and officers who have left the authority may still be able to access their accounts

Recommendation: Introduce a process to promptly disable leaver Iken accounts

Management Response & Actions
Response Type: Agreed

Response Comments: When a member of staff leaves, it is standard practice for IT to disable that member of staff's access to all systems. This would in turn prevent them from accessing Iken. However, legal services could disable the staff member's access to Iken at source, thereby being an additional safeguard against unauthorised access. To that end, a procedure for staff leaving will be created by Legal Management Team and included in the Procedure Manual referred to in the response to ***recommendation 09***.

Responsible officer:	**Implementation date**:
Terry Mortimer	01 April 2022

07 - Request for legal advice form	**Low (Priority 4)**

Finding Description: The form states it should be sent directly to the Principal Solicitor which contradicts the standing instruction which states the form should be sent to Legal Support.

The form refers officers to the intranet for further guidance. However, the information on the intranet is currently out of date and officers should be referred to the Smarthub instead. The link to the intranet also doesn't work.

Cause: Officer oversight.

Effect: Without clear guidance and procedures legal requests may be incomplete, be missed, or bypass the process altogether. Conflicting information leads to unnecessary confusion**.**

Recommendation: Update the request for legal advice form

Management Response & Action

Response Type: Agreed

Response Comments: This is accepted and has been implemented. The intranet is no longer in use and the obsolete link on one of the Smarthub forms to it has been removed. The inconsistent dispatch instructions on the form have been changed.

Responsible officer:	**Implementation date**:
Terry Mortimer	Implemented & Closed

08 - Acknowledgements	Low (Priority 4)

Finding Description: Legal Services do not send a standard acknowledgement upon the receipt of instructions.

Some officers are unaware of the acknowledgement template in Iken. Our testing of 10

cases found the following:

- An acknowledgement was sent for 6/10 cases.
- The information provided in the acknowledgements was inconsistent.

Cause: A standard acknowledgement process hasn't been embedded.

Effect: Instructing officers aren't consistently informed of the following:

- The assigned fee earner.
- Fee earner contact details.
- Alternative contact details should the fee earner be unavailable.
- Likely time scale for progressing the instruction.

Recommendation: Draft, agree and embed a standard acknowledgement process to ensure instructing officers are provided with consistent information.

Management Response & Action

Response Type: Agreed

Response Comments: Legal Services have a standard acknowledgement in use, we accept that this needs to be used more consistently. However, this does not and will not include a likely timescale as this will be discussed separately with the client when the matter/papers are reviewed with the client.

Further, there will be cases when standard instruction forms, and acknowledgement forms may not be completed - for example in cases of urgency.

Responsible officer:	**Implementation date**:
Terry Mortimer	01 April 2022

Appendix I: Audit Brief (As Originally Issued)

About the Service Area

Legal Services provide legal advice and support to the Council, its Members and officers. The Service is carrying a number of vacancies and has recently deleted the Head of Service post. The Director of Law and Governance will fulfil this role.

About the Audit

We complete all our work in full conformance with Public Sector Internal Audit Standards, CIPFA's Local Government Application Note and the Institute of Internal Audit's International Professional Practices Framework.

This includes the internal auditors' Code of Ethics that commits us to work with integrity, objectivity, confidentiality and competence.

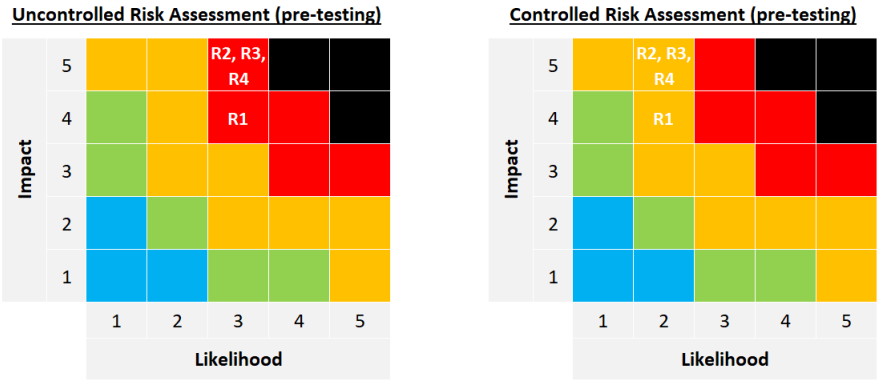
The audit seeks to provide assurance over the administration and processing of Legal cases as well as the Service's integration into Council processes.

Based on the Services' objectives we have agreed 4 risks:

Objective	Risk Title
To provide timely, relevant and comprehensible legal advice to the Council, its Members and Officers.	R1. Legal Service not sufficiently integrated into Council processes. R3. Legal Services not provided with comprehensive and timely instruction R4. **Updated** - Legal advice/support to clients is hindered by inadequate instruction and administrative processes
To conduct, on behalf of the Council, actual or threatened legal proceedings, and Ombudsman complaints that raise legal issues.	R2. Legal Services is not notified promptly of actual or threatened legal proceedings, and Ombudsman complaints that raise legal issues. R3. Legal Services not provided with comprehensive and timely instructions.

	R4. **Updated** - Legal advice/support to clients is hindered by inadequate instruction and administrative processes

We have used the following risk assessments to guide the testing we will undertake:



Our finding in this review will contribute towards the **internal controls** aspect of the Head of Audit Opinion, to be issued in June 2021.

Evaluation Criteria

Management currently base their assessment on performance of the service on:

- Internal procedures and service standards
- Professional standards e.g. Law society

We are satisfied they are appropriate criteria and will use the same to guide our review as well as best practice guidance from LEXCEL.

Audit Testing

Audit Tests	Sample Size
Evaluate process to provide updates to service users	0
Verify regular updates are provided to service users	0
Evaluate process to issue and update standing instructions	0
Verify evidence of standing instructions	3
Evaluate process to inform Legal Services of Ombudsman complaints with legal implications	0
Test a sample of Ombudsman complaints involving legal issues to ensure Legal Services were promptly notified	5

Audit Resources

Based on the objectives, scope and testing identified we expect this review will need **17.50** days' work to complete.

Audit Timeline

- Fieldwork Begins 22 April 2021
- Draft Report Issued 23 June 2021 ***(responses received and finalised on 01 September 2021)***

Audit Resources and Timeline Outturn

We completed this engagement 1.5 days over our original budget. This additional time was owing to the complex nature of some of the findings and to allow for time to meet with the service to ensure that all details in the report were factual and that each response had been given due consideration before being finalised. Due to Summer leave, this also meant that our report went over our original timeline estimates.

Disclaimer and Report Distribution

There are inherent limits to internal audit's work. All control systems, no matter how well designed, are vulnerable to risk of failure. This might arise, for example, following poor judgement, human error, deliberate subversion or unforeseeable circumstances. Our assessment of controls covers the period set out in scope detailed in the *About the Audit* section. As a historical review it may not provide assurance for future periods. This may be, for example, where control design becomes inadequate in changed circumstances or compliance with procedures weakens over time.

It is the responsibility of management to develop and preserve sound risk management, internal control and governance. Internal audit work cannot substitute for management's responsibilities over system design and operation. We plan our work in line with relevant Standards and our agreed Audit Charter(s) to maximise the reasonable assurance we can provide. However, internal audit procedures alone, even when conducted with due professional care, cannot guarantee detection of fraud or error or eliminate risk of failure.

We prepare and deliver this document for and to the individuals and organisations named on the front cover and in the *Report Distribution List* section. We may use all or part in reporting to Members. We can accept no liability to any third party who claims to use or rely, for whatever reason, on its conclusions or any extract. Recipients should not share this

document, in whole or part, without seeking permission of the Head of Audit Partnership. This includes where the document is subject to a statutory request under, for example, the Freedom of Information Act 2000.

Appendix II: Assurance & Priority level definitions

Assurance Ratings

Full Definition	Short Description
Strong – Controls within the service are well designed and operating as intended, exposing the service to no uncontrolled risk. There will also often be elements of good practice or value for money efficiencies which may be instructive to other authorities. Reports with this rating will have few, if any, recommendations and those will generally be priority 4.	Service/system is performing well
Sound – Controls within the service are generally well designed and operated but there are some opportunities for improvement, particularly with regard to efficiency or to address less significant uncontrolled operational risks. Reports with this rating will have some priority 3 and 4 recommendations, and occasionally priority 2 recommendations where they do not speak to core elements of the service.	Service/system is operating effectively
Weak – Controls within the service have deficiencies in their design and/or operation that leave it exposed to uncontrolled operational risk and/or failure to achieve key service aims. Reports with this rating will have mainly priority 2 and 3 recommendations which will often describe weaknesses with core elements of the service.	Service/system requires support to consistently operate effectively
Poor – Controls within the service are deficient to the extent that the service is exposed to actual failure or significant risk and these failures and risks are likely to affect the Council as a whole. Reports with this rating will have priority 1 and/or a range of priority 2 recommendations which, taken together, will or are preventing from achieving its core objectives.	Service/system is not operating effectively

Finding, Recommendation and Action Ratings

Priority 1 (Critical) – To address a finding which affects (negatively) the risk rating assigned to a Council strategic risk or seriously impairs its ability to achieve a key priority. Priority 1 recommendations are likely to require immediate remedial action. Priority 1 recommendations also describe actions the authority **must** take without delay.

Priority 2 (High) – To address a finding which impacts a strategic risk or key priority, which makes achievement of the Council's aims more challenging but not necessarily cause severe impediment. This would also normally be the priority assigned to recommendations that address a finding that the Council is in (actual or potential) breach of a legal responsibility, unless the consequences of non-compliance are severe. Priority 2 recommendations are likely to require remedial action at the next available opportunity, or as soon as is practical. Priority 2 recommendations also describe actions the authority **must** take.

Priority 3 (Medium) – To address a finding where the Council is in (actual or potential) breach of its own policy or a less prominent legal responsibility but does not impact directly on a strategic risk or key priority. There will often be mitigating controls that, at least to some extent, limit impact. Priority 3 recommendations are likely to require remedial action within six months to a year. Priority 3 recommendations describe actions the authority **should** take.

Priority 4 (Low) – To address a finding where the Council is in (actual or potential) breach of its own policy but no legal responsibility and where there is trivial, if any, impact on strategic risks or key priorities. There will usually be mitigating controls to limit impact. Priority 4 recommendations are likely to require remedial action within the year. Priority 4 recommendations generally describe actions the authority **could** take.

Advisory – We will include in the report notes drawn from our experience across the partner authorities where the service has opportunities to improve. These will be included for the service to consider and not be subject to formal follow up process.

Agenda Item No:	7
Report To:	Audit Committee
Date of Meeting:	1st February 2022
Report Title:	Interim Report
Report Author & Job Title:	Andrew Townsend: Interim Head of Audit Services (MKA)

ASHFORD BOROUGH COUNCIL

Summary:	This report provides updates on the progress made against the Audit Plan for Ashford Borough Council, which was presented to the Committee in March 2020.

Key Decision:	No
Significantly Affected Wards:	N/A
Recommendations:	**The Committee is recommended to:** **Note** the findings raised in MKA Interim Internal Audit report. **I.**
Policy Overview:	N/A
Financial Implications:	No new implications.

MID KENT AUDIT

Interim Internal Audit & Assurance Report

February 2022
Ashford Borough Council

MID KENT AUDIT

1. Introduction

1.1. This interim Internal Audit and Assurance Report covers the first three quarters of 2021/22.

1.2. Annex A provides an update on the Mid Kent Audit service. In summary despite a number of personnel changes the service continues to fully deliver the agreed internal audit service and there has been no diminution in compliance with the Public Sector Internal Audit Standards.

1.3. This report provides the updates as at the end of December 2021 on the following:

- Interim Head of Audit Opinion
- Audit Plan Progress – Closing of 2020/21
- Audit Plan 2021/22 Update
- Other Work
- Agreed Actions – Follow up Results

2. Interim Head of Audit Opinion

2.1. There are no matters identified from the internal audit work performed to date for 2021/22 which indicate that it will not be possible to provide a Head of Audit opinion for the financial year.

3. Audit Plan Progress – Closing of 2020/21

3.1. In the annual assurance report that was presented in June 2021, it stated that there were four audits that were still outstanding. These are now all finalised. The table summarises those audits detailing their opinion, final report date, and number of Critical, High, Medium, and Low recommendations made. A summary of the findings can be found after the table.

Audit	Opinion	Date of Issue	No of Crtcl	No of High	No of Med	No of Low
Development Management – Planning Admin	Sound	July 21	-	-	1	-
Commercial Property Income	Sound	Sep 21	-	-	3	-
Performance Management	Sound	Sep 21	-	-	2	1
Legal Services	Weak	Sep 21	-	2	5	4

3.2. The High and Medium findings from the reports in the table above are noted below:

Development Management – Planning Admin

3.3. Finding:

- (M) There was no documented policy on the retention and storage of files within the Planning and Development Service.

Commercial Property Income

3.4. Findings:

- (M) Procedure notes and process maps were in draft.
- (M) The underlying reason for variances for the income reconciliations for 2020/21 and the working file for 2021/22 were not detailed. In addition, any corrective action that may have been taken was not evidenced.
- (M) A proposal in May 2021 to provide monthly reports to the Head of Corporate Property & Projects detailing the percentage of income collection, rent growth, risks, potential write-offs, was not in place. The start date for these reports had also not been noted in the minutes, and they were not yet being provided as August 2021.

Performance Management

3.5. Key findings:

- (M) The Recovery Plan lists 44 performance metrics over four key themes. Pentana only had 40 of these. It was explained the difference was because of merging and adding of some metrics. However, there was no evidence of these changes being formally reported or agreed.
- (M) Of the 40 KPIs on Pentana, 33 KPIs had not yet been set a target. The quarterly performance report did not consistently indicate if the trend was good or bad.

Legal Services

3.6. This review had a 'Weak' assessment and the findings and management updates for this report can be found in the accompanying report.

4. Audit Plan 2021/22 Update

Audits Finalised Since the Previous Audit Committee Meeting

4.1. The Audit Plan for 2021/22 is well underway. Of the 16 audits due to be performed during 2021/22 five have now been finalised. A summary of the high and medium recommendations made are set out below.

Audit	Opinion	Date of Issue	No of Crtcl	No of High	No of Med	No of Low
Section 106 Income	Weak	06/12/21	-	6	4	5
IT: Phishing	Sound	11/11/21	-	-	-	2
Housing Rent Account (Rent Arrears)	Sound	21/12/21	-	-	2	-
Member Development	Sound	28/07/21	-	-	-	4
Environmental Protection (Noise)	Sound	06/01/22	-	-	-	3

Section 106 Income

4.2. This review has a 'weak' opinion and consequentially the findings and progress against the recommendations made for this report will be reported to Audit Committee in March 2022.

IT Phishing

4.3. There were no High or Medium recommendations made.

Housing Rent Accounts (Rent Arrears)

4.4. Findings:

- (M) – There was no system provision for separating a tenant's rent arrears when they enter 'Breathing Space' so the officer can track they are paying for their regular rent.
- (M) – Procedures and policies were not updated.

Member Development

4.5. There were no High or Medium recommendations made.

Environmental Enforcement -Noise

4.6. There were no High or Medium recommendations made.

Added and Cancelled / Deferred audits

4.7. Since the last meeting, there have been no additional audits added to the Audit Plan.

4.8. The Community Safety Partnerships audit was cancelled. At the request from the Head of Service asking to delay the audit until next year, we have cancelled it from this year's Plan and will consider it for the 2022/23 Audit Plan.

Overall Progress of the Audit Plan for 2021/22

4.9. The table below shows the progress of the 16 planned audits for 2021/22.

Audit	Due to start or Issue date	Opinion	Planning to Brief issue stage	Fieldwork Stage	Draft report stage	Finalised
Member Development	06/12/21	Weak	✔	✔	✔	✔
IT: Phishing	11/11/21	Sound	✔	✔	✔	✔
Section 106 Income	21/12/21	Sound	✔	✔	✔	✔
Housing Rent Account (Rent Arrears)	28/07/21	Sound	✔	✔	✔	✔
Environmental Protection (Noise)	06/01/22	Sound	✔	✔	✔	✔
Procurement (Processes & Compliance)	Qrt 3	-	✔			
Leisure Services	Qtr 3	-	✔			
Development Management	Qtr 3	-				
Payroll & Expenses	Qtr 3	-				
Recovery Plan	Qtr 4	-				
Licensing	Qtr 4	-				
Voids (Housing)	Qtr 4	-				
Ashford Port Health: Financial Controls	Qtr 4	-				
Apprenticeships	Qtr 4	-				
Transformation Programme	Qtr 4	-				

4.10. Due to the changes within the team (see appendix A), progress is behind schedule. While there are ten audits to complete by the end of April additional external resources have been procured at the start of January from BDO to cover for staff vacancies and this will assist with the timely delivery. The Monday resource management system operated by MKA indicates, barring unforeseen problems, these

ten reviews will be completed on time. Notwithstanding this the S151 Officer will be provided regular updates on progress and any additional actions required to facilitate the timely completion of the agreed Plan.

5. Other Work

5.1. There has been one consultancy review, COVID-19 Local Authority Compliance and Enforcement Grant. There were no issues identified.

6. Agreed Management Actions – Follow up Results

6.1. We follow up each action as it falls due in line with the plan agreed with management when we finish our reporting. We note any matters of continuing concern.

6.2. In November 2021 we issued the follow up report on actions due by the end of September 2021. The results of the follow up are:

- 35 actions fell due over eight audits.
- 19 (54%) of actions have been closed as agreed.
- 16 actions have been deferred with reset dates for implementation.
- No high-risk actions fell due during the period.
- There were no matters of continuing concern.

Appendix A

Audit Charter

I. This Committee approved MKA's Audit Charter in 2021 and it remains in place through the financial year.

Independence of internal audit

II. Mid Kent Audit works as a shared service between Ashford, Maidstone, Swale and Tunbridge Wells Borough Councils. A Shared Service Board including representatives from each Council supervises our work based on our collaboration agreement. The collaboration agreement is currently being reviewed, but this has no impact upon the independence of the service being provided by MKA.

III. Within Ashford BC during 2021/22 MKA has continued to enjoy complete and unfettered access to officers and records to complete our work. On no occasion have officers or Members sought or gained undue influence over our scope or findings.

IV. We confirm that MKA has worked with full independence as defined in our Audit Charter and Standard 1100.

Resources

V. An assessment on the resources available to the audit partnership for completing work at the Council was reported in our Audit Plan presented to this Committee in March 2021. That assessment was:*…we believe we have enough resource to deliver the 2021/22 plan.*

VI. Since March 2021 MKA has experienced much change within the audit team. Despite all this change MKA continues to make good progress with delivering the Audit Plan agreed earlier this year and has adequate resources available to deliver the 2021/22 Audit Plan and provide a robust opinion at year end. In the event this position changes we will promptly report to Senior Management and to the Audit Committee if we have any concerns that forecast will change.

Audit Quality and Improvement

Code of Ethics

VII. The Code is incorporated within MKA's Audit Manual and MKA also has policies and guidance in place on certain specifics, such as managing and reporting

conflicts of interest. We can confirm to the Audit Committee that MKA remains in conformance with the Code.

Compliance with the PSIAS

VIII. The requirements are that an external quality assessment (EQA) is carried out at least once every five years and in the intervening years an internal quality assessment (IQA) is performed. The EQA was carried out by CIPFA in 2020 and for 2021/22 the IQA will be performed by the interim Head of Audit. The findings of the IQA will be reported to the Audit Committee.

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Audit Committee - Future Meetings

2022/23

Dates to Note			
Date of Meeting	**15/03/2022**		
Publication of Agenda Date	03/03/2022		
Reports to Management Team	03/03/2022		
Full Council	21/04/2022		
Items for Inclusion on the Audit Agenda			
Part I - For Decision			
1	Statement of Accounts 2020/21 and External Auditors Findings	LF	
2	Internal Audit and Assurance Plan 2022/23	RH	
3	Internal Audit Charter and QAIP 2022/23	RH	
4	Presentation of Financial Statements	MS	
5	Corporate Risk Register (on agenda every six months) including update on APH risk register and focus on Cyber Security	CH	
6	Approval of Annual Governance Statement	CH	
Part II - Monitoring/Information Items			
7	2020/2021 Annual Audit Letter	Gr Th	
8	Audit Progress Report	Gr Th	
9	Report Tracker for Future Meetings	KM	

Dates to Note		
Date of Meeting	**21/06/2022**	
Publication of Agenda Date	09/06/2022	
Reports to Management Team	02/06/2022	
Full Council	21/07/2022	
Items for Inclusion on the Audit Agenda		
Part I - For Decision		
1	Draft Statement of Accounts 2021/22	LF
2	Internal Audit Annual Report & Opinion 2022	RH
3	Informing the Audit Risk Assessment 2021/22	LF
Part II - Monitoring/Information Items		
4	Audit Progress Report	Gr Th
5	2021/22 Audit Plan (External Audit)	Gr Th
6	Report Tracker & Future Meetings	KM

Dates to Note		
Date of Meeting	**04/10/2022**	
Publication of Agenda Date	22/09/2022	
Reports to Management Team	01/09/2022	
Full Council	20/10/2022	
Items for Inclusion on the Audit Agenda		
Part I - For Decision		
1	Corporate Risk Register (on agenda every six months) (on agenda every six months)	CH
2	Annual Governance Statement – Progress on Remedying Exceptions	CH
3	Corporate Enforcement Support & Investigations Team Annual Report 2021/22	DD
4	Annual Report of the Audit Committee	AB
5	Audit Fee Letter	GT
Part II - Monitoring/Information Items		
6	Audit Progress Report	Gr Th
7	Report Tracker & Future Meetings	KM

Dates to Note		
Date of Meeting	**29/11/2022**	
Publication of Agenda Date	17/11/2022	
Reports to Management Team	03/11/2022	
Full Council	02/03/2023	
Items for Inclusion on the Audit Agenda		
Part I - For Decision		
1	Statement of Accounts 2020/21 and External Auditors Findings	LF
2	Homes England – Compliance Audit Annual Report for Ashford Borough Council	MJ
Part II - Monitoring/Information Items		
3	Internal Audit Interim Report	AT/JH
4	Audit Progress Report	Gr Th
5	Report Tracker & Future Meetings	KM

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