ACCESS Support Unit
Final Internal Audit Report

Audit Plan Ref: FT4 2021/22

Audit Opinion:
Good Assurance

Date Issued: 2 December, 2021
ECC Function: Corporate Services
Audit Sponsor: Kevin McDonald, Director, ACCESS Support Unit

Distribution List: Nicole Wood - Executive Director, Corporate Services; **Kevin McDonald; Mark Paget,** ACCESS Contract Manager; **Dawn Butler,** ACCESS Support Officer; **Cllr. Barker**, Vice Chairman of the ACCESS Joint Committee; **Cllr. Whitbread**, Cabinet Member for Finance, Resources and Corporate Affairs and **Barry Pryke**, BDO External Auditor

Essex County Council

Assurance Opinion	No	Limited	Satisfactory	Good
				✓

Number of Issues	Critical	Major	Moderate	Low
			1	

Audit Objective

This audit reviewed whether the ASU is effectively fulfilling its responsibilities to the ACCESS Pool. The objective of this audit was to evaluate the control design and test the operating effectiveness of key controls in place over the ASU.

Scope of the Review and Limitations

The audit was not of the ACCESS Pool itself. It was solely about whether the ACCESS Support Unit (ASU) and therefore by extension ECC, is fulfilling its responsibilities as Accountable Body for the ASU. The scope was agreed with all participating authorities' S151 Officers after input from the administering authorities Internal Audit leads when drawing up the terms of reference.

Kent County Council is providing the secretarial support to the Pool since formation and is responsible for the production and publication of minutes and agenda. This activity was not covered in this review.

Key Messages

The ASU has been providing the day-to-day support for the purposes of implementing the Inter Authority Agreement and running the ACCESS Pool including programme management, contract management, administration and technical support services.

A Business Plan is proposed annually to the ACCESS Authorities by the Joint Committee (JC) on the basis of recommendations from the s151 Officer Group. The Joint Committee, on advice from the s151 Officer Group, determine a budget in order to deliver the annual Business Plan. Workstreams for the ASU are identified and monitored at the Officer Working Group (OWG) where key ACCESS business plan activity and deliverables for the fiscal year are considered; s151 Officers from the participating Authorities also contribute to the development of workstreams at their periodic meetings. The audit reviewed reporting packs presented to the ACCESS Joint Committee, s151 Officer meetings and the Officer Working Group meetings and found these to be timely, consistent and relevant.

Work upon last year's Internal Audit recommendation relating to completing the review and approval of the Governance Manual and Decision-Making Matrix resulted in a project being agreed by the s151 Officers which is being led by Technical Leads from West Sussex County Council. The project is focusing on areas of highest risk to the delivery of the ACCESS objectives and the governance, policies and procedures needed to achieve them. The key time critical tasks within the ACCESS Business Plan are implementation of approach to alternative / non-listed assets, the development and implementation of Environmental, Social and Governance (ESG) / Responsible Investment (RI) guidance, consideration of the future arrangements for Operator Services to the ACCESS Pool, and determination of future sub-funds. Once progress has been made in relation to the above, a third party will be engaged to carry out an audit of ACCESS governance as recommended by the Governance Working Group.

Direction of Travel

The Assurance Opinion remains at "Good", meaning that there continues to be sound systems of internal control in place. One Moderate action has been raised in this report.

Findings and Agreed Actions

Risk from Terms of Reference: Policies and Procedures

Moderate issue identified: Scope for improvement identified in current risk register

A review of the risk assessment and reporting mechanism was conducted by the ASU in the second quarter of 2021 and S151 Officers approved the move to assessing the risk, observing a '4x4' matrix style; using a scale of 1 to 4 to rate the likelihood of a risk occurring against the severity / impact of the risk. Previously 3x3 risk matrix was in use. JC members now get the risk register briefing information i.e., Risk Management Dashboard and Risk Management Assessment in the new format starting from June 2021.

A review of underlying information (spreadsheet) which is being used to create the periodic reports identified the below:

- Several sub sheets (tabs), containing new and old scoring / information must be consulted to review and understand the full risk register and underlying assessments tab.
- The primary sheet with complete details of each risk i.e., when the risk was raised, owner of the risk, description, mitigation measures etc. still has the old scoring / grading which was based on previous assessment(s).
- Three risks with 'open' status on the primary / main sheet were later closed on a following tab called 'change format'. These should have ideally been closed on the main spreadsheet or the status also been updated on the main sheet.
- Some closed risks do not have a close down date recorded against them.
- Seven out of ten tabs have 'old' in their title, despite containing the information which is still feeding the dashboard and assessment tabs, which makes the review slightly confusing.
- Three risks did not have a risk owner assigned to them.
- Risk owners are not named individual(s) to ensure clear accountability, but sub-groups e.g., ASU, LINK, JC, IDACU and OWG.
  Internal Audit Comment: *Although it is best practice to have named individuals as risk owners, the ASU have expressed a preference to keep the sub groups as the risk owners and Internal Audit are satisfied with this decision.*
- Not all fields have been populated for all risks e.g., 'when is it likely to happen' field is blank for some risks,' last updated' field does not have a date for all risks, 'progress' and 'comments' fields are not populated for all risks and some updates do not have a year recorded in the date making it unclear when the update/action was taken.
- There is only one 'risk level' column, which is residual risk. This is derived at by multiplying the impact and probability score and it is positioned after the mitigating actions column and therefore the gross risk score at the start, before the mitigation, is not available for all risks. If the gross risk score is shown, it can promote discussion on the effectiveness of the mitigations when compared to the residual (current risk) score.

- The risk register does not specify the frequency of review for each risk. Also, there is no evidence to support whether all risks were reviewed at their review interval/due date.

Agreed action 1		
The Risk Register will be amended to incorporate good practices relating to maintaining an effective risk register. **Internal Audit Comment:** *Subsequent to issuing the draft report at a meeting which took place on 18 November 2021, the revised Risk Log with dashboard, assessment and full details was shared with Internal Audit and we are satisfied that this action can now be recorded as implemented.*	**Action Owner:**	Mark Paget, ACCESS Contracts Manager
	Deadline for Implementation:	Implemented

Explanation of Assurance and Risk Priority Levels

Assurance level	Assessment Rationale
Good	There is a sound system of internal control designed to achieve the objectives of the system/process and manage the risks to achieving those objectives. Recommendations will normally only be of Low risk rating. Any Moderate recommendations would need to be mitigated by significant strengths elsewhere.
Satisfactory	Whilst there is basically a sound system of control, there are some areas of weakness, which may put the system/process objectives at risk.
Limited	There are significant weaknesses in key areas of the system of control, which put the system/process objectives at risk. Improvement in the design and/or operational effectiveness of the control environment is necessary to gain assurance that risks are being managed to an acceptable level, and core objectives will be achieved.
No	The system of internal control has serious weaknesses and controls are not effective in managing the key risks in scope. It is highly unlikely that core objectives will be met without urgent management intervention.

Risk Priority Level			Definition
Corporate	**Critical**	Red	Audit findings which, in the present state, represent a serious risk to the organisation as a whole, for example, reputational damage, significant financial loss (through fraud, error or poor value for money), intervention by external agencies and / or lack of compliance with statutory regulations. ***Remedial action is required immediately***
Service	**Major**	Amber	Audit findings indicate a serious weakness or breakdown in the control environment, which, if untreated by management intervention, is highly likely to put achievement of core service objectives at risk. ***Remedial action is required urgently***
	Moderate	Yellow	Audit findings which, if not treated by appropriate management action, are likely to put achievement of some of the core service objectives at risk. ***Prompt specific action should be taken***
	Low	Green	Audit findings indicate opportunities to implement good or best practice, which, if adopted, will enhance the control environment. ***Remedial action is suggested***

Controls Assessment Schedule

Programme Management Risks:

A programme for pooling assets is not agreed or delivered to due to ineffective ASU management of, and or support to, workstream and project leads.

The work of the ASU (and the pool's activity more widely) is not planned or delivered in a strategic, coordinated, or systematic manner due to the absence of a clear, agreed strategy and business plan.

Control	Control In Place and working effectively?	Action Plan Ref.
There is a clear, agreed strategy and business plan in place.	Yes	
An agreed programme for pooling assets is in place and is monitored.	Yes	
Pooling and specific sub-fund launch milestones are planned, and progress is reported to stakeholders.	Yes	
Reporting and accountability mechanism (in form of periodic reporting to sub-groups) exist to highlight to Joint Committee (and therefore administering authorities) any prospective failure in achieving the benefits of pooling investments.	Yes	
External professional expertise is available to Joint Committee and ASU to support them in technical and legal matters.	Yes	

Stakeholder Management Risks:

Progress toward pooling is delayed and specific sub-fund launch milestones are missed if stakeholders do not effectively cooperate with the ASU and therefore the work of the pool more widely.

There is ineffective evaluation of contract compliance, in particular of the operator
Or the ASU does not provide sufficient information on the pool's operation and specifically compliance with legal and regulatory required to section 151 officers to fulfil their responsibilities in relation to their Authority's participation in the pool.

Control	Control In Place and working effectively?	Action Plan Ref.
The role, responsibilities and objectives of the ASU are clearly defined and agreed.	Yes	
Workstreams are identified and monitored through OWG meetings with support from technical leads from other councils.	Yes	
The work of the ASU (and the pool's activity more widely) is planned and delivered in a strategic, coordinated and systematic manner due to clearly defined workstreams which are periodically reported to subgroups and Joint Committee.	Yes	
ASU Director and other ASU staff regularly meet with key stakeholders to receive and give key messages.	Yes	

Control	Control In Place and working effectively?	Action Plan Ref.
The ASU provide sufficient information on the pool's operation to section 151 officers to fulfil their responsibilities in relation to their Authority's participation in the pool.	Yes	
ASU's performance is assessed by way of regular reporting to Officer Working Group and Joint Committee on progress made on identified workstreams.	Yes	

Policies and Procedures Risks:

The pool's agreed governance arrangements are not complied with.

Changes to pool's governance arrangements are not made in line with the due process of the IAA

The ASU fails to identify and report on emerging, or all risks appropriately or timely to the Joint Committee, section 151 officers and the Officer Working Group on a quarterly basis. Or appropriate mitigations are not identified and put in place by relevant parties to manage the identified risks.

Control	Control In Place and working effectively ?	Action Plan Ref.
ACCESS Pool Inter-Authority Agreement is in place and is agreed by all participating authorities.	Yes	
Governance framework exists, and arrangements are in place for stakeholders to follow when discharging their duties.	Yes	
Policies, procedures and guidance is subject to periodic review.	Yes	
Risk register with sufficient detail and clear ownership of each risk on the register is in place. Periodic reporting in respect of emerging risks and mitigating actions are presented to subgroups and Joint Committee.	Partially	1

Managing Commercial and Contractual Relationships Risks:

The Operator and other service providers fail to meet their contractual requirements.

There is not the required rectification of performance issues or identified or notified breaches of investment objectives and restrictions.

Control	Control In Place and working effectively?	Action Plan Ref.
Policies, procedures and guidance relating to Operator (Link) are developed, agreed, approved, communicated and are made readily accessible to all stakeholders.	Yes	
Procedures are in place to identify and resolve any suboptimal Operator performance or failure to meet contractual requirements.	Yes	

Financial and Physical Resources Risks:

There are insufficient or ineffective contributions from partner Authorities to the Officer Working Group.

The ASU significantly overspends its agreed budget.

Control	Control In Place and working effectively?	Action Plan Ref.
Robust budget monitoring process is in place to prevent ASU from overspending its agreed budget.	Yes	
There is sufficient and effective contribution from partner authorities to the Officer Working Group and ASU.	Yes	

Management Information and KPI reporting:

There is insufficient or ineffective management information available to partner Authorities.

Absent or ineffective management information/KPI reporting, resulting in reactive and delayed decision-making and preventing the ACCESS Joint Committee from putting timely corrective measures in place.

Control	Control In Place and working effectively?	Action Plan Ref.
KPIs are quantifiable and are based on specific goals and objectives which are critical for performance management and are regularly presented to appropriate audience to predict and address deviation from targets in a timely manner.	Yes	
Management information is sufficiently reliable, useful and timely to allow effective decision-making.	Yes	

Web Vulnerabilities and Website Security:

The ACCESS Pool website may become a victim of security or data breach leading to significant financial, legal and / or reputational consequences.

Control	Control In Place and working effectively?	Action Plan Ref.
Cyber security controls are in place to safeguard network vulnerabilities and data hacks, providing protection to organisational public-facing website from cyber-attacks.	Yes	

Further Information

Management Responsibility: It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal Audit (IA) work should not be seen as a substitute for management's responsibilities for the design and operation of these systems. IA endeavour to plan work so they have a reasonable expectation of detecting significant control weaknesses and, if detected, IA and Counter Fraud will carry out additional work directed towards identification of consequent fraud or other irregularities. However, IA procedures alone do not guarantee that fraud will be detected.

Following the Final Report: It is the owner's responsibility to ensure the agreed actions are implemented within agreed timescales and to update Pentana on a timely basis.

Internal Audit are regularly required to provide updates on the status of recommendations to ECC's Audit Governance and Standards Committee, to the Corporate Governance Steering Board and to Functional Leadership Teams. We also receive ad-hoc requests for updates e.g. from the relevant Cabinet Member.

Internal Audit use the updates provided by Recommendation Owners on Pentana for this purpose, so it is essential that progress is recorded regularly and accurately and when a recommendation becomes overdue that a revised date to indicate when the recommendation will be implemented is provided.

Audit Sponsor Responsibility:

- Approve the draft terms of reference to confirm their understanding and agreement of the risks, scope and nature of the review
- Inform appropriate staff associated with the process under review about the nature of the review and what is required of them. Facilitate timely access to staff, records and systems
- Approve and/or complete the Action Plan in the Draft Report and return to the Internal Audit Team within 15 working days to enable the Final Report to be issued promptly
- Have oversight to ensure all agreed Actions are implemented within the agreed timescales as recorded in the Action Plan in the Final Report

Head of Assurance	Paula Clowes
Audit Manager	Sarah Harris
Auditor	Murad Khan
Fieldwork Completed	27 Sep 2021
Draft Report Issued	18 October 2021
Management Comments Requested by	8 November 2021
Management Comments Received	1 December 2021
Final Report	2 December 2021