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CYNGOR SIR YNYS MÔN
ISLE OF ANGLESEY COUNTY COUNCIL

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RHYBUDD O GYFARFOD	**NOTICE OF MEETING**
PWYLLGOR ARCHWILIO A LLYWODRAETHU	**AUDIT AND GOVERNANCE COMMITTEE**
DYDD MAWRTH, 8 RHAGFYR, 2015 am 2 o'r gloch y prynhawn	**TUESDAY, 8 DECEMBER 2015 at 2.00 pm**
SIAMBR Y CYNGOR, SWYDDFEYDD Y CYNGOR, LLANGEFNI	**COUNCIL CHAMBER, COUNCIL OFFICES, LLANGEFNI**

Swyddog Pwyllgor	**Ann Holmes 01248 752518**	**Committee Officer**

AELODAU / MEMBERS
Cynghorwyr / Councillors:-

Annibynnol / Independent

Jim Evans, Dafydd Rhys Thomas and Richard Owain Jones

Plaid Cymru / The Party of Wales

John Griffith (Is-Gadeirydd/Vice-Chair), Alun W Mummery and Nicola Roberts

Grwp Chwyldroad/ Revolutionist Group

Peter Rogers

Heb Ymaelodi/Unaffiliated

R.Llewelyn Jones (Cadeirydd/Chair)

AELODAU LLEYG / LAY MEMBERS

Mrs Sharon Warnes and Mr Richard Barker

A G E N D A

1 DECLARATION OF INTEREST

To receive any declaration of interest by any member or officer in respect of any item of business.

2 MINUTES 23 SEPTEMBER, 2015 MEETING (Pages 1 - 6)

To present the minutes of the previous meeting of the Audit Committee held on 23 September, 2015.

3 FOOD STANDARDS AGENCY AUDIT (Pages 7 - 120)

To submit the report of the Chief Public Protection Officer.

4 EXTERNAL AUDIT - ANNUAL AUDIT LETTER 2014/15 (Pages 121 - 122)

To submit the Annual Audit Letter for 2014/15.

5 EXTERNAL AUDIT - CERTIFICATE OF COMPLIANCE (Pages 123 - 128)

- To present a Certificate of Compliance with regard to the audit of the Isle of Anglesey County Council's assessment of 2014/15 performance.

- To present an update on the EA Performance Work Programme.

6 INTERNAL AUDIT PROGRESS REPORT (Pages 129 - 156)

To submit the Internal Audit Progress Report to 31 October, 2015.

7 REVISION OF THE INTERNAL AUDIT PROTOCOL (Pages 157 - 176)

To submit the report of the Internal Audit Manager with regard to revising the Internal Audit Protocol to include follow-up audits.

AUDIT AND GOVERNANCE COMMITTEE

Minutes of the meeting held on 23 September, 2015

PRESENT:	Councillor R.Llewelyn Jones (Chair) Councillor John Griffith (Vice-Chair) Councillors Jim Evans, Alun Mummery, Peter Rogers Dafydd Rhys Thomas
IN ATTENDANCE:	Chief Executive Interim Head of Resources & Section 151 Officer Accountancy Services Manager (BHO) Head of Internal Audit (MH) Audit Manager (SP) Interim Accountant (AK) (for item 3) Committee Officer (ATH)
APOLOGIES:	Councillor Richard Owain Jones, Mr Richard Barker, Mrs Sharon Warnes (Lay Members)
ALSO PRESENT:	Mr Andy Bruce (Wales Audit Office), Mr Martin George (Engagement Manager – PwC)

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1. DECLARATION OF INTEREST

Councillor Peter Rogers declared a personal interest as a farmer and landowner with regard to item 3 on the agenda in relation to any part of the discussion that may involve the smallholdings estate.

2. MINUTES 27 JULY, 2015 MEETING

The minutes of the previous meeting of the Audit and Governance Committee held on 27 July, 2015 were presented and confirmed as correct.

Arising thereon –

- With reference to correspondence with North Wales Police regarding the investigation of the attempted fraud against the Council as part of a wider deception perpetrated against local authorities both in Wales and England, the Interim Head of Resources and Section 151 Officer said that the detailed response from the Police which he had reported was awaited at the Committee's July meeting had not as yet been received and he suggested it was now timely given the two months' time lapse to write again to the Chief Constable to obtain assurance that the investigation is being progressed. The Committee endorsed the suggestion and proposed that the correspondence be directed to the North Wales Police and Crime Commissioner and a copy provided to the Chief Constable of North Wales Police.

  ACTION ARISING: Interim Head of Resources and Section 151 Officer to write to North Wales Police and Crime Commissioner on the lines agreed.

- With reference to enhancing Lay Member involvement in the appointment of the Audit and Governance's Chair and Vice-Chair, the Interim Head of Resources and Section 151 Officer confirmed that the Chief Executive had discussed the matter with the Political Group Leaders and that it had been agreed that when the election of Committee Chairs and Vice-Chairs is next held, this Committee's Lay Members will be invited to a pre-meeting with the Group Leaders when the

discussion relates to the election of the Chair and Vice-Chair of the Audit and Governance Committee.

3. STATEMENT OF ACCOUNTS 2014/15 AND ISA 260 REPORT

3.1 The report of the Interim Head of Resources and Section 151 Officer incorporating the final Statement of Accounts for 2014/15 was presented for the Committee's consideration. The report confirmed that for the fourth consecutive year the statutory deadline for completion of the audited accounts had been met and that the improvements in the audit process identified the previous year had continued with the issues arising therefrom having been dealt with promptly and in a satisfactory manner.

The Interim Head of Resources and Section 151 Officer said that he was satisfied with the way in which the closure of accounts process had been conducted and that he anticipated that an unqualified audit opinion on the financial statements would be issued.

The Accountancy Services Manager referred the Committee to the key sections of the accounts covering the Movement in Reserves Statement; the Comprehensive Income and Expenditure Statement and the Balance Sheet. The Officer said that the General Fund is relatively stable at £7.193m; the HRA reserve is up at £2.821m and there is also an overall increase in usable reserves.

3.2 The report of the External Auditor on the outcome of the audit of the Financial Statements for 2014/15 (Report under International Standard on Auditing 260) was presented for the Committee's consideration.

Mr Martin George, Engagement Manager, PwC confirmed that subject to the satisfactory completion of outstanding work as outlined in paragraph 6 of the report, it is the Auditor General's intention upon receipt of a Letter of Representation (based on that set out in Appendix 1) to issue an unqualified audit report on the financial statements (as per Appendix 2). The Auditor elaborated on the more significant issues arising from the audit to which the Committee's attention was drawn as the committee with oversight of the financial reporting process as follows:

- There are no misstatements identified in the financial statements that remain uncorrected.
- A summary of the corrections made to the draft financial statements which have been accepted and actioned by Management are listed in Appendix 3 to the report. Many of those involve reclassifications on the Balance Sheet which do not affect the General Fund; neither do those adjustments that relate to the revaluation of property affect the Fund. The net impact on the General Fund is £279k (the balance of the General Fund in the draft statement being £7.47m revised down to £7.193m in the final statement)
- The significant and elevated audit risks identified during the audit planning process were dealt with in accordance with the procedures set out in the Financial Audit Strategy and the outcome is set out in paragraph 13 of the report. An additional elevated risk was identified in relation to the accounting of the Job Evaluation exercise and an amendment proposed to the treatment thereof in the accounts. The Auditors will continue to monitor this area until the accounts are signed off.
- The audit findings arising from the examination of areas that are subject to estimation risk are provided in paragraph 16 to 40 of the report. Those areas relate to o Fixed asset valuation methodology and assumptions; pension liabilities; Equal Pay liabilities; Job Evaluation and Waste provision.
- No risks of material misstatements of the financial statements due to fraud were identified during the course of the audit.
- There were no concerns regarding the qualitative aspects of the Authority's accounting practices and financial reporting. The information provided was found to be relevant, reliable, comparable and easy to understand.
- The Auditors did not encounter any significant difficulties during the audit and no significant matters were discussed and corresponded upon with management that need to be reported to the Committee.
- Whilst no material weaknesses in the Authority's internal controls were identified there are areas wherein it is deemed it would be possible to improve control and recommendations to that end are made in Appendix 4 of the report. These relate to the revaluation of the Council's

property assets and the accuracy of the information provided in the Pensions Annual Return to Gwynedd Council.

- The Authority's Annual Governance Statement was reviewed and found to be compliant with the CIPFA/SOALCE Delivering Good Governance in Local Government framework.

The Committee considered the information presented and made the following points thereon –

- The Committee acknowledged that the accounts had been prepared, presented and audited within the statutory timescale and that they were qualitatively sound. The Committee also took assurance from the External Auditor's positive views regarding the qualitative aspects of the Authority's accounting practices and financial reporting.
- The Committee sought confirmation that the improvements in practice recommended by the External Auditor with regard to Revaluation and Pensions would be implemented and the Committee provided with an update thereon. The Interim Head of Resources confirmed that reporting on the response to the recommendations of the External Auditor has been scheduled for the Committee's first meeting in the New Year.
- With reference to the valuation of the Council's property assets and the adjustments recommended by the External Auditor in relation thereto, the Committee queried whether the Authority should be seeking specialist external input with regard to the valuation of its asset portfolio. Mr Martin George said that PwC does engage one of its internal valuation specialists to consider the valuation work undertaken by the Authority in order to obtain an opinion on the appropriateness of the valuation. The Authority's investment properties are all revalued annually whilst its operational assets are revalued on a rolling basis. The PwC valuer has raised certain points, but subject to the amendments proposed by the Auditors, the view is that the valuation for the purpose of the accounts is appropriate. The Interim Head of Resources confirmed that as the report indicates, Management, as part of its response to the recommendation made, is considering the options around the provision of services for valuations for next year and will include this as part of the process.
- The Committee noted that the process for selling assets identified as not required by the Authority has been slow. The Committee sought clarification of whether the Authority has in place a schedule of those assets listed for sale and whether it is monitoring that process. The Interim Head of Resources and Section 151 Officer confirmed that such a schedule has been formulated and that steps are in place to market for sale assets and to bring their sale to a successful conclusion.

It was resolved –

- **To recommend to the County Council that it approves the Statement of Accounts for 2014/15.**
- **To accept the report of the External Auditor on audit of the Financial Statements and to note the findings therein.**
- **To approve the Annual Governance Statement for 2014/15 and to refer it to the Leader of the Council and the Chief Executive to be signed.**

ACTION ARISING: Interim Head of Resources and Section 151 Officer to circulate the schedule of the Authority's for sale assets to Members of the Audit and Governance Committee.

4. EXTERNAL AUDIT – PERFORMANCE WORK PROGRAMME UPDATE

Mr Andy Bruce, WAO updated the Committee on the status of the Wales Audit Office Performance Work Programme comprising of items of work under Local Government Studies from 2014/15 through to 2016/17; Improvement Audit Assessment work for 2015/16 and National Value for Money Studies (as per the appended table).

The Officer highlighted the following points -

- That he would endeavour with regard to studies undertaken on an All-Wales basis to extrapolate information from those studies that is relevant to Anglesey and bring it to the Audit and Governance Committee's attention.

- That with regard to the 2016/17 Programme of Local Government Studies, the process of developing and finalising a list of potential study topics for consultation on the future programme of work is underway. In developing a programme of work, the WAO seeks to identify what is likely to be the most useful areas of study to a local authority and in the event that a potential local study is not undertaken by the Auditor General, it can if it is deemed locally relevant and useful, be carried out the following year as part of the local programme.
- That with regard to the Financial Resilience review the draft feedback for Anglesey is positive.
- That work in relation to the performance management review on benchmarking social services costs against performance across all six North Wales Councils has commenced and will involve in-depth discussions with each council.

The Committee referred to the Independence of Older People Study and suggested that the programme to reconfigure older people's care provision in Anglesey might be lagging behind that of other authorities and it sought clarification of what the study would be able to contribute in terms of moving this programme forwards. Mr Andy Bruce clarified that the study was identified as part of the stakeholder consultation process in 2014/15 and will seek among other things to identify examples of good practice that may be more widely adopted to address the issues arising in this service area.

The Interim Head of Resources and Section 151 Officer requested that Anglesey be given the opportunity to contribute with regard to the National Value for Money Study on Public Procurement and the National Procurement Service. Mr Andy Bruce said that ordinarily with such studies, a consultation group is established involving the WLGA and according to where the fieldwork is taking place, expertise drawn from a peer review group of either officers or members; however, he could pass on the request by Anglesey.

It was resolved to note the report and the information presented.

NO FURTER ACTION ENSUING

5. INTERNAL AUDIT PROGRESS REPORT

The report of the Internal Audit Manager on the work of the Internal Audit Service during the period from 1 April to 31 August, 2015 relative to the 2015/16 Audit Plan was presented for the Committee's consideration.

The Internal Audit Manager highlighted the following main points –

- That a schedule of performance targets for the period ending 31 August 2015 was attached at Appendix A and indicates that the Service is broadly on target.
- That the vacancy within the Internal Audit Team has now been filled and an appointment made.
- A summary of all audit assignments completed during the year to date including work in progress from 2014/15 is set out in the schedule at Appendix D which summarises the audit opinion and recommendations in respect of each area reviewed and will form the basis of the opinion contained in the Annual Statement of Assurance of the overall adequacy and effectiveness of the Authority's governance, risk management and internal control framework for 2015/16.
- Since 1 April, 2015 ten final reports have been issued from the 2014/15 Internal Audit Operational Plan and three from the 2015/16 Operational Plan.
- Two of the planned audits completed during the year to date are assessed as not providing positive levels of assurance. During the period 1 April 2015 to 31 August 2015 the ICT Disaster Recovery Audit resulted in a Minimal Assurance rating and the Business Continuity Management Audit was assessed as providing Limited Assurance.
- Audit recommendations are rated high, medium or low according to the perceived risk. The percentage implementation rate at 4 September, 2015 was 66% of high and medium recommendations having been recorded as implemented.
- A report by the previous Interim Audit Manager to the Committee in July 2015 identified that work is required to improve the monitoring and reporting of progress in implementing agreed recommendations. It is intended to review the follow up process within the Internal Audit Service so as to provide assurance to the Committee that the recommendations made in Internal Audit reviews are implemented by Management within agreed timescales. A report to that end will be presented to the Committee in due course.

The Committee considered the report and noted that some of the reviews listed at Appendix D were recorded as providing Limited or Minimal Assurance e.g. ICT Disaster Recovery and it sought clarification of the issues involved. The Interim Head of Resources and Section 151 Officer said that Business Continuity management of which ICT Disaster Recovery forms a part has been an area of longstanding concern for the Council and has been identified as an issue by previous audit reports. A new ICT Manager is now in post and steps are being taken to provide him with the funding necessary to improve the robustness of ICT disaster recovery arrangements. It is anticipated that a significant improvement will have been made by the time of the next audit review.

It was resolved to accept the report and to note its contents.

NO FURTHER ACTION ENSUING

6. RISK MANAGEMENT

The Risk and Insurance Manager updated the Committee on the latest position with regard to Risk Management as follows –

- The Corporate Risk Register has been updated at the end of Quarter 1 and is to be considered by the Senior Leadership Team at its meeting next week.
- Two new Political risks (changes to political stability, and Member response to Welsh Government proposals for local government reorganisation) have been put forward to the SLT for consideration. These are not necessarily a reflection of the actual situation but are identified as risks going forwards and, in the case of the first risk, is considered relevant in situations where the political balance is close.
- Two risks have emerged from the service risk registers both of which relate to the Council's ability to meet its statutory responsibilities, the first being a risk to some areas of service in the event of further budget reductions, and the other a risk arising from an increase in the demand for a service e.g. Children's Services, which is unplanned for.

The Committee noted the information presented and sought confirmation that services are now taking full ownership and accountability for risk management and risk assessment. The Risk and Insurance Manger said that the situation is an improving one.

The Committee also noted anti-social behaviour linked to certain pockets of poor housing as an emerging risk area and suggested that this needs to be highlighted. Mr Andy Bruce, Wales Audit Office said that the North Wales Safer Communities Board has identified anti-social behaviour in housing as a significant issue and one of its high risk areas; the Officer said that it can have a potential impact on resources and services. The Board in seeking to address the issue is to take a more co-ordinated approach across North Wales. The Officer said that he would try to identify relevant feedback from the Community Safety study to report to the next Audit Committee meeting.

The Chief Executive said that he was aware of the work being undertaken by the North Wales Safer Communities Board in this context. The Authority has held discussions with North Wales Police on how to respond locally to this challenge which will include reviewing the Authority's internal arrangements to ensure they correspond to the new requirements arising for the future. A key aspect in terms of being able to successfully address this challenge will be to respond on a multi-agency basis.

It was resolved to note the position with regard to Risk Management and the Corporate Risk Register.

NO FURTHER ACTION ENSUING

Councillor R.Llewelyn Jones
Chair

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ISLE OF ANGLESEY COUNTY COUNCIL	
REPORT TO	**AUDIT AND GOVERNANCE COMMITTEE**
DATE	**8 DECEMBER 2015**
SUBJECT	**FOOD STANDARDS AGENCY REPORT ON THE FOOD AND FEED LAW ENFORCEMENT SERVICE ON THE ISLE OF ANGLESEY**
LEAD OFFICER	**CHIEF PUBLIC PROTECTION OFFICER – DAVID RILEY**
CONTACT OFFICER	**CHIEF PUBLIC PROTECTION OFFICER – DAVID RILEY**
Nature and reason for reporting – The Food Standards Agency Report on the Food and Feed Law Enforcement Service on the Isle of Anglesey followed an audit that took place in July 2014. A number of findings were reported upon which gave rise to a number of recommendations by the Food Standards Agency audit team. These recommendations were responded to by way of an Action Plan detailing how each recommendation would be addressed. This report introduces the original FSA report and Action Plan and updates the Action Plan detailing progress made so far.	

1. INTRODUCTION

1.1 The Food Standards Agency (FSA) have the power to set standards, monitor and audit local authority food and feed law enforcement services by virtue of the Food Standards Act 1999 and the Official Feed and Food Controls (Wales) Regulations 2009. The audit of the food and feed service at Isle of Anglesey County Council was undertaken under section 12(4) of the Act and Regulation 7 of the Regulations.

1.2 The audit was carried out by the FSA during the week beginning 14th July and lasted 5 days. The FSA assessed the authority's conformance against "The Standard". The Standard forms part of the FSA's Framework Agreement with local authorities. The Framework Agreement can be found on the FSA's website at: www.food.gov.uk/enforcement/enforcework/frameagree

1.3 The audit covered the Isle of Anglesey's arrangements for the delivery of food hygiene, food standards and feed law enforcement services. These functions are delivered by the Public Protection section of the Planning and Public Protection Division. Work was at the time delivered by officers in the Environmental Health and Trading Standards teams.

1.4 The authority received the formal report on 21st July 2015.

2. BACKGROUND INFORMATION

2.1 The FSA audit report (separate attachment) examines the local authority's Food and Feed Law Enforcement Service. The assessment includes consideration of the systems and procedures in place for interventions at food and feed businesses, food and feed sampling, internal management, control and investigation of outbreaks and food related infectious disease, advice to business, enforcement, food and feed safety promotion.

2.2 The main findings of the audit are contained in the Executive Summary. They are summarised as follows:

- The authority had recently undertaken a review of its management structure to address the forecast budget reduction target for Public Protection for 2013-16.
- The authority had developed a Food Service Plan for 2014/15. The plan did not fully address the significant number of businesses overdue food hygiene, standards and feed interventions. There is a need to provide a comparison of the staff resources against the staff resources available to the authority to ensure sufficient resource is identified and available to deliver an appropriate level of service.
- Checks confirmed that the food establishment databases were generally accurate

and the authority had been able to provide an electronic Local authority Enforcement Monitoring System (LAEMS) return to the FSA.

- The arrangements set out in the Service Plan for the delivery of programmed interventions for food hygiene, food standards and feed fell short of those required by the Food and Feed Law Codes of Practice. At the time of the audit there were a significant number of overdue interventions.
- In respect of food standards and feed official controls, it was not always possible for auditors to establish whether businesses had been subject to interventions at the correct frequencies, as the risk rating scheme which had been used was not equivalent to those set out in the Food and Feed Law Codes of Practice. A significant number of feed establishments had been awarded a risk rating without an inspection, effectively rendering a significant number of establishments overdue for an intervention.
- Generally, food hygiene records had been adequately maintained. Food Standards and feed records were not being adequately maintained and many frequently incomplete. This made effective internal monitoring difficult and can impact on the ability of officers to adopt a graduated approach to enforcement.
- The authority had been proactive in providing advice and guidance to food and feed businesses and in promoting food safety using a variety of media and public events.
- There was some evidence of internal monitoring for food hygiene, standards and feed services, however it required further development to enable the authority to verify its conformance with all elements of the Standard, the relevant Codes of Practice, centrally issued guidance and the authority's own documented policies and procedures.

2.3 As a result of the findings the service submitted an Action Plan addressing all the detailed recommendations contained in the FSA report. This is contained in the main Report by the FSA as Annexe A.

2.4 Work began to address the recommendations following the informal feedback session delivered by the FSA auditors on 18th July 2014. The Action Plan has been a "live" document and has been updated on a regular basis as the agreed actions have been completed. The latest version of the Action Plan is attached to this report – Appendix 1.

2.5 The majority of recommendations are of a procedural nature and have been addressed. However, the need to have sufficient staff resources to carry out all the necessary Food Hygiene, Food Standards and Feed Hygiene inspections remains a concern. Current analysis of the workload shows a staff resource gap of 2 officers. One to carry out Food Hygiene inspections and one to carry out Food Standards and Feed Hygiene inspections. However further analysis and operational testing needs to take place to ratify the analysis. Following the audit and changes to procedures officers are finding inspections are taking longer to complete.

2.6 The service is in the process of transformation in order to address such challenges, however it is likely that even with a more agile, modern and flexible workforce there will remain a resource gap. In an environment of reducing service budgets this will be the inevitable consequence. The mitigation is to ensure well evidenced and informed prioritisation of the use of staff resource. It is important to justify what we do and just as importantly what we are unable to do to the public and businesses on Anglesey as well as those bodies who scrutinise our work.

2.7 The FSA will return to formally assess progress against the full report before 31st March 2016. This will involve an on-site visit and they will produce a subsequent report which will again be published.

3. CONCLUSION

3.1 The FSA Report on the Food and Feed Law Enforcement Service on the Isle of Anglesey highlights the areas of improvement required by the authority in order to meet the requirements of the Standard for Official Feed and Food Controls required of local authorities.

3.2 The authority has produced and Action Plan to progress these improvements and this has been approved by the FSA.

3.3 The updated Action Plan shows good progress has been achieved to date and the service anticipates being able to meet the majority of suggested actions by the time the FSA returns in March 2016.

3.4 The enforcement of Feed Controls is now being delivered collaboratively across North Wales and meets the recommendations identified by the FSA Report.

3.5 The lack of staffing resources to meet the target numbers of Food Hygiene and Food Standards inspections remains a concern against the decreasing Public Protection service budget.

Appendix 1 - Action Plan for Anglesey County Council
Audit Date: 14-18 July 2014

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
3.21 The authority should: (i) Ensure that future Food and Feed Law Enforcement Service Plans are developed in accordance with the Service Planning Guidance in the Framework Agreement. An analysis of the resources required against those available, and plans to address any shortfalls identified should be included. [The Standard – 3.1]	*31/7/15*	Produce 15/16 service plan in accordance with COP which addresses the resource requirement needed to carry out the intervention policy and identifies available resources. Plan needs to include reference to work we should be undertaking, in addition to work that has been done. Identify the resources required to carry out the service plan against those available and plan to address any shortfall in resources	**Analysis of shortfall being undertaken.** **Engaging in North Wales feed delivery project. FSA overseeing project and content this approach addresses the shortcomings in the Feed Enforcement delivery issues on Anglesey.**
(ii) Address any variance in meeting the Service Plan in subsequent service plans. [The Standard-3.3]	*31/7/15*	Address variance by including resources required to make up shortfall in analysis for 15/16 plan. 15/16 Plan to include estimation of resources needed against actual resources. Better explanation of shortfall in inspection etc needed. Address variance by including resources required to make up shortfall in analysis and commit to addressing that variance for 15/16 plan.	**Analysis of shortfall being undertaken.** **Engaging in North Wales feed delivery project**
5.16 The authority should: Review and amend the authorisation procedure to include reference to the arrangements for refresher training and monitoring for newly qualified and returning officers, in accordance	*Completed* *End of 3/16*	Amend procedure to refer to training, monitoring of newly qualified officers and those returning after absence. Ensure Food EHO returning from	**Completed**

with the requirement of the Food Law Code of Practice. [The Standard – 5.1]		Maternity leave has 10 hours CPD	
(i) Review and amend food standards and feed officer authorisations to include the appropriate Official Feed and Food Control legislation to carry out the work set out in the Service Plan. Amend the authorisation of the unqualified Trading Standards enforcement officer to reflect their competency, in accordance with the Codes of Practice. Ensure the duties of food standards and feed officers do not exceed their authorisations. [The Standard – 5.3]	*Completed* *Completed*	Amend authorisation to include appropriate legislation: Official Food & Feed Control regulations 2009. Remove Authorisation from TS Enforcement Officer, North Wales feed delivery project will address.	**Completed** **Completed**
(ii) Appoint a sufficient number of suitably authorised food hygiene and food standards officers to carry out the work set out in the Service Plan and ensure that they are authorised under the appropriate legislation. The level of authorisation of feed officers should be consistent with their qualifications. [The Standard – 5.3]	*31/03/16*	Following on from analysis in the service plan, staffing resources will be reviewed and a bid will be presented to the Executive for the necessary additional officers required **(resource availability to do this**)	**Currently the service does not have sufficient officers to meet this requirement. Once the Public Protection restructure is complete further analysis will take place to assess compliance.**
(iii) Ensure that all authorised food hygiene officers receive 10 hours Continuous Professional Development training, in accordance with the Code of Practice.	*3/16*	**Ensure Training for all staff with minimum CPD requirement of 10 hours**	**On-going**

[The Standard – 5.4] (iv) Maintain records of the relevant qualifications, training and experience of each authorised officer and appropriate support staff in accordance with the relevant Codes of Practice. [The Standard - 5.5]	*Completed*	Review individual officer's files and take corrective action.	**Completed**
6.8 The authority should: (i) Ensure that the necessary facilities and equipment that are required for the effective delivery of all activities associated with the feed service are made available. [The Standard - 6.1] (ii) Amend the documented procedure for calibrating temperature measuring equipment to include testing frequencies for all devices, operating temperatures for refrigeration equipment and ensure tolerances are applied in accordance with centrally issued guidance. [The Standard - 6.2]	*Completed* Completed	Share/buy the required equipment: chisels and sampling tubes for liquids. It may be that the North Wales feed delivery project will have the resources needed.	North Wales Feed project addressing equipment requirements Procedure amended and now refers to a tolerance of +/- 0.5 C Thermometers no longer in use have been disposed of and new chart for logging UV thermometer checks. Fridge temperatures recorded on form
7.26 The authority should: (i) Ensure that food establishment interventions/inspections are carried out at the minimum frequency specified by the Food Law Code of	**Completed**		All B rated premises brought forward in inspection programme. Staff now ensure that B rated premises get priority for inspection

Practice. [The Standard -7.1]			
(ii) Ensure that full inspections and alternative enforcement strategies are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]	**30/03/17**	This is the need to carry out inspections within 28 days of 'due date' – Can't comply at present unless additional staff made available or time allowed for "catch up". A bid will be made for a short term resource to be made available to "catch up"	A and B rated premises are inspected within 28 days of "due date", rest are inspected asap "Short" inspection form extended and adapted to cover additional details
(iii) Assess the compliance of establishments in its area to the legally prescribed standards; and take appropriate action on any non-compliance found, in accordance with the authority's Enforcement Policy. [The Standard - 7.3]	**Completed**		Procedure amended to include instruction as to non return of AS questionnaire and this form requires EHO to sign off updating /visit needed
(iv) Amend its Food Interventions Procedure in respect of Alternative Enforcement Strategies (AES) to include details of the criteria against which completed questionnaires are assessed and to set out the triggers for undertaking another type of intervention. [The Standard – 7.4]	**Completed**		Source and Imported Food reference is now on Inspection form
(v) Ensure observations made in the course of an inspection, in particular relating to checks carried out to verify the source of foods and to demonstrate	**Completed**		

that consideration has been given to imported foods, shall be recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]			
7.34 The authority should: (i) Ensure that vessel inspections are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]	*Completed*	Will leave APHA form on all visits, even if just to ascertain if someone has inspected at a previous port.	Recent inspections have been on resident ferries, which always involve the use of the APHA inspection form
(ii) Ensure observations made in the course of an inspection, are recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]	*Completed*	As above	
7.50 The authority should: (i) Ensure that food standards interventions are carried out at a frequency not less than that determined under the intervention rating scheme set out in the Food Law Code of Practice. [The Standard -7.1]	*Completed*	NTSB risk rating scheme has been adopted, which is equivalent to the COP rating scheme. Work ongoing on database.	NTSB scheme adopted 14/15
(ii) Implement a food standards intervention risk rating scheme which is in	*31/7/15*	Service plan for 2015/16 will plan interventions in accordance with the	Service plan in process of completion

accordance with the scheme established under annex V of the Food Law Code of Practice. [The Standard - 7.2]		scheme.	
(iii) Provide food businesses with a report after each inspection/intervention, develop and implement an intervention policy for unrated and "non-inspectable risk" food standards establishments, ensure that food standards establishments are only inspected by appropriately authorised officers and ensure that announced visits and revisits are carried out in accordance with the relevant legislation, Code of Practice, centrally issued guidance and the authority's own policies and procedures. [The Standard -7.2]	*31/7/15*	New inspection report template to be used. An intervention policy for unrated or low risk premises is being developed. Intervention duties will be allocated in accordance with the plan, to appropriately authorised officers	New reports adopted Policy in place, assessing premises currently to establish risk rating
(iv) Take appropriate action on any non-compliance found at food standards establishments, in accordance with the authority's enforcement policy. {The Standard -7.3]	*Completed*	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(v) Set up a revisit policy which accords with the Food Law Code of Practice. [The Standard – 7.4]	*Completed*	Devise a revisit policy in accordance with 7.4 of the standard.	Completed
(vi) Ensure that officers' contemporaneous records of food standards	*Completed*	Data capture on electronic inspection forms to be linked to CIVICA system	

interventions are recorded in a timely manner and stored in such a way that they are retrievable. [The Standard - 7.5]		Use aide memoir forms to record inspection observations as for feed inspection forms	
7.63 The authority should:			
(i) Ensure that feed establishment interventions and inspections are carried out at the frequency specified by the Feed Law Enforcement Code of Practice. [The Standard - 7.1]	*Completed*	North Wales feed delivery project will allocate interventions.	Feed Lead Officer has attended meetings to set up north wales programme. Planned programme in place and being progressed
(ii) Carry out inspections / interventions and approve or register feed establishments in accordance with relevant legislation and the Feed Law Enforcement Code of Practice and centrally issued guidance. [The Standard - 7.2]	*Completed*	Will adopt policies and procedures from the North Wales project and use appropriately authorised officers.	Completed
(iii) Ensure appropriate action is taken to follow up non-compliance in accordance with the Enforcement Policy. [The Standard – 7.3]	Completed	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(iv) Ensure documented procedures relating to inspection of feed establishments are fully developed in accordance with the Feed Law Enforcement Code of Practice. Develop documented procedures for interventions relating to co-products establishments, imported	*Completed*	Will adopt procedures from the North Wales project and use appropriately authorised officers.	Completed

feed, applications for feed approvals and registrations. [The Standard – 7.4]			
(v) Ensure that all observations made in the course of interventions are recorded in a timely manner and officers' contemporaneous records of interventions are stored in such a way as to be retrievable. [The Standard – 7.5]	*30/7/15*	Data capture on electronic inspection forms to be linked to CIVICA system	Have not linked paper and civica systems to date. Smarter working project? Currently considering transferring to different software provider – Tascomi. Part of All- Wales Procurement Framework for Public Protection
8.10 The authority should:			
(i) Review and update the complaints procedures to include reference to complaints against food and the condition of feed establishments. [The Standard – 8.1]	*Completed*	Amend food and feed complaints procedure to refer to condition of establishments	Completed
(ii) Investigate complaints received in accordance with the Food Law Code of Practice, centrally issued guidance and its own policy and procedures. [The Standard – 8.2]	*Completed*	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(iii) Take appropriate action on complaints received in accordance with the authority's Enforcement Policy. [The Standard – 8.3]	*Completed*	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.

11.5 The authority should: (i) Maintain its database of food and feed establishments, ensuring food and feed businesses are properly registered and included in the food and feed interventions programmes. [The Standard – 11.1]	ongoing	Ongoing work carried out to register and risk assess against NTSB risk scheme.	Ongoing work. Visiting unrated premises
12.11 The authority should: (i) Amend the Food and Feed Sampling Policy to include reference to its approach to notifying/liaising with Primary and Home Authorities. [The Standard – 12.4]	*Completed*	Amend the policy.	*Completed*
(ii) Set-up, maintain and implement a documented procedure for the procurement or purchase, continuity of evidence and the prevention of deterioration or damage of informal food standards samples in accordance with the Food Law Code of Practice and relevant centrally issued guidance. [The Standard – 12.5]	*Completed*	Set up an equivalent procedure to the formal samples for informal samples. Procedure to address; purchase, continuity of evidence, prevention of deterioration and damage to samples in accordance with the COP	*Completed*
(iii) Take appropriate action in accordance with its Enforcement Policy where food hygiene sample results are not considered to be satisfactory. [The Standard – 12.7]	Completed		*Sampling Policy amended and Home Authority contacted with results. Some HAs only want results if there are failures*

13.8 The authority should: (i) Amend the Outbreak Control Plan to ensure that it includes the relevant local authority contacts. [The Standard – 13.1] (ii) Further develop the documented procedure for investigation of infectious diseases to include reference to sampling and ensure the procedure is fully implemented. [The Standard -13.2]	Completed Completed	.	*Relevant section of the plan was amended at same time as update of Port Health Action Plan* *Plan now refers to the relation between food samples and collected faecal samples*
14.7 The authority should: (i) Notify the FSA of any serious localised food hazards in accordance with the Food Law Code of Practice. [The Standard – 14.5]	Completed	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
15.14 The authority should: (i) Review and amend its Enforcement Policy to include reference to the approach to enforcement at establishments where it is the food or feed business operator and place a copy of its Enforcement Policy, or instructions on how to obtain a copy, on its website. Ensure that the Enforcement Policy is fully implemented. [The Standard – 15.1]	31/07/15	Consult with Webmaster This is a reference to need to include a section on what we do in council premises	Part of overall review of Enforcement Policy to reflect legislative changes and demands

(ii) Set up documented procedures for undertaking food hygiene prosecutions and Simple Cautions, the suspension and withdrawal of feed establishment approvals and for the enforcement of inland imported feed in accordance with the Codes of Practice and official guidance. [The Standard -15.2]	Completed	Adopt procedure in place for food standards and amend appropriately. RIAMS version to be looked at.	Completed
(iii) Amend the procedures for food hygiene detention, seizure and certification and food standards in accordance with the relevant Codes of Practice and official guidance. [The Standard -15.2]	Completed		EH Food Detention Procedure now refers to disposal method for detained foods Completed
(iv) Amend the procedures for feed prosecutions and simple cautions in accordance with the relevant Codes of Practice and official guidance, to ensure that CPIA officer roles are clearly identified in prosecution and simple caution files together with a consideration of the Enforcement Policy and the relevant legal tests. Ensure that this procedure is fully implemented. [The Standard -15.2]	Completed	Amend current standard forms where necessary.	HI Notice procedure now requires written request for extension of notice period and letter to confirm compliance
(v) Ensure that food hygiene enforcement is carried out in accordance with the relevant Codes			

of Practice and centrally issued guidance. [The Standard – 15.3] (vi) Ensure that all decisions on enforcement action are made following consideration of the authority's Enforcement Policy and that the reasons for any departure from the criteria set out in the enforcement policy are documented. [The Standard –15.4]	Completed	Amend standard forms where necessary.	Completed
16.7 The authority should: (i) Ensure that up to date food business registration details are maintained and letters provided to businesses following interventions/inspections contain all of the information required by the Food Law Code of Practice. [The Standard -16.1	Completed	Two businesses had different t registration details to those on letter. To be done email to be sent to staff. Keep copy with Registration procedure.	Completed Updating to be done and officers to check Reg details during/after inspection
16.18 The authority should: (i) Maintain up to date food standards records in retrievable form on all food establishments in its area in accordance with the Food Law Code of Practice and centrally issued guidance. These records shall include sample results, the date, time, areas seen and documents examined during an intervention, the type, size and	*31/7/15*	Discontinue use of current inspection forms. Use model forms electronically linked to CIVICA system for interventions/premises details/ samples/ etc. Inspection report forms will be amended to meet the requirements of the COP including: designation of inspecting officer, contact details of senior officer and the address of the authority.	Existing stocks being used and new template has been produced

scale of a business, determination of compliance with legal requirements made by the authorised officer, details of action to be taken by the authority and action taken where non-compliance were identified, the timescale for compliance and the name of the food business operator. Inspection reports shall also include the designation of the inspecting officer, the contact details of a senior officer and the address of the authority. [The Standard -16.1]			
16.24 The authority should: (i) Maintain up to date, accurate records in a retrievable form on all relevant feed establishments and imported feed in accordance with the Feed Law Enforcement Code of Practice and centrally issued guidance. These records should include reports of all interventions / inspections, the determination of compliance with legal requirements made by the officer and details of action taken. [The Standard – 16.1]	Completed	As 16.18 above, will adopt All Wales procedures and forms in accordance with policies and procedures implemented by the North Wales regional collaboration feed service scheme.	North Wales feed project forms in use
19.9 The authority should: (i) Further develop, maintain and implement internal monitoring procedures for food	31/07/15	Develop monitoring procedures in common with Food Hygiene service. Procedure to address conformity with The	Liaison with Food Hygiene service and North Wales feed project lead.

hygiene, food standards and feed to verify its conformance with the Standard, relevant legislation, the relevant Codes of Practice, centrally issued guidance and its own documented policies and procedures. [The Standard – 19.1 and 19.2]		Standard, legislation, Codes of Practice, guidance and internal policies and procedures. North Wales feed project will have internal monitoring system.	
(ii) Ensure that records of internal monitoring activities are maintained for two years [The Standard– 19.3]	31/07/15	Implement procedure to record internal monitoring and maintain records for two years.	Developing Internal monitoring procedure.

Report on the Food and Feed Law Enforcement Service

Isle of Anglesey County Council
14-18 July 2014

Foreword

Audits of local authority food and feed law enforcement services are part of the Food Standards Agency's (FSA) arrangements to improve consumer protection and confidence in relation to food and feed. These arrangements recognise that the enforcement of UK food and feed law relating to food safety, hygiene, composition, labelling, imported food and feedingstuffs is largely the responsibility of local authorities. These local authority regulatory functions are principally delivered through their Environmental Health and Trading Standards Services.

The attached audit report examines the local authority's Food and Feed Law Enforcement Service. The assessment includes consideration of the systems and procedures in place for interventions at food and feed businesses, food and feed sampling, internal management, control and investigation of outbreaks and food related infectious disease, advice to business, enforcement, food and feed safety promotion. It should be acknowledged that there may be considerable diversity in the way and manner in which authorities provide their food enforcement services reflecting local needs and priorities.

FSA audits assess local authorities' conformance against the Feed and Food Law Enforcement Standard. "The Standard", which was published by the FSA as part of the Framework Agreement on Official Feed and Food Controls by Local Authorities (amended April 2010) is available on the FSA's website at:
www.food.gov.uk/enforcement/enforcework/frameagree

The main aim of the audit scheme is to maintain and improve consumer protection and confidence by ensuring that authorities are providing effective food and feed law enforcement services. The scheme also provides the opportunity to identify and disseminate good practice, and provides information to inform FSA policy on food safety, standards and feedingstuffs and can be found at:
www.food.gov.uk/enforcement/auditandmonitoring

The report contains some statistical data, for example on the number of food establishment inspections carried out. The FSA's website contains enforcement activity data for all UK local authorities and can be found at: www.food.gov.uk/enforcement/auditandmonitoring

The report also contains an action plan, prepared by the authority, to address the audit findings.

For assistance, a glossary of technical terms used within the audit report can be found at Annex C.

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Annexes

1 Introduction

1.1 This report records the results of an audit of food hygiene, food standards and feedingstuffs at Isle of Anglesey County Council under the headings of the FSA Feed and Food Law Enforcement Standard. It has been made publicly available on the FSA's website at ***www.food.gov.uk/enforcement/auditandmonitoring/auditreports***

Reason for the Audit

1.2 The power to set standards, monitor and audit local authority food and feed law enforcement services was conferred on the FSA by the Food Standards Act 1999 and the Official Feed and Food Controls (Wales) Regulations 2009. The audit of the food and feed service at Isle of Anglesey County Council was undertaken under section 12(4) of the Act and Regulation 7 of the Regulations.

1.3 Regulation (EC) No. 882/2004 on official controls performed to ensure the verification of compliance with feed and food law, includes a requirement for competent authorities to carry out internal audits or to have external audits carried out. The purpose of these audits is to verify whether official controls relating to feed and food law are effectively implemented. To fulfil this requirement, the FSA, as the central competent authority for feed and food law in the UK, has established external audit arrangements. In developing these, the FSA has taken account of the European Commission guidance on how such audits should be conducted.[1]

1.4 The authority was audited as part of a three year programme (2013 – 2016) of full audits of the 22 local authorities in Wales.

Scope of the Audit

1.5 The audit covered the Isle of Anglesey's arrangements for the delivery of food hygiene, food standards and feed law enforcement services. The on-site element of the audit took place at the authority's offices at

[1] Commission Decision of 29 September 2006 setting out the guidelines laying down criteria for the conduct of audits under Regulation (EC) No. 882/2004 of the European Parliament and of the Council on Official Controls to verify compliance with feed and food law, animal health and animal welfare rules (2006/677/EC).

Llangefni on 14-18 July 2014, and included verification visits at food and feed businesses to assess the effectiveness of official controls implemented by the authority, and more specifically, the checks carried out by the authority's officers, to verify food and feed business operator (FBO/FeBO) compliance with legislative requirements.

1.6 The audit also afforded the opportunity for discussion with officers involved in food and feed law enforcement with the aim of exploring key issues and gaining opinions to inform FSA policy.

1.7 The audit assessed the authority's conformance against "The Standard". The Standard was adopted by the FSA Board on 21st September 2000 (and was subject to its fifth amendment in April 2010), and forms part of the FSA's Framework Agreement with local authorities. The Framework Agreement can be found on the FSA's website at www.food.gov.uk/enforcement/enforcework/frameagree

Background

1.8 The Isle of Anglesey County Council is a unitary authority in north-west Wales, which covers an area of 71,106 Hectares. As an island authority it is separated by the Menai Straits from its two neighbouring local authorities Conwy and Gwynedd.

1.9 The Isle of Anglesey has 201km of coastline, which is rural in character. Parts of the coastline form an Area of Outstanding Natural Beauty (AONB) which along the way takes in the towns of Holyhead, Cemaes and Beaumaris.

1.10 The isle of Anglesey is largely a rural county with tourism and agriculture the main industries. There are approximately 33,042 bed spaces on the island provided by the tourist industry, which together with day visitors doubles the population of Anglesey during the holiday season.

1.11 The authority has a port situated at Holyhead which is currently classified as a Dormant Border Inspection Post, as all foods received have been produced in the Irish Republic or have entered through Border Inspection Posts in that country. A number of ship movements take place each year for which the authority provides a service issuing

ship sanitation certificates and advice regarding food hygiene and water supply hygiene aboard vessels.

1.12 The authority has a number of commercial shellfish beds producing mussels, cockles and oysters, from which it takes regular samples of shellfish and water to monitor the safety of the food produced.

1.13 The Isle of Anglesey has a population of 68,592. The main population centres are Holyhead (4757 inhabitants) and Porthyfelin (7398 inhabitants). A total of 98.8% of the population are from a white background and 62% speak Welsh.

1.14 The Isle of Anglesey as a whole has low levels of deprivation. However, there are pockets of deprivation around Holyhead town.

1.15 Food and feed law enforcement was being carried out by officers in the authority's Public Protection Division within the Sustainable Development Department. Food standards and feed official controls were carried out by officers in the Trading Standards section. Food hygiene official controls, port health and infectious disease control were carried out by officers in Environmental Health.

1.16 A staffing restructure planned for implementation during the week following the audit was intended to combine two existing posts, the Chief Trading Standards Officer and Chief Environmental Health Officer, to create a new post of Chief Public Protection Officer.

1.17 Officers and support staff responsible for food hygiene, food standards and feed were based at the County Council Offices in Llangefni. Services were available between the hours of 08:45 to 17:00 Monday to Friday.

2 Executive Summary

2.1 The authority had recently undertaken a review of its management structure, combining two existing posts to oversee the delivery of all food and feed law enforcement services. The review formed part of an ongoing strategy to address the forecast budget reduction target for Public Protection for 2013-16.

2.2 The authority had developed a Food Service Plan for 2014/15, broadly in line with Service Planning Guidance. However, the plan did not fully address the significant number of businesses overdue food hygiene, standards and feed interventions. The plan also needed to provide a comparison of the staff resources required to deliver food and feed law enforcement services against the staff resources available to the authority. The absence of such information makes it difficult to ensure sufficient resource is available to deliver an appropriate level of service.

2.3 Work procedures had been developed to ensure the accuracy of the authority's commercial premises database. Audit checks confirmed that the food establishment databases were generally accurate and the authority had been able to provide an electronic Local authority Enforcement Monitoring System (LAEMS) return to the FSA. Improving the feed establishment database had been identified by the authority as a priority, and work was ongoing to improve its accuracy.

2.4 The arrangements set out in the Service Plan for the delivery of programmed interventions for food hygiene, food standards and feed fell short of those required by the Food and Feed Law Codes of Practice. Further, at the time of the audit there were a significant number of overdue interventions.

2.5 In respect of food standards and feed official controls, it was not always possible for auditors to establish whether businesses had been subject to interventions at the correct frequencies, as the risk rating scheme which had been used was not equivalent to those set out in the Food and Feed Law Codes of Practice. Further, a

significant number of feed establishments had been awarded a risk rating without an inspection, effectively rendering a significant number of establishments overdue for an intervention.

2.6 Generally, food hygiene records had been adequately maintained. Food Standards and feed records were not being adequately maintained. Records that were available were frequently incomplete. The lack of comprehensive records made it difficult to ascertain the nature and scope of food business operations, the extent of officers' interventions or whether effective assessments of food/feed business compliance had been made. This made effective internal monitoring difficult and can impact on the ability of officers to adopt a graduated approach to enforcement.

2.7 The authority had been proactive in providing advice and guidance to food and feed businesses and in promoting food safety using a variety of media and public events.

2.8 There was some evidence of internal monitoring for food hygiene, standards and feed services, however it required further development to enable the authority to verify its conformance with all elements of the Standard, the relevant Codes of Practice, centrally issued guidance and the authority's own documented policies and procedures.

2.9 The authority's Strengths

Advice to Business

The authority had been proactive in providing assistance to businesses to help them comply with food hygiene, food standards and feed legislation. The authority had liaised with the local Food technology Centre to raise food standards awareness and, in collaboration with other North Wales authorities, the authority had published a regular newsletter for farmers.

Liaison

The authority was able to demonstrate effective liaison with neighbouring authorities and was contributing to the development of the North Wales collaboration agenda “Collaboration Plus”. Liaison arrangements were also in place with other appropriate bodies aimed at facilitating consistent enforcement.

2.10 The authority’s Key Areas for Improvement

Food Hygiene, Food Standards and Feed Intervention Frequencies

The authority was not carrying out food hygiene, food standards or feed interventions at the minimum frequencies required in the Codes of Practice. Interventions carried out at the minimum frequency ensure that risks associated with food businesses are identified and followed up in a timely manner.

Food Hygiene, Food Standards and Feed Interventions

The risk rating scheme which had been used for food standards and, in some cases, feed was not consistent with or equivalent to the risk rating scheme in the Food and Feed Law Codes of Practice. Further, a significant number of feed businesses had been risk rated without the benefit of an inspection. This affected the ability to deliver a risk based interventions programme.

Food Hygiene, Food Standards and Feed Inspection Records

Records of food hygiene, food standards and feed inspections were not always sufficiently detailed to establish that effective interventions had been carried out. Further, food standards and feed inspection reports were not sufficient to inform a graduated and consistent approach to enforcement and enable effective internal monitoring.

Internal Monitoring

The authority operated a corporate performance monitoring framework and performance measures and targets had been identified for Food Hygiene and Trading Standards. Performance targets fell short of those

required by the Food and Feed Law Codes of Practice. Documented internal monitoring procedures required further development to enable the authority to verify its conformance with all elements of the Standard and audit findings indicated that qualitative internal monitoring had not succeeded in achieving complete conformance with the Standard, relevant legislation, the relevant Codes of Practice, centrally issued guidance and its own documented policies and procedures.

Audit Findings

3 Organisation and Management

Strategic Framework, Policy and Service Planning

3.1 The authority operated a Cabinet style of local government with a Constitution that set out its decision making arrangements. Under the Constitution, decisions on certain specific matters had been delegated to officers.

3.2 The authority had developed a 'Food Service Enforcement Plan 2014/15' ('the Service Plan') which detailed the arrangements for the delivery of food hygiene, food standards and feed official controls. The Service Plan had been adopted on behalf of the Council by the Deputy Leader, Planning and Environment portfolio holder.

3.3 A 'North Wales Trading Standards Services Animal Feed Service Delivery Plan 2014/15' had been developed collaboratively by local authorities in North Wales which included information relating to official feed controls on the Isle of Anglesey.

3.4 Considered together, the plans contained much of the information set out in the Service Planning Guidance in the Framework Agreement, including a profile of the authority, the organisational structure and the scope of the service. The times of operation and service delivery points had not been included.

3.5 The contribution of food and feed law enforcement services to the authority's strategic aims and objectives, and the aims and objectives of the food hygiene, food standards and feed services were highlighted in the plans.

3.6 The Service Plan indicated that there were 866 registered food establishments on the Isle of Anglesey of which 840 were subject to food hygiene inspections. Due to lack of resources, it was stated that some businesses preparing food, including child minders were 'inspected on a limited basis.'

3.7 A total of 806 food establishments were reported in the Service Plan to be subject to food standards official controls and there were 739 registered feed establishments.

3.8 The Service Plan included the following risk profiles of food and feed establishments:

Food hygiene risk ratings:

Risk category	Total establishments
A	0
B	22
C	383
D	146
E	274
Unrated	15

Food standards risk ratings:

Risk category	Total establishments
High	43
Medium	276
Low	367
Unrated and Outside	120

Feed risk ratings:

Risk category	Total establishments
A	0
B1	43
B2	9
C	687

3.9 In respect of food hygiene, the Service Plan stated that 80% of food establishments in risk categories A-E would be inspected during the

year. The actual number of food hygiene interventions due was not provided. This approach is not in accordance with the requirement of the Food Law Code of Practice which requires that all due interventions are carried out. Further, the approach did not enable the authority to demonstrate a risk based approach to food hygiene interventions. Neither an estimate of the number of revisits that would be required nor the number of new businesses due their first inspection during the year had been provided. Quantifying the planned interventions programme will enable the authority to estimate the resources required against those actually available.

3.10 The demands placed on the food hygiene service by the port at Holyhead and the local shellfish industry, including the requirement for sampling of shellfish beds and sea water was highlighted in the Service Plan. However, no estimate of the resource implications of this work had been provided. Further, the Service Plan did not make reference to the authority's approved establishments of which 23 had been reported to the FSA.

3.11 The total officer resource available to deliver food hygiene official controls was not clear in the Service Plan which stated that four members of staff make up the food safety section supported by a Principal Environmental Health Officer. However, it became apparent during the audit that some of these officers spent a significant proportion of their time carrying out other duties.

3.12 The Food Standards interventions targets for 2014/15 were set out in the Service Plan. These were to undertake primary visits to 95% of high risk, 50% of medium risk and 20% of low risk establishments due for inspection. These targets did not accord with those required to meet the requirements of the Food Law Code of Practice. Whilst it was estimated that 10% of establishments would require revisits, an estimate of the number of new businesses that would require inspection during the year had not been provided. The resource available to carry out planned food standards interventions was one full time equivalent officer. An estimate of the actual resources required had not been made.

3.13 The authority provided a commitment in the Service Plan to undertake primary feed visits to 100% high risk, 50% of medium risk and 20% of low risk establishments. The number of feed establishments due for an

intervention or that had not previously been subject to an intervention was not indicated in the Service Plan. The planned arrangements did not, therefore, meet the requirements of the Feed Law Enforcement Code of Practice. It was estimated that 10% of establishments would require revisits. An estimate of the number of new feed businesses that would require inspection during the year had not been provided. Although an estimate of the resources required had not been made, it was stated in the Service Plan that a 0.4 full time equivalent officer resource was available for this work.

3.14 The authority's commitment to the Primary authority Scheme and Home authority Principle was emphasised in the Service Plan which stated that it would seek to establish formal Home authority arrangements with all relevant businesses on the island. Preliminary discussions had taken place with businesses with a view to entering into Primary authority Partnerships, although at the time of the audit none had been formalised.

3.15 Arrangements for food and feed sampling were detailed in the Service Plan. Sampling priorities for food hygiene, food standards and feed were identified together with an estimate of the number of samples to be taken and the resource implications.

3.16 A statement in relation to the authority's policy on the investigation of food poisoning notifications and outbreaks had been included in the Service Plan, together with an estimate of likely demand based on previous years. However, an estimate of the resources required to undertake this work had not been provided.

3.17 Statements on food/feed incidents, liaison with other organisations, food and feed promotional work, advice to business and food and feed complaints had all been included in service planning documents. Except in the case of complaints, the demand and resource requirements had not been indicated.

3.18 Arrangements for internal monitoring *'quality assessment'* were set-out in the Service Plan with an acknowledgement that this was an area for further development.

3.19 The costs of providing the food hygiene, food standards and feed services were not clear from the information provided in the Service Plan

as these were incorporated into the costs identified for Environmental Health and Trading Standards. Auditors explained the requirement to provide more detailed information on expenditure together with an examination of the trend of growth reduction.

3.20 The Service Plan included a review of 2012/13 achievements and areas for improvement in 2013/14 were identified. These included:-

- Ensuring targets for food hygiene interventions are met
- Working to deliver the collaborative North Wales Feed Service Delivery Plan
- Improved planning of the food standards interventions programme and more qualitative internal monitoring

Recommendations

3.21 The authority should:

(i) Ensure that future Food and Feed Law Enforcement Service Plans are developed in accordance with the Service Planning Guidance in the Framework Agreement. An analysis of the resources required against those available, and plans to address any shortfalls identified should be included. [The Standard – 3.1]

(ii) Address any variance in meeting the Service Plan in subsequent service plans. [The Standard-3.3]

4 Review and Updating of Documented Policies and Procedures

4.1 The authority had developed a range of documented policies and procedures to support the delivery of official food and feed controls. Some of these had been based on templates produced collaboratively by local authorities across Wales, others were specific to the Isle of Anglesey.

4.2 A document control procedure for the Environmental Health Commercial Section had the stated aim *"to ensure that all Food Safety related documents are familiar to staff and that versions of documents are up to date, thus avoiding the use of incorrect or superseded documentation."*

4.3 The Principal Environmental Health Officer (Commercial) was responsible for developing new policies and procedures, updating existing procedures, notifying officers of amendments to documents and ensuring the removal of superseded documents.

4.4 Although the control system for documentation relating to food standards and feed had not been documented, the Principal Trading Standards Officer ensured up to date copies of appropriate documentation were available, subject to regular review and that superseded documents were removed from use.

4.5 Auditors were able to verify that food and feed law enforcement officers had access to policies and procedures, legislation and centrally issued guidance electronically on a shared drive and on the internet. Controlled documents had been protected with read only access for officers.

4.6 There was evidence that policies and procedures had been subject to recent review and no superseded documents were identified during the audit.

5 Authorised Officers

Authorisation

5.1 The authority's scheme of delegation had been set out in its Constitution and provided the Head of Service – Planning and Public Protection with delegated powers to appoint and authorise officers, carry out formal enforcement and instigate legal proceedings. Some key pieces of legislation were not referred to in the constitution and auditors advised the authority to review the scope of the catch-all phrase at paragraph 3.5.1.11 of the Constitution with their legal department to ensure its adequacy.

5.2 The authority had a documented procedure for the authorisation of food and feed enforcement officers, which specified the authorising officer identified by the scheme of delegation. The procedure to authorise officers was based on an assessment of the competency of officers. The procedure required amendment to include reference to the arrangements for refresher training and the monitoring of newly qualified officers and officers returning to food after a period of absence, in accordance with the Codes of Practice.

5.3 The authority had put in place a Staff Development Plan which defined the broad training objectives for food hygiene, standards and feed services. These objectives included meeting the Continuous Professional Development (CPD) requirements of the Codes of Practice and addressing competency requirements. Each staff member received at least one annual appraisal meeting a year, at which their development needs were agreed with their line manager and formalised in an "Individual Learning and Development Plan".

5.4 The authority had appointed and authorised lead officers who had the requisite specialist knowledge, qualifications and training for food hygiene, infectious disease investigations, food standards and feed services.

5.5 The Service Plan had not identified the number of full time equivalent officers that had been allocated food hygiene work. The Service Plan review had identified that intervention targets had not been met,

indicating that the resources in place to deliver the full range of food hygiene controls had not been sufficient.

5.6 The food standards service had estimated the full time equivalent officer resource it had available as 1.00. Auditors found that intervention targets had not been met, indicating that the resources allocated to deliver the full range of food standards controls had not been sufficient.

5.7 The feed standards service had estimated the full time equivalent officer resource it had available as 0.4. Auditors found that there had been a significant shortfall in the number of due interventions carried out, indicating that the resources allocated to deliver the full range of feed controls had not been sufficient.

5.8 At the time of the audit one of the food hygiene officers had been allocated Civica administration work for a number of authority departments to meet the demand created by a lost administrative post. Auditors also noted the imminent departure of the Chief Environmental Health Officer Post to facilitate the creation of a shared managerial post with the food standards and feed service.

5.9 The authorisation and training records of 10 food hygiene, food standards and feed officers were examined by auditors.

5.10 All food hygiene officers were qualified, appropriately experienced and trained in accordance with their level of authorisation and duties. All relevant officers had received HACCP training, Annex 5 consistency training and had attended training on the FSA's Control of Cross Contamination Guidance. One food hygiene officer had only received one day's training according the authority's records, falling short of the requirement for 10 hours Continuous Professional Development. Three officers (including the lead food officer) were authorised to inspect high risk (A and B) establishments, serve Remedial Action Notices and Hygiene Emergency Prohibition Notices.

5.11 In respect of the food standards and feed officers, the level of authorisation and duties of officers was found to be generally consistent with their qualifications, training, experience and the requirements of the Code of Practice. Two officers were appropriately authorised to carry out

interventions at high risk food standards establishments and level 2 feed establishments, and both were qualified lead auditors.

5.12 Food standards and feed officers had not been authorised the enforce the Official Food and Feed Control Regulations 2009, and a Trading Standards enforcement officer authorised to carry out feed work was not qualified to do so, contrary to the Feed Law Enforcement Code of Practice. One food standards officer was found to have carried out two high risk inspections despite not being authorised to do so.

5.13 All food standards and feed officers had received the ten hours CPD training required by the Codes of Practice.

5.14 Training records were generally well maintained by the authority, although the records of five officers across all three service areas were missing some information and/or certification.

5.15 The FSA had authorised 17 of the authority's officers under the Food and Environment Protection Act 1985.

Recommendations

5.16 The authority should:

(i) Review and amend the authorisation procedure to include reference to the arrangements for refresher training and monitoring for newly qualified and returning officers, in accordance with the requirement of the Food Law Code of Practice. [The Standard – 5.1]

(ii) Review and amend food standards and feed officer authorisations to include the appropriate Official Feed and Food Control legislation to carry out the work set out in the Service Plan. Amend the authorisation of the unqualified Trading Standards enforcement officer to reflect their competency, in accordance with the Codes of Practice. Ensure the duties of food standards and feed officers do not exceed their authorisations. [The Standard – 5.3]

(iii) Appoint a sufficient number of suitably authorised food hygiene and food standards officers to carry out the work set out in the Service Plan and ensure that they are authorised under the appropriate legislation. The level of authorisation of feed officers should be consistent with their qualifications. [The Standard – 5.3]

(iv) Ensure that all authorised food hygiene officers receive 10 hours Continuous Professional Development training, in accordance with the Code of Practice. [The Standard – 5.4]

(v) Maintain records of the relevant qualifications, training and experience of each authorised officer and appropriate support staff in accordance with the relevant Codes of Practice. [The Standard - 5.5]

6 Facilities and equipment

6.1 The authority had most of the necessary facilities and equipment required for the effective delivery of food hygiene and food standards services, and for undertaking animal feed sampling activities. The equipment was appropriately stored and accessible to the relevant officers. A small number of items, infrequently required for feed sampling, were absent such as a chisel for solid material and tubes with accessories for sampling liquid materials.

6.2 A procedure for the calibration and maintenance of temperature measuring equipment had been developed for the food hygiene service. This procedure detailed the arrangements for ensuring that equipment, such as thermometers and refrigeration equipment were properly identified, assessed for accuracy and withdrawn from use when found to be defective. The procedure made reference to some testing frequencies and tolerances together with action to be taken where tolerances were exceeded. Testing frequencies were listed for some devices but not for others. The stated tolerance of 1ºC for thermometers was not in accordance with centrally issued guidance whilst operating temperatures were not set for refrigeration equipment.

6.3 Officers had been supplied with infra-red and probe thermometers, which were being calibrated using a reference thermometer, calibration test caps and against each other. Some equipment allocated to officers was calibrated at least annually. Records relating to calibration were being maintained by the authority.

6.4 An examination of records relating to five devices selected for audit confirmed that all devices had been calibrated and were operating within the appropriate tolerances. A refrigerator was found to be operating at a suitable temperature.

6.5 The authority's food and feed databases were capable of providing the information required by the FSA. A number of checks were carried out during the audit which confirmed that databases were operated in such a way to enable accurate reports to be generated.

6.6 The food and feed databases, together with other electronic documents used in connection with food and feed law enforcement services were subject to regular back -up to prevent the loss of data.

6.7 The authority had an Acceptable Usage Policy which 'defined the standards and compliancy for acceptable ICT usage'. The policy aimed to minimise damage by preventing or reducing the impact of security incidents. In respect of food and feed law enforcement services, officers had been provided with individual passwords, access for entering and deleting data had been restricted, and officers had been trained in the use of ICT.

Recommendations

6.8 The authority should:

(i) Ensure that the necessary facilities and equipment that are required for the effective delivery of all activities associated with the feed service are made available. [The Standard - 6.1]

(ii) Amend the documented procedure for calibrating temperature measuring equipment to include testing frequencies for all devices, operating temperatures for refrigeration equipment and ensure tolerances are applied in accordance with centrally issued guidance. [The Standard - 6.2]

7 Food and Feedingstuffs Establishment Interventions and Inspections

Food Hygiene

7.1 In 2013/14 the authority had reported through LAEMS that 92.07% of all category A-E rated food businesses due to be inspected had been inspected, and 95.88% of food businesses were 'broadly compliant' with food hygiene law (excluding unrated businesses and those outside the scope of the risk rating scheme).

7.2 The authority had developed a documented procedure aimed at establishing a uniform approach to carrying out official controls in respect of food hygiene interventions, which included a section on the approval of product specific food establishments. A Revisit Policy based on the model developed by the Wales Heads of Environmental Health (WHoEHG) Food Safety Expert Panel had also been recently adopted. An examination of these procedures confirmed that all made reference to relevant legislation, had been subject to recent review and updating, and were in accordance with the requirements of the Food Law Code of Practice and relevant centrally issued guidance.

7.3 Information supplied by the authority from its food establishment database during the on-site audit indicated that there were a total of 151 establishments, excluding unrated businesses, which were overdue an official control intervention by more than 28 days. A total of 98 of the overdue establishments were categorised as higher-risk (A, B or C rated), including five that were category B rated. All of the higher-risk establishments had been due for inspection within a period of 10 months preceding the audit. The authority advised that targets for undertaking inspections of food establishments were not being achieved due to the absence of one officer and the reassignment of duties of another officer.

7.4 The remainder, i.e. 53 establishments that had been identified as being overdue were lower-risk and had all been programmed to receive an intervention with the past 12 months.

7.5 Auditors were advised that the authority had a system for proactively managing interventions at new businesses. The system involved inputting food establishment details onto the database on receipt of

completed food registration forms, and officers actively monitoring these businesses, using local knowledge to identify when they begin trading. It was noted that the date when the authority first became aware of a business trading was not being captured on the database. Auditors discussed the benefits of routinely recording this information to assist with accurately reporting its performance in managing interventions at new businesses.

7.6 A Food Hygiene Routine/New Premises Inspection form had been developed by the authority to assist officers in their inspections of food businesses by providing a structured approach. The inspection form contained all the necessary elements to facilitate carrying out checks on compliance with legal requirements in accordance with the Food Law Code of Practice. A Food Premises Inspection Record sheet had also been produced for use in undertaking inspections of category C–E rated establishments that had not been subject to changes to their operations since the last visit. However, the record sheet did not set-out the aspects of a food business which an officer should consider in their assessment of compliance or ensure consistency in the approach to the inspection process.

7.7 During the audit an examination of records relating to 10 food establishments was undertaken. The file histories for six establishments confirmed that in recent years they had been inspected at the frequencies required by the Food Law Code of Practice. However, the remaining four establishments, which were categorised as higher-risk, had not been inspected at the required frequencies. The delay between inspections ranged from five weeks to six months beyond the due date. The Food Law Code of Practice requires that interventions take place within 28 days of their due date.

7.8 Inspection records were available and legible for the 10 food establishments audited. In five cases the latest inspection had been undertaken by officers using the Food Hygiene Routine/New Premises Inspection form. The information recorded by officers on these inspection forms was sufficient to demonstrate that a comprehensive assessment of business compliance in respect of requirements relating to Hazard Analysis Critical Control Point (HACCP) had been undertaken.

7.9 In these five cases auditors were also able to confirm that officers had undertaken an adequate assessment of hygiene training of food handlers, and that discussion with individuals other than the food business operators had taken place. Further, there was evidence that officers had undertaken an appropriate assessment of the effectiveness of cross contamination controls. However, the authority was unable to demonstrate that consideration had been given to imported foods or that foods had been subject to incoming traceability checks.

7.10 In respect of the records examined for the other five establishments, the latest inspection had been undertaken by officers using the Food Premises Inspection Record sheet. However, in four cases auditors were unable to determine the scope of the inspection. In addition, the information recorded by officers on the record sheet was not sufficient to identify the food activities undertaken by the business or to demonstrate that a thorough assessment of compliance with requirements relating to HACCP, hygiene training of food handlers, cross contamination controls and traceability had been undertaken. In the remaining case, it was evident that an adequate assessment of compliance had taken place, having regard to the low-risk nature of the food operations carried out.

7.11 In all but one case, letters had been sent to the business within 14 days of the inspection, as required by the authority's procedures. The delay in that case had been four days.

7.12 The risk rating categories applied to establishments were generally consistent with the potential hazards associated with the businesses and the officers' assessment of compliance. Nonetheless, auditors noted that in seven cases officers were applying scores of '5' under the business compliance categories, despite not having identified any contraventions. This is contrary to the Food Law Code of Practice.

7.13 The risk rating history of one of the establishments examined had changed following the latest inspection, which had resulted in a reduction of risk category. However, the reason for revising the risk rating was not documented contrary to authority's procedure and the Food Law Code of Practice.

7.14 The authority's Food Hygiene Revisits Policy stated that, 'Generally any food business assessed as not being 'broadly compliant' with food

hygiene legislation will be subject to revisit(s) together with any necessary enforcement action, with the aim of achieving compliance.' Included within the policy are criteria relating to the timing of revisits, based on the food hygiene rating applied to a business.

7.15 In the 10 cases examined, the authority had identified that one of the establishments required a revisit. A record was available to confirm that a revisit had been carried out, but this had taken place some five months following the discovery of the contraventions contrary to the authority's revisit policy. Auditors noted that in another case, where a rating of 2 had been applied under the Food Hygiene Rating Scheme (FHRS), the establishment had not been identified for revisit, as required by the revisit policy.

7.16 In the two cases where the need for follow-up action was required to address significant and/or on-going contraventions, it was noted that in one case relevant information had been recorded in the 'Are there any significant on-going issues?' section of the inspection form. In the other case, in which on-going issues relating to food safety management had been identified, these had not been highlighted/red-flagged on the establishment file in accordance with the authority's procedure.

7.17 The authority had informed the FSA prior to the audit that there were 23 approved establishments in its area. The records relating to nine of these were examined; but it was ascertained that two of these related to separately approved activities undertaken at the same establishment. Records pertaining to these two approvals were reviewed together.

7.18 Approved establishment files contained most of the information required by the Food Law Code of Practice and centrally issued guidance, but in a minority of cases synopses, training matrices, raw material, product or water test results, and customer/product lists, were either unavailable or had not been kept up to date.

7.19 Inspection histories of the approved establishments confirmed that in recent years all had been inspected at the frequencies required by the Food Law Code of Practice. Inspections had been undertaken using the appropriate record form and in all cases the information captured by officers was sufficient to confirm that a full scope inspection, which considered all aspects of the establishment, including structure, food

safety management and management arrangements had taken place. However, in four cases the officer had not recorded the range of products produced by the businesses.

7.20 Procedures for issuing approvals in accordance with official controls regulations had been correctly followed by the authority in all but one case. In this particular instance, relating to a business for which conditional approval had been granted, a revisit to check compliance with operational requirements had not taken place within three months. Full approval was later granted following a second visit made to the establishment within six months of the conditional approval.

7.21 The risk ratings that had been applied to the approved establishments were consistent with the inspection findings. In one case auditors noted that the 'type of food and method of handling' score did not appear to correspond with the products produced or operations carried out at the establishment. Nonetheless, the officer was able to provide a satisfactory explanation for applying an alternative score for this element of the risk rating assessment.

7.22 An Alternative Enforcement Strategy (AES) for maintaining surveillance of category E rated establishments had been developed and was being implemented by the authority. The approach to AES contained within the Food Interventions Procedure consisted of issuing a questionnaire to eligible businesses which would be assessed by an Environmental Health Officer (EHO) on their return in order to determine whether an inspection was required. However, auditors noted that the procedure did not set-out criteria against which completed questionnaires were to be assessed or specify the action to be taken for non-responses.

7.23 In addition, the questionnaire did not facilitate the collection of all necessary information to enable the authority to identify any changes to the potential hazards associated with a business, specifically the number of consumers at risk if there was a failure of food hygiene procedures. Further, auditors advised the authority of the benefits of requesting additional details from business operators in respect of implementation of any food safety management procedures.

7.24 Records of 10 establishments that had been subject to AES were examined. Auditors noted that all businesses had been sent the relevant

questionnaire and that these had been completed and returned in all cases. However, six out of the 10 establishments had been inappropriately subject to an AES, as four of these had not previously received a primary inspection and the other two were category C and D rated. The Food Law Practice Guidance states that, an establishment must have been subject to an initial formal inspection and subsequently determined to be low-risk (category E rated) for it to be included in an AES.

7.25 In all cases there was no evidence that the completed questionnaires had been assessed by an EHO. Further, as information relating to the business customer base had not been requested, it was not always possible for auditors to verify whether the AES should have triggered a visit.

Recommendations

7.26 The authority should:

(i) Ensure that food establishment interventions/inspections are carried out at the minimum frequency specified by the Food Law Code of Practice. [The Standard -7.1]

(ii) Ensure that full inspections and alternative enforcement strategies are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]

(iii) Assess the compliance of establishments in its area to the legally prescribed standards; and take appropriate action on any non-compliance found, in accordance with the authority's Enforcement Policy. [The Standard -7.3]

(iv) Amend its Food Interventions Procedure in respect of Alternative Enforcement Strategies (AES) to include details of the criteria against which completed questionnaires are assessed and to set out the triggers for undertaking another type of intervention. [The Standard – 7.4]

(v) Ensure observations made in the course of an inspection, in particular relating to checks carried out to verify the source of foods and to demonstrate that consideration has been given to imported foods, shall be recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]

Verification Visits to Food Establishments

7.27 During the audit, verification visits were made to two food establishments with authorised officers of the authority who had carried out the last food hygiene inspections. The main objective of the visits was to consider the effectiveness of the authority's assessment of food business compliance with food law requirements.

7.28 The officers were knowledgeable about the businesses and possessed an appropriate understanding of the food safety risks associated with the activities at each establishment. The officers demonstrated that they had carried out a detailed inspection and had appropriately assessed compliance with legal requirements and centrally issued guidance, and were offering helpful advice to the food business operators.

7.29 The findings of the previous inspection, detailed on the records held on file, reflected the conditions observed at the establishment.

Port Health Interventions

7.30 The authority had a port at Holyhead at which a variety of roll-on roll-off ferries, cargo vessels and cruise ships docked, all of which featured in the list of interventions selected by auditors. The port accommodated arrivals from EU and Irish ports together with the occasional vessel arriving from a third country. Holyhead did not receive any third country food imports and had been designated as a dormant Border Inspection Post.

7.31 The authority had put in place a documented procedure governing ship sanitation inspections, which included food hygiene interventions. The procedure was in accordance with the requirements of the Food Law Code of Practice.

7.32 Auditors examined 10 ship intervention records. The authority was carrying out ship inspections in accordance with recognised Association of Port Health authority (APHA) Practices and the International Health Regulations.

7.33 The authority was using the APHA aide-memoire and its own inspection form. In a small number of cases the absence of the APHA form left the auditors unable to find evidence of the time of inspection or the report having been communicated to the Master, owner or shipping company/operator.

Recommendations

7.34 The authority should:

(i) Ensure that vessel inspections are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]

(ii) Ensure observations made in the course of an inspection, are recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]

Food Standards

7.35 In 2012/13 the authority had reported through LAEMS that there were no high risk or medium risk food standards interventions overdue. Five low risk food standards interventions remained outstanding.

7.36 At the time of the audit, a programmed intervention was overdue for 141 low risk establishments, 153 medium risk and 33 high risk establishments. Interventions were overdue for 166 unrated establishments, approximately 38 of which were medium risk and the remainder low risk.

7.37 The authority had a food standards interventions programme for 2014/15 which was detailed in the Service Plan.

7.38 Auditors noted that food establishments had been designated as non-inspectable risk without always having received an initial inspection. A number of these businesses were identified as potentially medium risk.

7.39 The food standards service reported that it did not operate an AES.

7.40 Although the authority was hoping to move towards implementation of the National Trading Standards Board (NTSB) risk-rating scheme in the future, at the time of the audit it was using the 2004 Local authority Co-

ordinating and Regulatory Services body (LACORS) Trading Standards Risk Assessment Scheme, which was not compatible with the risk rating scheme laid down in the Food Law Code of Practice.

7.41 The authority had developed three aide memoire based on the LACORS templates, one for 'general inspections' which had no reference to food inspection, one for 'manufacturing businesses' and another for 'non-manufacturing businesses'. The authority had set up, implemented and was maintaining a food standards retail inspection activity procedure and a food manufacturing inspection activity procedure.

7.42 The authority did not have a documented revisit policy. It appeared that inspections were generally carried out unannounced but there was no clear policy on the criteria to be applied when carrying out announced inspections. The authority should establish and document both policies to support clarity and consistency.

7.43 Auditors examined 10 establishment histories for the food standards service. One was discounted from further examination as it had been incorrectly reported as a food intervention. Another was discounted as it had not begun trading.

7.44 The use by the authority of the LACORS risk rating scheme made it impossible in most cases to be certain that inspections were being carried out at the frequency required by the Food Law Code of Practice, as the two schemes are incompatible. Two establishments had registered with the authority seven months and six years respectively before receiving their first inspection. These delays were contrary to the intervention frequencies specified in the Code of Practice.

7.45 All inspections had been carried out by an appropriately authorised officer, with the exception of one high-risk establishment which had been inspected in 2014 by an officer only authorised to inspect medium and low risk establishments.

7.46 The authority clearly indicated through inspection records that compliance with food labelling requirements was being assessed. Aide-memoire had been used and a report had been left on site or sent after the most recent inspection in all cases. However, inspection records did not generally reflect in sufficient detail the scope and depth of

observations made and/or data obtained in the course of an inspection, contrary to the Code of Practice. Missing information included records of an assessment of compliance with presentation requirements (three of the eight cases), evidence of an assessment of the compliance of the business with supplier specifications (four of five relevant cases) and evidence of an assessment of the existence and effectiveness of a quality management system and an assessment of compliance with composition requirements (seven of the eight cases).

7.47 Records were not made in any case of an assessment of traceability requirements, product recall/withdrawal arrangements, nor an assessment of imported food handling. In all eight cases, officers had failed to record the details of other businesses supplying, producing for, importing for or buying from the business. A failure to record adequate inspection/intervention information compromises the ability of the authority to assure consistency and effectiveness of official control and enforcement over time.

7.48 The appropriate follow-up of significant contraventions had been carried out in all but one case where a number failures to comply with labelling and durability indication requirements over two consecutive inspections had not been followed up between inspections. The most recent inspection indicated that compliance had now been achieved.

7.49 Observations recorded in the course of an inspection were legible in all cases. The authority was able to demonstrate that there was an intervention record filing system in place which was accessible to all officers, however not all contemporaneous records were stored in this filing system. Officers often used their PACE notebooks which contained unique information not copied into the filing system, which were kept locked in desk drawers in their absence, making them inaccessible to colleagues.

Recommendations

7.50 The authority should:

(i) Ensure that food standards interventions are carried out at a frequency not less than that determined under the intervention rating scheme set out in the Food Law Code of Practice. [The Standard -7.1]

(ii) Implement a food standards intervention risk rating scheme which is in accordance with the scheme established under annex V of the Food Law Code of Practice. [The Standard -7.2]

(iii) Provide food businesses with a report after each inspection/intervention, develop and implement an intervention policy for unrated and "non-inspectable risk" food standards establishments, ensure that food standards establishments are only inspected by appropriately authorised officers and ensure that announced visits and revisits are carried out in accordance with the relevant legislation, Code of Practice, centrally issued guidance and the authority's own policies and procedures. [The Standard -7.2]

(iv) Take appropriate action on any non-compliance found at food standards establishments, in accordance with the authority's enforcement policy. {The Standard -7.3]

(v) Set up a revisit policy which accords with the Food Law Code of Practice. [The Standard – 7.4]

(vi) Ensure that officers' contemporaneous records of food standards interventions are recorded in a timely manner and stored in such a way that they are retrievable. [The Standard -7.5]

Verification Visits to Food Establishments

7.51 During the audit, two verification visits were made to food manufacturing businesses with the authorised officers of the authority who had carried out the last food standards inspection. The main objective of the visits was to consider the effectiveness of the authority's assessment of food business compliance with food law requirements.

7.52 Both officers had a good level of understanding of the businesses. The visits provided assurance that officers were undertaking an assessment of compliance of establishments and systems to the legally prescribed standards. A report had been left on site or sent after the inspection in both cases.

Feed establishments

7.53 Information provided in the authority's Service Plan 2014/15 and the annual feed return 2012/13 (updated December 2013) indicated inconsistencies within each document in the number of feed establishments within the authority's boundary. In pre-audit information, the database report indicated that there were 638 registered feed establishments within the authority, all of which had received a risk rating; including five establishments approved by DEFRA for placing medicated feed on the market.

7.54 Auditors identified problems with the configuration of risk rating data. Only 37 establishments had been risk rated following an appropriate visit by a qualified officer. 28 visits had been risk rated using a scheme which incorporated an assessment of non-feed activities and so was not compatible with Annex 5 of the Feed Law Enforcement Code of Practice (FLECP)(including some of the above) and the remaining majority of establishments had been rated using National Trading Standards Board (NTSB) specified rating maps without being subject to a visit by an officer. The latter was as a result of an exercise to apportion a risk rating under the NTSB scheme to all establishments. All establishments not rated following a primary inspection by a qualified officer remained overdue for an inspection, regardless of the due date indicated from their rating. The exact number remained unidentified but was in the region of 600 establishments. Further, 169 animal health visits (where feed was considered) had been undertaken by an unqualified officer.

7.55 The authority had developed procedures, in the form of activity documents, for some types of feed inspections. Activity documents for the inspection of retail and farm establishments provided limited information on how to undertake inspections of such establishments and referred to the use of the inspection report forms. The activity documents contained a statement specifying that inspections should be by appointment within 48 hours of the inspection contrary to the Feed Law Enforcement Code of Practice, which requires unannounced visits and only allows 48 hour notification in certain circumstances. The procedures required more detail of the work to be covered by officers during an inspection.

7.56 The authority had not developed procedures for dealing with co-products establishments, imported feed or applications for feed approvals and registrations. Whilst not all of these activities were taking place in the County, the authority would benefit from development of the procedures in the event that the demand arises.

7.57 File checks were carried out on 10 establishments indicated in pre-audit material as having been subject to an inspection. Only eight of those files related to feed visits to establishments whilst one had been an attempted inspection on an establishment that had closed and one had no feed activity following a visit for other matters. Five of the 10 establishments had been subject to inspections by an appropriately qualified officer whereas, three establishments had been subject to a registration activity review by an unqualified officer. All 10 establishments had received an NTSB rated inspection risk rating, but in the case of the five that had not been inspected, this was contrary to the FLECP. All five establishments that had received a primary inspection had received timely visits; contemporaneous inspection records for all but one were legible and retrievable. FSA inspection forms were being used to capture information during inspections and information on the key assessments required to be made was available in all but one inspection where no record was available.

7.58 Information on the size and scale and type of establishment was available on the database or hard copy file in seven cases. Of the inspected establishments, risk ratings were appropriate to the activities taking place.

7.59 Auditors examined the consistency of records between database and hard copy files. Aside from the five cases of application of risk ratings without inspection, in two inspection records officers had indicated that there was a need for follow-up, for which there was no further record.

7.60 Inspection records and verification visits demonstrated that the authority had, generally, assessed the compliance of food business establishments and systems to the legally prescribed standards.

7.61 Auditors identified that the need for further follow-up action was required in four cases, to address contraventions or undertake further investigation. In one case, a further primary inspection did not take place where this was indicated following a registration review. Of the remaining three cases, a revisit took place in only one case. Furthermore, in two of the cases requiring a revisit, significant contraventions had been identified which had not been communicated in a letter to the feed business operator contrary to the Enforcement Policy.

7.62 The authority was not operating an AES for low risk establishments.

Recommendations

7.63 The authority should:

(i) Ensure that feed establishment interventions and inspections are carried out at the frequency specified by the Feed Law Enforcement Code of Practice. [The Standard - 7.1]

(ii) Carry out inspections / interventions and approve or register feed establishments in accordance with relevant legislation and the Feed Law Enforcement Code of Practice and centrally issued guidance. [The Standard - 7.2]

(iii) Ensure appropriate action is taken to follow up non-compliance in accordance with the Enforcement Policy. [The Standard – 7.3]

(iv) Ensure documented procedures relating to inspection of feed establishments are fully developed in accordance with the Feed Law Enforcement Code of Practice. Develop documented procedures for interventions relating to co-products establishments, imported feed, applications for feed approvals and registrations. [The Standard – 7.4]

(v) Ensure that all observations made in the course of interventions are recorded in a timely manner and officers' contemporaneous records of interventions are stored in such a way as to be retrievable. [The Standard – 7.5]

Feed Establishment Verification Visits

7.64 During the audit, verification visits were made to two feed businesses with authorised officers of the authority, who had carried out the last feed inspection. The main objective of the visits was to assess the effectiveness of the authority's assessment of feed business compliance with feed law requirements.

7.65 The officers demonstrated a good knowledge of the establishments and the operations carried out and it was evident that thorough assessments

of the key issues had been undertaken. In one case, the reality visit confirmed the findings of the file check that the authority should ensure it has maintained a record of key assessments made during the inspection on file. The second reality visit confirmed the findings of the file check that the authority should ensure appropriate follow up action is taken in accordance with the Enforcement Policy and revisit to ensure compliance has been achieved.

8 Food, Feed and Food Establishment Complaints

8.1 The food hygiene service had a documented Food Complaints Procedure, based on that developed the Wales Heads of Environmental Health Food Safety Expert Group. The procedure outlined the arrangements for liaison with Home, Primary and Originating authorities, the single liaison body and the actions to take on receiving a complaint relating to products originating in “third countries”, in accordance with the requirements of the Framework Agreement. Appended to the procedure was an advice leaflet for complainants.

8.2 Although there was no procedure for dealing with complaints about the condition of food establishments, the Service Plan stated that the food hygiene service had a target response time of five working days to complaints about both food and hygiene of establishments.

8.3 The food standards/feed service had a documented Food and Feed Complaints Policy and procedure. The procedure outlined the arrangements for liaison with Home, Primary and Originating authorities, the single liaison body and the actions to take on receiving a complaint relating to products originating in “third countries”, in accordance with the requirements of the Framework Agreement.

8.4 Complaints about the condition of feed establishments were not included within the scope of the procedure. The food standards and feed service had a target response time of three working days for food/feed complaints.

8.5 The authority also had in place short supplementary feed and food procedures detailing the information to be recorded on receipt of a complaint.

8.6 Auditors examined 10 food hygiene complaints and 10 food standards complaints. The authority had received no feed complaints in the two years prior to the audit.

8.7 In all cases the authority had recorded details of the complainant, complaint and implicated food business and had maintained contact with the business.

8.8 All food hygiene complaints had been responded to within the authorities target of five days. The investigations had been carried out in accordance with the Food Law Code of Practice and the authority's own procedure in all but one case concerning an alleged food poisoning where insufficient consideration had been given to the validation of food safety management by the officer while at the implicated establishment. Appropriate action had been taken by the authority in all cases.

8.9 All food standards complaints had been responded to within the authority's target first response time. The investigations had been carried out in accordance with the Food Law Code of Practice and the authority's own procedure and appropriate action had been taken in all but one case, where a member of the public had suffered illness as a result of being misled about the nut content of a meal. There had been an unacceptable delay in the officer visiting the implicated establishment and the follow-up of the complaint had been inadequate when subsequent interventions and testing had found that the contravention had been repeated. The authority had taken no enforcement action contrary to its own Enforcement Policy and procedure. No authorised departure from the policy had been recorded.

Recommendations

8.10 The authority should:

(i) Review and update the complaints procedures to include reference to complaints against food and the condition of feed establishments. [The Standard – 8.1]

(ii) Investigate complaints received in accordance with the Food Law Code of Practice, centrally issued guidance and its own policy and procedures. [The Standard – 8.2]

(iii) Take appropriate action on complaints received in accordance with the authority's Enforcement Policy. [The Standard – 8.3]

9 Primary authority Scheme and Home authority Principle

9.1 The authority's policy supporting the Primary authority Scheme and Home authority Principle was set-out in the Service Plan. One of the objectives of the food standards and feed service was 'to promote the use of the concept of the Home authority Principle and Primary authority to businesses on the Isle of Anglesey in relation to responsibilities under food safety /agricultural standards legislation'.

9.2 Key officers had attended Primary authority training and auditors were able to verify that food and feed law enforcement officers had been provided with passwords to enable them to access the Primary authority website.

9.3 At the time of the audit the authority was not acting as a Primary authority for any food businesses.

9.4 Reference had been made to Primary authority considerations in some work procedures, including the Food and Feed Enforcement Procedures, the Hygiene Improvement Notices Procedure and the Food/Feed Complaints Procedure.

9.5 The authority had a formal Home authority Agreement in place with one local food manufacturer and was acting in accordance with Home authority principles to support a further four. Records examined during the audit demonstrated that the authority had responded to requests for advice from these businesses and from other local authorities.

9.6 Although the authority had no Primary authority agreements in place, auditors were able to verify that, in its capacity as an enforcing authority, it had regard to Primary authority guidance and followed up matters of concern with Primary Authorities, as appropriate.

10 Advice to Businesses

10.1 The authority had been proactive in providing food hygiene, food standards and feed advice to businesses. It demonstrated its commitment to assisting local businesses to comply with the law in delivering a number of initiatives which included:

- Advisory packs for new businesses
- Attendance at a local Food Business Forum
- Business advice sessions
- Work with the Food Technology Centre to raise awareness of food standards
- Provision of a newsletter for farmers in conjunction with other local authorities in North Wales

10.2 Technical advice was being provided to businesses in respect of which it acted as Home authority.

10.3 Comprehensive food standards and food hygiene advice for businesses was provided on the authority's website.

10.4 The authority had accessed FSA funding to assist businesses in developing their food safety management systems.

10.5 There was evidence that advice was provided to businesses during inspections as well as on request.

11 Food and Feed Establishment Database

11.1 The authority had procedures in place to ensure that its food and feed establishment databases were up to date and accurate.

11.2 The procedures provided details of the methods that would be used in ensuring accuracy, which included routine checks of planning applications, surveillance by officers during inspections, checks on social media and cross referencing records held by the authority on care homes, child-minders and nurseries.

11.3 Auditors selected 11 food establishments and two feed establishments located in the authority's area from an Internet search. All but two food establishments were found to be included on the authority's food establishment database, registered, and included in the food hygiene interventions programme. Four of the establishments had not been included in the food standards interventions programme. One of the two feed establishments had not been recorded on the authority's feed database, registered or included in the feed interventions programme.

11.4 Work to improve the feed establishment database had been identified by the authority as a priority. Progress was being made and work was ongoing to ensure its accuracy.

Recommendation

11.5 The authority should:

(i) Maintain its database of food and feed establishments, ensuring food and feed businesses are properly registered and included in the food and feed interventions programmes. [The Standard – 11.1]

12. Food and Feed Inspection and Sampling

12.1 The Service Plan 2014/15 contained aims and objectives that made specific reference to the monitoring and sampling of food and feedingstuffs to ensure compliance with statutory requirements. In respect of microbiological sampling, the plan stated that the authority took samples at food and feed establishments as part of co-ordinated national and regional projects.

12.2 The authority had developed a Food and Feed Sampling Policy that outlined its approach to the sampling of food and feedingstuffs and the factors taken into account in formulating the sampling programme. However, the policy did not make reference to Primary or Home Authorities.

12.3 A Food Sampling Procedure which described how and when microbiological samples should be taken had been adopted. The procedure, based on the model developed by the Wales Food Safety Expert Panel was in accordance with the Food Law Code of Practice and relevant official guidance. Further, the authority's Food Interventions Procedure indicated that officers should undertake an assessment of the need to take samples during an intervention.

12.4 A procedure for taking formal food standards samples and a Feed Sampling Procedure had also been developed by the authority. These documents both made reference to relevant Codes of Practice, guidance and legislation. The authority did not have a procedure which documented its approach to taking informal food standards samples.

12.5 The authority had produced separate food hygiene, food standards and feed sampling programmes, the contents of which reflected the criteria for sampling food and feedingstuffs, as referenced in the 2014/15 Service Plan. These programmes had regard to the FSA's National Enforcement Priorities and were consistent with the programme set-out in the North Wales Trading Standards Services Animal Feed Service Delivery Plan 2014/15. Auditors discussed the benefits of including additional information in the food standards sampling programme, such as an estimate of the number of samples to be taken in the year ahead.

12.6 In addition to funding its own sampling, the authority had previously applied for grants from the FSA to fund food hygiene and feedingstuffs sampling activities.

12.7 The authority had appointed a Public and Agricultural Analyst for carrying out examination and analysis of food and feed samples, and had a formal agreement in place with Public Health Wales (PHW) for the microbiological analyses of food. The appointed laboratories were both accredited by UKAS and were on the FSA list of UK designated Official Laboratories.

12.8 During the audit, records of 10 samples submitted for microbiological analysis were examined. The details of samples obtained, the results of analysis and correspondence notifying businesses of the outcome were available in all cases. With regards to the sample results, six were satisfactory, two were border-line and two were unsatisfactory. Where follow-up to investigate sampling results was required, appropriate action had taken place in three of the four cases. In the remaining case, relating to an unsatisfactory sample, contact had been made with the business by telephone to provide advice, but no further investigation had ensued. None of the unsatisfactory results related to pathogenic bacteria. Two of the four cases related to foods supplied by businesses with Primary authority Partnerships, but there was no record of the authorities having been informed of the results.

12.9 Records relating to 10 food standards and 10 feed samples were selected for audit. However, the information relating to one of the food standards samples was not retrievable. In respect of eight of the nine food standards samples and all of the feed samples examined, the results of analysis had been uploaded onto UKFSS and were also available in hardcopy. Where results indicated that follow-up action was required, there was evidence that investigations had been carried out. It was not possible to ascertain whether follow-up was required in the one case, where the results of sampling were not supplied.

12.10 Audit checks confirmed that all microbiological, food standards and feed samples had been taken by appropriately trained and authorised officers.

Recommendations

12.11 The authority should:

(i) Amend the Food and Feed Sampling Policy to include reference to its approach to notifying/liaising with Primary and Home Authorities. [The Standard – 12.4]

(ii) Set-up, maintain and implement a documented procedure for the procurement or purchase, continuity of evidence and the prevention of deterioration or damage of informal food standards samples in accordance with the Food Law Code of Practice and relevant centrally issued guidance. [The Standard – 12.5]

(iii) Take appropriate action in accordance with its Enforcement Policy where food hygiene sample results are not considered to be satisfactory. [The Standard – 12.7]

13 Control and Investigation of Outbreaks and Food Related Infectious Disease

13.1 The authority had identified a lead officer for communicable disease and had been represented at events as part of the Wales Lead Officer Training Programme. The authority had also developed a procedure for dealing with outbreaks in the form of an Outbreak Control Plan in consultation with relevant stakeholders which had been approved for adoption by the appropriate elected member. The plan was based on a template that had been produced by a multi-agency group, including Public Health Wales and Welsh Government.

13.2 The Outbreak Control Plan required updating to include the details of key local contacts in the event of an outbreak.

13.3 The Service Plan detailed the out of hours arrangements for handling outbreaks or notifications of infectious disease.

13.4 A procedure for investigating sporadic cases of foodborne disease had been developed in association with all relevant organisations. It was supported by a range of advisory leaflets and questionnaires. The procedure included reference to all key areas of investigation with the exception of food sampling.

13.5 Notifications relating to 10 cases of food related infectious diseases were examined. One case related to a familial outbreak, however this had not been reported as an outbreak prior to the audit.

13.6 Investigations were generally timely and thorough, however a delay of five days had taken place in the investigation of one high risk infection, contrary to procedure. In another two cases, investigations of high risk infections had only partially been completed before questionnaires were sent to families for completion, rather than those investigations being completed by the investigating officer. Records of investigations were generally comprehensive with the exception of one high-risk case where the food history was not completed on a case interview questionnaire. In all cases appropriate follow up action had been taken where this had been identified as necessary.

13.7 All records relating to the control and investigation of outbreaks and food related infectious disease had been kept for at least 6 years.

Recommendations

13.8 The authority should:

(i) Amend the Outbreak Control Plan to ensure that it includes the relevant local authority contacts. [The Standard – 13.1]

(ii) Further develop the documented procedure for investigation of infectious diseases to include reference to sampling and ensure the procedure is fully implemented. [The Standard -13.2]

14 Feed and Food Safety Incidents

14.1 The authority had documented procedures which provided guidance for food and feed law enforcement officers in responding to Food Incidents, Food Alerts for Action and Product Withdrawal/Recall Information Notices, including those received outside normal office hours. The procedures made reference to the Rapid Alert System for Food and Feed (RASFF).

14.2 The authority had a computer system that was capable of receiving notifications and it was stated in the procedure that *'actions taken in response to Action Alerts should be recorded so that it is retrievable for possible follow up action or audit by the FSA'.*

14.3 The procedures stated that the Principal Environmental Health Officer (Commercial) and the Principal Trading Standards Officer were responsible for their effective operation. The procedures included the authority's arrangements for alerting the FSA where an actual or potential food hazard was identified locally.

14.4 Auditors examined records in respect of six food alerts for action issued during the previous three years. All had been promptly received and responded to in accordance with FSA advice. There was evidence that effective liaison had taken place between officers of the food safety team and Food Standards officers where appropriate.

14.5 Action taken by the authority had been detailed on the authority's database. All correspondence, including officer emails relating to food alerts had been maintained on file and was easily retrievable.

14.6 In the two years preceding the audit the authority had not identified any food or feed incidents or hazards locally for notification to the FSA. However, auditors have identified a food complaint in this report which should have been reported to the FSA as a serious localised food hazard.

Recommendations

14.7 The authority should:

(i) Notify the FSA of any serious localised food hazards in accordance with the Food Law Code of Practice. [The Standard – 14.5]

15 Enforcement

15.1 The authority's Public Protection Service had developed an "Enforcement Policy" which had been endorsed by the relevant Cabinet Member in June 2014. The policy promoted a proportionate, risk-based and graduated approach to enforcement and set out the criteria to be applied by officers in deciding the appropriate enforcement sanction. The policy made reference to the outdated Home Office guidance on simple cautions rather than the Ministry of Justice guidance which has replaced it. The policy did not make reference to the approach to enforcement at its own establishments.

15.2 The Public Protection Service Enforcement Policy was not available on the authority's website at the time of the audit. The policy was available to members of the Public at the authority's offices.

15.3 A number of environmental health enforcement procedures had been developed and recently reviewed. The environmental health Hygiene Improvement Notices procedure, Remedial Action Notices procedure, procedures to direct the service of notices to deal with illegally imported food and Hygiene Emergency Prohibition procedure were all found to be in compliance with the Food Law Code of Practice and official guidance.

15.4 The authority had developed a documented procedure for the detention, seizure and voluntary surrender of food found to be in contravention of the food safety requirements. The procedure was generally in compliance with the Food Law Code of Practice, however, in circumstances where food is certified as unsafe, it would benefit from a clarification of whether sampling of the food should be required. The procedure made no reference to the method of disposal to be applied to unsafe food which has been permanently removed from the market by the authority.

15.5 An investigation and enforcement procedure had been developed by the food standards and feed services and this prescribed the information to be included in prosecution and simple caution files. The authority would benefit from further developing the procedure to prescribe the implementation and documentation of Criminal Procedure and Investigations Act (CPIA) disclosure roles and to prescribe the need to document a consideration of the authority's enforcement policy and the

relevant legal tests. The feed service had not developed any illegally imported feed procedures. Further, there was no procedure for the suspension or withdrawal of feed approvals.

15.6 A procedure had not been developed for undertaking prosecutions or simple cautions for food hygiene cases.

15.7 The authority had reported in pre-audit documentation that five Hygiene Improvement Notices (HINs) had been served in the two years prior to the audit. All been served by the same officer on the same day at the same establishment.

15.8 Hygiene Improvement notices had been signed by an appropriately authorised officer who had witnessed the contravention. In all cases the notices had been the appropriate course of action and had been served on the food business operator. All notices contained the food business operator's full name and details of the regulation contravened. The reason for the notice and the measures to be taken were clear in every case. Time limits were appropriate and appeal details were included with the notice.

15.9 Timely checks on compliance with Hygiene Improvement Notices had been carried out in four of the five cases. Four notices had been complied with at the time of the first revisit, however the food business operator had not been issued with written confirmation of compliance, contrary to the Food law Code of Practice.

15.10 The notice which had not been complied with had been extended without written application being received from the food business operator and had not been cancelled and re-issued, contrary to the Code of Practice. The authority had not carried out any further follow-up to confirm compliance with the notice following the expiry of the informal extended compliance deadline.

15.11 The authority had not reported carrying out any voluntary surrenders, food detentions, seizures or certifications nor served any RANs, HEPNs, voluntary closures or imported food and feed notices in the two years prior to the audit.

15.12 One prosecution for food standards offences had been instigated by the authority in the two years prior to the audit. The prosecution had been an appropriate course of action and had been approved by an officer with the proper authorisation. This officer undertook the roles of disclosure and prosecuting officer but the role of officer in charge was unidentified, contrary to the requirements of the CPIA. Further, a consideration of the required legal tests and the Enforcement Policy had not been recorded on the file. The prosecution had otherwise been carried out in accordance with the relevant Codes of Practice, centrally issued guidance and the authority's Enforcement Policy.

15.13 No formal enforcement action had been taken in respect of feed.

Recommendations

15.14 The authority should:

(i) Review and amend its Enforcement Policy to include reference to the approach to enforcement at establishments where it is the food or feed business operator and place a copy of its Enforcement Policy, or instructions on how to obtain a copy, on its website. Ensure that the Enforcement Policy is fully implemented. [The Standard – 15.1]

(ii) Set up documented procedures for undertaking food hygiene prosecutions and Simple Cautions, the suspension and withdrawal of feed establishment approvals and for the enforcement of inland imported feed in accordance with the Codes of Practice and official guidance. [The Standard -15.2]

(iii) Amend the procedures for food hygiene detention, seizure and certification and food standards in accordance with the relevant Codes of Practice and official guidance. [The Standard -15.2]

(iv) Amend the procedures for feed prosecutions and simple cautions in accordance with the relevant Codes of Practice and official guidance, to ensure that CPIA officer roles are clearly identified in prosecution and simple caution files together with a consideration of the Enforcement Policy and the relevant legal tests. Ensure that this procedure is fully implemented. [The Standard -15.2]

(v) Ensure that food hygiene enforcement is carried out in accordance with the relevant Codes of Practice and centrally issued guidance. [The Standard – 15.3]

(vi) Ensure that all decisions on enforcement action are made following consideration of the authority's Enforcement Policy and that the reasons for any departure from the criteria set out in the enforcement policy are documented. [The Standard –15.4]

16 Records and Interventions/Inspections Reports

Food Hygiene

16.1 Food business records, including registration and approval documents, inspection forms/record sheets and correspondence had been maintained by the authority on hard copy establishment files. Details of the date and type of interventions associated with food businesses, as well as food establishment risk profiles, had also been maintained on the authority's electronic database. Auditors noted that records on all food establishment files examined were well organised and copies of correspondence with businesses were held in chronological order. Where relevant, information relating to the last three inspections was retrievable and records were being retained for six years.

16.2 Officers were using inspection letters to communicate inspection findings to food businesses, which clearly differentiated between legal requirements and recommendations for good practice. These letters also detailed the corrective actions required to achieve compliance.

16.3 Auditors were able to confirm that the information held on hard copy intervention records was consistent with that on the electronic database and that registration forms and approval documents were available for all establishment files examined. However, in two cases the food business operator's details on the registration forms were not consistent with those contained on the documentation relating to the most recent inspections.

16.4 Audit checks confirmed that inspection forms/record sheets and inspection letters contained details of the food business operator, inspection dates, type of business, the overarching legislation under which the intervention was carried out, areas inspected, name and designation of inspecting officer, documents examined, whether samples were taken and the authority's address and contact details of a senior officer in case of dispute. However, information on the key points discussed during the visit, action to be taken by the authority or timescales for achieving compliance had not been consistently provided.

16.5 In all but one case, letters had been sent to food businesses within 14 days of inspection, as required by the authority's procedures. Where there had been a delay in sending a letter, this was by four days.

16.6 All records had been kept for at least six years.

Recommendations

16.7 The authority should:

(i) Ensure that up to date food business registration details are maintained and letters provided to businesses following interventions/inspections contain all of the information required by the Food Law Code of Practice. [The Standard -16.1]

Food Standards

16.8 Food business records, including inspection forms, report of inspection summary sheets, inspection letters and correspondence were maintained by the authority on hard copy establishment files for some high risk manufacturing establishment. Records of interventions at the remaining establishments were stored in both hard copy and on the authority's Civica database. Contemporaneous records of inspection were not retrievable where these had been made in officers' PACE notebooks. Auditors noted that where available, records were held in chronological order. Information relating to the last three inspections was retrievable within the last six years.

16.9 Officers were using both inspection report summary sheets and letters to communicate inspection findings to food businesses.

16.10 Auditors checked the establishment records and inspection reports of the establishments evaluated in section seven of this report against the Food Law Code of Practice. In most cases checked, the inspection record also served as an inspection report, a carbon-copy of which was left with the food business operator.

16.11 The food business had been notified in writing of the outcome of the most recent inspection in all cases, stating the legislation under which the inspection had been conducted. The key points discussed were indicated in every case.

16.12 Records of the type of food activity were present in all but one case although an indication of the size and scale of the business was almost entirely absent.

16.13 Details of the food business representative interviewed, the date and time of the inspection and an indication of the areas inspected were present in all but one case.

16.14 In most cases inspection reports differentiated between legal requirements and recommendations for good practice. This distinction was not clear in three of the eight cases examined. Auditors noted that the reference by the report proforma to “advice” rather than “legal requirements” was not assisting officers make the distinction clear. Notwithstanding this issue all contraventions where relevant had been identified and the measures needed to secure compliance listed. However a timescale for follow-up had not been given in four of the eight cases.

16.15 The actions to be taken by the authority following each inspection were detailed in five of the eight inspections. The name of the food business operator had not been included in half the cases, the contact details of a senior officer and the address of the authority were absent in most cases and the designation of the inspecting officer was not given in any case seen.

16.16 All reports contained the inspecting officer’s name in capital letters, and all but one report was signed by the inspecting officer.

16.17 All records had been kept for at least six years.

Recommendations

16.18 The authority should:

(i) Maintain up to date food standards records in retrievable form on all food establishments in its area in accordance with the Food Law Code of Practice and centrally issued guidance. These records shall include sample results, the date, time, areas seen and documents examined during an intervention, the type, size and scale of a business, determination of compliance with legal requirements made by the authorised officer, details of action to be taken by the authority and action taken where non-compliance were identified, the timescale for compliance and the name of the food business operator. Inspection reports shall also include the designation of the inspecting officer, the contact details of a senior officer and the address of the authority. [The Standard -16.1]

Feed interventions

16.19 File information was held electronically on the database and in the form of hard copy records.

16.20 All but one of the establishments had valid registration information available on the database. The remaining establishment had not been registered by the feed business operator.

16.21 Reports of visit forms had been left with the feed business operator in eight cases. The reports did not include all of the information required by Annex six of the FLECP including, specific legislation, designation of officer, contact details of senior officer, and occasionally sufficient information on areas and documents examined. Where contraventions were identified, a clear distinction between legal requirements and recommendations had not always been made and timescales for compliance had not always been specified, contrary to the FLECP.

16.22 In only three cases out of 10 was the inspection material and database information consistent, up to date and accurate.

16.23 All records had been kept for at least six years.

Recommendations

16.24 The authority should:

(i) Maintain up to date, accurate records in a retrievable form on all relevant feed establishments and imported feed in accordance with the Feed Law Enforcement Code of Practice and centrally issued guidance. These records should include reports of all interventions / inspections, the determination of compliance with legal requirements made by the officer and details of action taken. [The Standard – 16.1]

17 Complaints about the Service

17.1 The authority had published and implemented a two stage Concerns and Complaints Policy which was available to the public and food businesses on its website. Where customers were not satisfied of the outcome of complaint investigations at stage two –the formal stage, they were signposted to the Local Government Ombudsman.

17.2 Whilst no complaints had been received about food or feed services in the two years prior to the audit, the authority was able to demonstrate that effective arrangements were in place within the service to investigate and report on the outcome of complaint investigations.

17.3 Auditors noted that in respect of food hygiene, senior officer details were provided on correspondence should businesses wish to complain following an inspection or other intervention.

18 Liaison with Other Organisations

18.1 The authority had liaison arrangements in place with neighbouring authorities and was contributing to the development of the North Wales collaboration agenda “Collaboration Plus”.

18.2 Liaison arrangements were in place with other appropriate bodies aimed at facilitating consistent enforcement. They included participation in the following:

- Directors of Public Protection Wales (DPPW);
- Wales Heads of Environmental Health (WHoEHG);
- North Wales Heads of Trading Standards
- North Wales Food Safety Technical Panel;
- Welsh Food Microbiological Forum;
- North Wales Food and Metrology Panel
- Wales Animal Health and Welfare Panel
- All Wales Port Health Technical Panel
- North Wales Shellfish Liaison Group
- The Centre for Environment, Fisheries and Aquaculture Science (Cefas)

18.3 Minutes of liaison group meetings were available and confirmed attendance by appropriate service representatives.

18.4 The authority also had liaison arrangements with:

- Food Standards Agency
- Public Health Wales
- Veterinary Medicines Directorate
- Rural Payments Wales
- The Animal Health and Veterinary laboratories Agency
- Gangmasters Licensing authority
- Consultant in Communicable Disease
- All Wales Port Health Technical Panel
- North Wales Police Environmental Crime Officer
- Merseyside Port Health

19 Internal Monitoring

19.1 The authority had developed a corporate performance monitoring framework. Performance measures and targets had been identified for Food Hygiene and Trading Standards (including food standards and feed services) which had been included in the Planning and Public Protection Business Plan. Performance was reported quarterly to senior managers and the relevant elected member.

Performance measures for Food Hygiene:

- Percentage of food establishments which are 'broadly compliant' with food hygiene standards
- Percentage of high-risk businesses that were liable to a programmed inspection that were inspected
- Percentage of National Food Hygiene Rating Certificates issued within 28 days

Performance measure for Trading Standards:

- Percentage of high-risk trade establishments subject to planned inspections to ensure compliance with Trading Standards legislation.
- Percentage of Trading Standards investigations completed within half the legal time limits
- Percentage of clients who contacted the Trading Standards service who were satisfied with the service
- Percentage of clients who received a response to their request for service within 1 day

19.2 Auditors noted that the performance targets that had been set in the corporate performance monitoring framework relating to the inspection of high risk businesses fell short of those required by the Food and Feed Law Codes of Practice. Further, the target of 28 days for issuing Food Hygiene Ratings fell short of the requirement in the Food Hygiene Rating (Wales) Act 2013 for food authorities to provide written notification of ratings to food business operators within 14 days of inspection.

19.3 The authority was committed to ensuring the quality of services provided and Trading Standards customer satisfaction questionnaires had been used to determine customer satisfaction. Feedback from the customer satisfaction survey had been positive and auditors discussed the potential benefits of sharing these results more widely within and outside the organisation.

19.4 Regular team meetings assisted in ensuring a consistent approach by officers and provided managers with the opportunity to report progress in delivering the service against the targets set in the Service Plan

19.5 It was the authority's policy for correspondence relating to official food and feed controls to be signed by the Principal Officers. This meant that in practice they had close oversight of officers' work.

19.6 Documented internal monitoring procedures for the Environmental Health Commercial Section (food hygiene) and Trading Standards Service (food standards and feed) had been developed. These required further development to enable the authority to verify its conformance with all elements of the Standard, the relevant Codes of Practice, centrally issued guidance and the authority's own documented policies and procedures.

19.7 Planned internal monitoring activities carried out in practice included:

- Officer work reviews
- Desktop, qualitative monitoring of inspections and follow-up action
- Accompanied inspections
- Formal reviews of enforcement decisions

19.8 Some qualitative internal monitoring records had been maintained by the Principal Officers. They included internal monitoring forms for accompanied visits, inspections and post inspection letters/paperwork. Corrective actions had been identified and included in feedback provided to officers. Not all internal monitoring however was being recorded.

Recommendations

19.9 The authority should:

(i) Further develop, maintain and implement internal monitoring procedures for food hygiene, food standards and feed to verify its conformance with the Standard, relevant legislation, the relevant Codes of Practice, centrally issued guidance and its own documented policies and procedures. [The Standard – 19.1 and 19.2]

(ii) Ensure that records of internal monitoring activities are maintained for two years [The Standard– 19.3]

20 Third Party or Peer Review

20.1 A focused FSA audit ‘Local authority Official Controls and Food Business Operator Controls in Approved Establishments' had taken place in 2009 and matters identified for action had been completed.

20.2 In January 2014 the authority, in common with the other 21 local authorities in Wales, had submitted information in respect of two FSA focused audits - Response of Local Government in Wales to the Recommendations of the Public Inquiry into the September 2005 Outbreak of E. coli O157 in South Wales and Local authority Management of Interventions in Newly Registered Food Businesses In Wales. These focused audit reports are available at the following link:

www.food.gov.uk/enforcement/auditandmonitoring

20.3 The authority’s Environmental Health Service, which included food hygiene and the investigation of food related infectious disease, had been subject to a review by the Wales Audit Office in 2013/14. At the time of the audit the outcome of this review had not been published.

21 Food and Feed Safety and Standards Promotion

21.1 The authority had delivered a number of initiatives with the aim of promoting food safety, standards and feed.

21.2 In respect of food safety, the authority had participated in Food Safety week and in 2014 had been proactive raising awareness of Campylobacter. Activities included an exhibition, staff survey and quiz.

21.3 Action to raise consumer awareness of the Food Hygiene Rating Scheme had been taken, including information in the local press.

21.4 There was evidence that safe food handling practices and hand hygiene had been routinely discussed with cases during infectious disease investigations. Further, the lead officer for food hygiene was able to demonstrate that food safety promotion had been included in talks to community groups.

21.5 Officers of the Public Protection Department had promoted food safety and standards issues at a local Healthy Lifestyle and Safer Home Fair.

21.6 The authority had worked collaboratively with other authorities across north Wales, through the North Wales Heads of Trading Standards Animal Health and Welfare Panel, to produce a newsletter aimed at farmers. The newsletter included an article to promote feed business registration. The newsletter was available on the authority's website.

21.7 Records of promotional work were being maintained by officers.

Auditors:

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ANNEX A

Action Plan for Anglesey County Council
Audit Date: 14-18 July 2014

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
3.21 The authority should:			
(i) Ensure that future Food and Feed Law Enforcement Service Plans are developed in accordance with the Service Planning Guidance in the Framework Agreement. An analysis of the resources required against those available, and plans to address any shortfalls identified should be included. [The Standard – 3.1]	*31/07/15*	Produce 15/16 service plan in accordance with COP which addresses the resource requirement needed to carry out the intervention policy and identifies available resources. Plan needs to include reference to work we should be undertaking, in addition to work that has been done. Identify the resources required to carry out the service plan against those available and plan to address any shortfall in resources	Analysis of shortfall being undertaken. Engaging in North Wales feed delivery project
(ii) Address any variance in meeting the Service Plan in subsequent service plans. [The Standard-3.3]	*31/07/15*	Address variance by including resources required to make up shortfall in analysis for 15/16 plan. 15/16 Plan to include estimation of resources needed against actual resources. Better explanation of shortfall in inspection etc needed. Address variance by including resources required to make up shortfall in analysis and commit to addressing that variance for 15/16 plan.	Analysis of shortfall being undertaken. Engaging in North Wales feed delivery project

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
5.16 The authority should:			
Review and amend the authorisation procedure to include reference to the arrangements for refresher training and monitoring for newly qualified and returning officers, in accordance with the requirement of the Food Law Code of Practice. [The Standard – 5.1]	*31/07/15* *31/03/16*	Amend procedure to refer to training, monitoring of newly qualified officers and those returning after absence. Ensure Food EHO returning from Maternity leave has 10 hours CPD	
(i) Review and amend food standards and feed officer authorisations to include the appropriate Official Feed and Food Control legislation to carry out the work set out in the Service Plan. Amend the authorisation of the unqualified Trading Standards enforcement officer to reflect their competency, in accordance with the Codes of Practice. Ensure the duties of food standards and feed officers do not exceed their authorisations. [The Standard – 5.3]	*31/07/15* *31/07/15*	Amend authorisation to include appropriate legislation: Official Food & Feed Control regulations 2009. Remove Authorisation from TS Enforcement Officer, North Wales feed delivery project will address.	

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(ii) Appoint a sufficient number of suitably authorised food hygiene and food standards officers to carry out the work set out in the Service Plan and ensure that they are authorised under the appropriate legislation. The level of authorisation of feed officers should be consistent with their qualifications. [The Standard – 5.3]	*31/03/16*	Following on from analysis in the service plan, staffing resources will be reviewed and a bid will be presented to the Executive for the necessary additional officers required	
(iii) Ensure that all authorised food hygiene officers receive 10 hours Continuous Professional Development training, in accordance with the Code of Practice. [The Standard – 5.4]	*31/03/16*	Ensure Training for all staff with minimum CPD requirement of 10 hours	
(iv) Maintain records of the relevant qualifications, training and experience of each authorised officer and appropriate support staff in accordance with the relevant Codes of Practice. [The Standard - 5.5]	*31/07/15*	Review individual officer's files and take corrective action.	

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
6.8 The authority should: (i) Ensure that the necessary facilities and equipment that are required for the effective delivery of all activities associated with the feed service are made available. [The Standard - 6.1] (ii) Amend the documented procedure for calibrating temperature measuring equipment to include testing frequencies for all devices, operating temperatures for refrigeration equipment and ensure tolerances are applied in accordance with centrally issued guidance. [The Standard - 6.2]	*31/7/15* Completed	Share/buy the required equipment: chisels and sampling tubes for liquids. It may be that the North Wales feed delivery project will have the resources needed.	Procedure amended and now refers to a tolerance of +/- 0.5 C Thermometers no longer in use have been disposed of and new chart for logging UV thermometer checks. Fridge temperatures recorded on form
7.26 The authority should: (i) Ensure that food establishment interventions/inspections are carried out at the minimum frequency specified by the Food Law Code of Practice. [The Standard -7.1]	Completed		All B rated premises brought forward in inspection programme. Staff now ensure that B rated premises get priority for inspection

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(ii) Ensure that full inspections and alternative enforcement strategies are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]	01/04/16	This is the need to carry out inspections within 28 days of 'due date' – A bid will be made for a short term resource to be made available to "catch up"	A and B rated premises are inspected within 28 days of "due date", rest are inspected asap
(iii) Assess the compliance of establishments in its area to the legally prescribed standards; and take appropriate action on any non-compliance found, in accordance with the authority's Enforcement Policy. [The Standard -7.3]	Completed		"Short" inspection form extended and adapted to cover additional details
(iv) Amend its Food Interventions Procedure in respect of Alternative Enforcement Strategies (AES) to include details of the criteria against which completed questionnaires are assessed and to set out the triggers for undertaking another type of intervention. [The Standard – 7.4]	Completed		Procedure amended to include instruction as to non return of AS questionnaire and this form requires EHO to sign off updating /visit needed

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(v) Ensure observations made in the course of an inspection, in particular relating to checks carried out to verify the source of foods and to demonstrate that consideration has been given to imported foods, shall be recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]	Completed		Source and Imported Food reference is now on Inspection form
7.34 The authority should:			
(i) Ensure that vessel inspections are carried out in accordance with the Food Law Code of Practice, centrally issued guidance, and the authority's policies and procedures. [The Standard – 7.2]	*Completed*	Will leave APHA form on all visits, even if just to ascertain if someone has inspected at a previous port.	Recent inspections have been on resident ferries, which always involve the use of the APHA inspection form
(ii) Ensure observations made in the course of an inspection, are recorded in a timely manner to prevent loss of relevant information. [The Standards – 7.5]	*Completed*	As above	

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
7.50 The authority should: (i) Ensure that food standards interventions are carried out at a frequency not less than that determined under the intervention rating scheme set out in the Food Law Code of Practice. [The Standard -7.1]	*Completed*	NTSB risk rating scheme has been adopted, which is equivalent to the COP rating scheme Work ongoing on database.	NTSB scheme adopted 14/15
(ii) Implement a food standards intervention risk rating scheme which is in accordance with the scheme established under annex V of the Food Law Code of Practice. [The Standard -7.2]	*31/07/15*	Service plan for 2015/16 will plan interventions in accordance with the scheme.	
(iii) Provide food businesses with a report after each inspection/intervention, develop and implement an intervention policy for unrated and "non-inspectable risk" food standards establishments, ensure that food standards establishments are only inspected by appropriately authorised officers and ensure that announced visits and revisits are carried out in accordance with the relevant legislation, Code of Practice, centrally issued guidance and the authority's own policies and procedures. [The Standard -7.2]	*31/07/15*	New inspection report template to be used. An intervention policy for unrated or low risk premises is being developed. Intervention duties will be allocated in accordance with the plan, to appropriately authorised officers	

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(iv) Take appropriate action on any non-compliance found at food standards establishments, in accordance with the authority's enforcement policy. {The Standard -7.3]	Completed	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(v) Set up a revisit policy which accords with the Food Law Code of Practice. [The Standard – 7.4]	31/07/15	Devise a revisit policy in accordance with 7.4 of the standard.	
(vi) Ensure that officers' contemporaneous records of food standards interventions are recorded in a timely manner and stored in such a way that they are retrievable. [The Standard -7.5]	31/07/15	Data capture on electronic inspection forms to be linked to CIVICA system Use aide memoir forms to record inspection observations as for feed inspection forms	
7.63 The authority should: (i) Ensure that feed establishment interventions and inspections are carried out at the frequency specified by the Feed Law Enforcement Code of Practice. [The Standard - 7.1]	*31/07/15*	North Wales feed delivery project will allocate interventions.	Feed Lead Officer has attended meetings to set up north wales programme.
(ii) Carry out inspections / interventions and approve or register feed establishments in accordance with relevant legislation and the Feed Law Enforcement Code of Practice and centrally issued guidance. [The Standard - 7.2]	*01/06/15*	Will adopt policies and procedures from the North Wales project and use appropriately authorised officers.	

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(iii) Ensure appropriate action is taken to follow up non-compliance in accordance with the Enforcement Policy. [The Standard – 7.3]	Completed	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(iv) Ensure documented procedures relating to inspection of feed establishments are fully developed in accordance with the Feed Law Enforcement Code of Practice. Develop documented procedures for interventions relating to co-products establishments, imported feed, applications for feed approvals and registrations. [The Standard – 7.4]	01/06/15	Will adopt procedures from the North Wales project and use appropriately authorised officers.	
(v) Ensure that all observations made in the course of interventions are recorded in a timely manner and officers' contemporaneous records of interventions are stored in such a way as to be retrievable. [The Standard – 7.5]	30/07/15	Data capture on electronic inspection forms to be linked to CIVICA system	

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
8.10 The authority should: (i) Review and update the complaints procedures to include reference to complaints against food and the condition of feed establishments. [The Standard – 8.1]	*31/07/15*	Amend food and feed complaints procedure to refer to condition of establishments	Looking at alternative of having a separate procedure that covers food premises complaints individually
(ii) Investigate complaints received in accordance with the Food Law Code of Practice, centrally issued guidance and its own policy and procedures. [The Standard – 8.2]	*Completed*	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
(iii) Take appropriate action on complaints received in accordance with the authority's Enforcement Policy. [The Standard – 8.3]	*Completed*	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.
11.5 The authority should: (i) Maintain its database of food and feed establishments, ensuring food and feed businesses are properly registered and included in the food and feed interventions programmes. [The Standard – 11.1]	*31/07/15*	Ongoing work carried out to register and risk assess against NTSB risk scheme.	

TO ADDRESS (RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
12.11 The authority should:			
(i) Amend the Food and Feed Sampling Policy to include reference to its approach to notifying/liaising with Primary and Home Authorities. [The Standard – 12.4]	*30/7/15*	Amend the policy.	*Sampling Policy amended and Home Authority contacted with results. Some HAs only want results if there are failures*
(ii) Set-up, maintain and implement a documented procedure for the procurement or purchase, continuity of evidence and the prevention of deterioration or damage of informal food standards samples in accordance with the Food Law Code of Practice and relevant centrally issued guidance. [The Standard – 12.5]	*31/7/15*	Set up an equivalent procedure to the formal samples for informal samples. Procedure to address; purchase, continuity of evidence, prevention of deterioration and damage to samples in accordance with the COP	
(iii) Take appropriate action in accordance with its Enforcement Policy where food hygiene sample results are not considered to be satisfactory. [The Standard – 12.7]	Completed		

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
13.8 The authority should: (i) Amend the Outbreak Control Plan to ensure that it includes the relevant local authority contacts. [The Standard – 13.1] (ii) Further develop the documented procedure for investigation of infectious diseases to include reference to sampling and ensure the procedure is fully implemented. [The Standard - 13.2]	Completed Completed		*Relevant section of the plan was amended at same time as update of Port Health Action Plan* *Plan now refers to the relation between food samples and collected faecal samples*
14.7 The authority should: (i) Notify the FSA of any serious localised food hazards in accordance with the Food Law Code of Practice. [The Standard – 14.5]	Completed	Review previous actions with the relevant officer and carry out revision training where necessary.	Review meeting held with officer that confirmed understanding of procedures and policies. Discussed expected outcomes if similar scenario arose.

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
15.14 The authority should:			
(i) Review and amend its Enforcement Policy to include reference to the approach to enforcement at establishments where it is the food or feed business operator and place a copy of its Enforcement Policy, or instructions on how to obtain a copy, on its website. Ensure that the Enforcement Policy is fully implemented. [The Standard – 15.1]	31/07/15	Consult with Webmaster This is a reference to need to include a section on what we do in council premises	
(ii) Set up documented procedures for undertaking food hygiene prosecutions and Simple Cautions, the suspension and withdrawal of feed establishment approvals and for the enforcement of inland imported feed in accordance with the Codes of Practice and official guidance. [The Standard -15.2]	31/07/2015	Adopt procedure in place for food standards and amend appropriately. RIAMS version to be looked at.	
(iii) Amend the procedures for food hygiene detention, seizure and certification and food standards in accordance with the relevant Codes of Practice and official guidance. [The Standard -15.2]	Completed		EH Food Detention Procedure now refers to disposal method for detained foods and the need to sample detained foods where possible, within 28 days of detention.

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
(iv) Amend the procedures for feed prosecutions and simple cautions in accordance with the relevant Codes of Practice and official guidance, to ensure that CPIA officer roles are clearly identified in prosecution and simple caution files together with a consideration of the Enforcement Policy and the relevant legal tests. Ensure that this procedure is fully implemented. [The Standard -15.2]	31/07/15	Amend current standard forms where necessary.	
(v) Ensure that food hygiene enforcement is carried out in accordance with the relevant Codes of Practice and centrally issued guidance. [The Standard – 15.3]	Completed		HI Notice procedure now requires written request for extension of notice period and letter to confirm compliance. Visits must be made to the premises following expiry of notices.
(vi) Ensure that all decisions on enforcement action are made following consideration of the authority's Enforcement Policy and that the reasons for any departure from the criteria set out in the enforcement policy are documented. [The Standard –15.4]	31/07/15	Amend standard forms where necessary.	

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
16.7 The authority should: (i) Ensure that up to date food business registration details are maintained and letters provided to businesses following interventions/inspections contain all of the information required by the Food Law Code of Practice. [The Standard - 16.1	31/07/15	Two businesses had different t registration details to those on letter. To be done email to be sent to staff. Keep copy with Registration procedure.	Updating to be done and officers to check Reg details during/after inspection
16.18 The authority should: (i) Maintain up to date food standards records in retrievable form on all food establishments in its area in accordance with the Food Law Code of Practice and centrally issued guidance. These records shall include sample results, the date, time, areas seen and documents examined during an intervention, the type, size and scale of a business, determination of compliance with legal requirements made by the authorised officer, details of action to be taken by the authority and action taken where non-compliance were identified, the timescale for compliance and the name of the food business operator. Inspection reports shall also include the designation of the inspecting officer, the contact details of a senior officer and the address of the authority. [The Standard - 16.1]	*31/07/15*	Discontinue use of current inspection forms. Use model forms electronically linked to CIVICA system for interventions/premises details/ samples/ etc. Inspection report forms will be amended to meet the requirements of the COP including: designation of inspecting officer, contact details of senior officer and the address of the authority.	

TO ADDRESS RECOMMENDATION INCLUDING STANDARD PARAGRAPH)	BY (DATE)	PLANNED IMPROVEMENTS	ACTION TAKEN TO DATE
16.24 The authority should: (i) Maintain up to date, accurate records in a retrievable form on all relevant feed establishments and imported feed in accordance with the Feed Law Enforcement Code of Practice and centrally issued guidance. These records should include reports of all interventions / inspections, the determination of compliance with legal requirements made by the officer and details of action taken. [The Standard – 16.1]	*31/07/15*	As 16.18 above, will adopt All Wales procedures and forms in accordance with policies and procedures implemented by the North Wales regional collaboration feed service scheme.	
19.9 The authority should: (i) Further develop, maintain and implement internal monitoring procedures for food hygiene, food standards and feed to verify its conformance with the Standard, relevant legislation, the relevant Codes of Practice, centrally issued guidance and its own documented policies and procedures. [The Standard – 19.1 and 19.2]	31/07/15	Develop monitoring procedures in common with Food Hygiene service. Procedure to address conformity with The Standard, legislation, Codes of Practice, guidance and internal policies and procedures. North Wales feed project will have internal monitoring system.	Liaison with Food Hygiene service and North wales feed project lead.
(ii) Ensure that records of internal monitoring activities are maintained for two years [The Standard– 19.3]	31/07/15	Implement procedure to record internal monitoring and maintain records for two years.	

ANNEX B

Audit Approach/Methodology

The audit was conducted using a variety of approaches and methodologies as follows:

(1) Examination of Local authority policies and procedures

The following policies, procedures and linked documents were examined:

- Isle of Anglesey County Council Food Service Enforcement Plan 2014/2015
- North Wales Trading Standards Services Animal Feed Service Delivery plan 2014-2015
- Isle of Anglesey County Council annual Delivery Document (Improvement Plan) 2014/2015
- Trading Standards Staff Development Plan 2013/14
- Planning and Public Protection Staff Development Plan 2014/15
- Public Protection Staff Development Plan 2013/14
- Public Protection Staff Development Plan 2014/15
- Environmental Health Commercial Section Documented Procedure for the Authorisation of Officers
- Agreement For Provision Of Microbiological Services Between Public Health Wales And Isle Of Anglesey Council
- Report Appointing Public Analyst and Agricultural Analyst
- Environmental Health Commercial Section Procedure for the Calibration of Food Safety Equipment
- Environmental Health Commercial Section Food Interventions Procedure
- Environmental Health Commercial Section Ship Sanitation Inspection Procedure
- On Farm Inspection Procedure (Feed)
- Manufacturer Placing On Market Feed Materials R07 Inspection Procedure
- Environmental Health Commercial Section Food/Foodstuff Complaints Procedure
- Food And Feed Complaints Policy And Procedure
- Activity: Feed; Subject Area: Complaint Contaminated Feed
- Activity: Food Subject Area: Labelling Service Request
- Activity : Food Labelling And Composition Subject : Complaint

- Trading Standards Section Enforcement Action And Investigation Internal Policies And Procedures
- North Wales Food Safety And Communicable Disease Panel Meeting; Minutes Of Meeting – 11th June 2014
- Environmental Health Commercial Section Food Hygiene Rating Procedure
- Environmental Health Commercial Section Food Hygiene Revisits Procedure
- Environmental Health Commercial Section Procedure For The Detention And Seizure Of Food
- Environmental Health Commercial Section Procedure For The Registration Of Food Business Establishment
- Environmental Health Commercial Section Remedial Action Notice Procedure
- Environmental Health Commercial Section Procedure For The Serving Of Hygiene Improvement Notices
- Trading Standards Minutes Of Team Meeting, 10th April 2014
- Trading Standards Minutes Of Team Meeting, 24th January 2014
- Trading Standards Minutes Of Team Meeting, 17th February 2014
- Environmental Health Food Team Meeting Minutes 2012-2014
- Food And Feed Incidents And Hazards Procedures
- Environmental Health Commercial Section Procedure For Dealing With Food Alerts And Incidents
- Wales Communicable Disease Expert Panel Minutes 29th May 2014
- Wales Food safety Expert Panel Minutes 4th June 2014
- North Wales Food Safety Technical Panel 17th October 2013
- North Wales Food Safety Technical Panel 11th June 2014
- North Wales Heads Of Trading Standards Minutes 25th June 2014
- North Wales Food And Metrology Panel Minutes 7th March 2013, 6th June 2013
- North Wales Food And Metrology Panel Minutes 23rd September 2013
- Trading Standards Internal Monitoring Procedure
- Environmental Health Commercial Section Internal Monitoring Procedure
- Trading Standards Feed Sampling Plan 2013-14
- Trading Standards Feed Sampling Plan 2014-15
- Trading Standards Food Sampling Programme 2013-14
- Trading Standards Food Sampling Programme 2014-15
- Activity: Food Sample; Subject : Formal
- Feed Sampling Procedures, Procurement, Storage and Analysis
- Food And Feed Sampling Policy

- Environmental Health Commercial Section Food Sampling Procedure
- Activity: Feed Sample; Subject : Formal
- Public Protection Service Enforcement Policy
- The Communicable Disease Outbreak Plan For Wales
- Environmental Health Commercial Section Food Poisoning Investigation Procedure
- Acceptable Usage Policy (IT)
- Incident Reporting And Resolution Policy (IT)
- Removable Media Policy (IT)
- Data Loss Reporting And Resolution Policy
- Environmental Health Commercial Section Procedure For Keeping The Establishment Database Up To Date
- Unacceptable Actions by Complainants Policy
- Concerns and Complaints Policy

(2) File reviews

A number of Local authority records were reviewed during the audit, including:

- Approved establishment files
- Food and Feed establishment intervention records
- Sampling records
- Food and food establishment complaint records
- Formal enforcement records
- Officer authorisations and training records
- Internal monitoring records
- Calibration records
- Food Incident records

(3) Review of Database records:

A selection of database records were considered during the audit in order to:

- Review and assess the completeness of database records of food/ feed inspections, food/feed and food/feed premises complaint investigations, samples taken by the authority, formal enforcement and other activities and to verify consistency with file records

- Assess the completeness and accuracy of the food and feed establishment databases
- Assess the capability of the system to generate food/feed law enforcement activity reports and the monitoring information required by the Food Standards Agency.

(4) *Officer interviews*

Officer interviews were carried out with the purpose of gaining further insight into the practical implementation and operation of the authority's food/feed Control arrangements. The following officers were interviewed:

Chief Environmental Health Officer
Chief Trading Standards Officer
Principal Environmental Health Officer (Commercial)
Principal Trading Standards Officer
Environmental Health Officers
Food Safety Officer
Trading Standards Officer
Trading Standards Enforcement Officers

Opinions and views raised during officer interviews remain confidential and are not referred to directly within the report.

(5) *On-site verification checks:*

Verification visits were made with officers to four local food businesses and two feed businesses. The purpose of these visits was to verify the outcome of the last inspections carried out by the LA and to assess the extent to which enforcement activities and decisions met the requirements of relevant legislation, the relevant Codes of Practice and centrally issued guidance documents.

ANNEX C

Glossary

Approved establishments	Food manufacturing establishment that has been approved by the local authority, within the context of specific legislation, and issued a unique identification code relevant in national and/or international trade.
Authorised officer	A suitably qualified officer who is authorised by the local authority to act on its behalf in, for example, the enforcement of legislation.
Codes of Practice	Government Codes of Practice issued under Section 40 of the Food Safety Act 1990 as guidance to local authorities on the enforcement of food legislation.
CPIA	The Criminal Procedures and Investigations Act 1996 – governs procedures for undertaking criminal investigations and proceedings.
Critical Control Point (CCP)	A stage in the operations of a food business at which control is essential to prevent or eliminate a food hazard or to reduce it to acceptable levels.
Directors of Public Protection Wales (DPPW)	An organisation of officer heading up public protection services within Welsh local authorities.
Environmental Health Professional/Officer (EHP/EHO)	Officer employed by the local authority to enforce food safety legislation.
Food Examiner	A person holding the prescribed qualifications who undertakes microbiological analysis on behalf of the local authority.
Food Hazard Warnings/	This is a system operated by the Food Standards

Food Alerts	Agency to alert the public and local authorities to national or regional problems concerning the safety of food.
Food/feed hygiene	The legal requirements covering the safety and wholesomeness of food/feed.
Food Hygiene Rating Scheme (FHRS)	A scheme of rating food businesses to provide consumers with information on their hygiene standards.
Food standards	The legal requirements covering the quality, composition, labelling, presentation and advertising of food, and materials in contact with food.
Food Standards Agency (FSA)	The UK regulator for food safety, food standards and animal feed.
Framework Agreement	The Framework Agreement consists of: • Food Law Enforcement Standard • Service Planning Guidance • Monitoring Scheme • Audit Scheme The **Standard** and the **Service Planning Guidance** set out the FSA's expectations on the planning and delivery of food law enforcement. The **Monitoring Scheme** requires local authorities to submit quarterly returns to the FSA on their food enforcement activities i.e. numbers of inspections, samples and prosecutions. Under the **Audit Scheme** the Food Standards Agency will be conducting audits of the food law enforcement services of local authorities against the criteria set out in the Standard.
Full Time Equivalents (FTE)	A figure which represents that part of an individual officer's time available to a particular role or set of

	duties. It reflects the fact that individuals may work part-time, or may have other responsibilities within the organisation not related to food enforcement.
HACCP	Hazard Analysis Critical Control Point – a food safety management system used within food businesses to identify points in the production process where it is critical for food safety that the Control measure is carried out correctly, thereby eliminating or reducing the hazard to a safe level.
Home authority	An authority where the relevant decision making base of an enterprise is located and which has taken on the responsibility of advising that business on food safety/food standards issues. Acts as the central contact point for other enforcing authorities' enquiries with regard to that company's food related policies and procedures.
Hygiene Improvement Notice (HIN)	A notice served by an Authorised Officer of the local authority under Regulation 6 of the Food Hygiene (Wales) Regulations 2006, requiring the proprietor of a food business to carry out suitable works to ensure that the business complies with hygiene regulations.
Inspection	The examination of a food or feed establishment in order to verify compliance with food and feed law.
Intervention	A methods or technique used by an authority for verifying or supporting business compliance with food or feed law.
Inter authority Auditing	A system whereby local authorities might audit one anothers' food law enforcement services against an agreed quality standard.
LAEMS	Local authority Enforcement Monitoring System is an electronic system used by local authorities to report their food law enforcement activities to the Food Standards Agency.

Member forum	A local authority forum at which Council Members discuss and make decisions on food law enforcement services.
National Trading Standards Board (NTSB)	An association of chief trading standards officers.
OCD returns	Returns on local food law enforcement activities required to be made to the European Union under the Official Control of Foodstuffs Directive.
Official Controls (OC)	Any form of control for the verification of compliance with food and feed law.
Originating authority	An authority in whose area a business produces or packages goods or services and for which the authority acts as a central contact point for other enforcing authorities' enquiries in relation to the those products.
PACE	The Police and Criminal Evidence Act 1984 – governs procedures for gathering evidence in criminal investigations.
Primary authority	A local authority which has developed a partnership with a business which trades across local authority boundaries and provides advice to that business.
Public Analyst	An officer, holding the prescribed qualifications, who is formally appointed by the local authority to carry out chemical analysis of food samples.
Registration	A legal process requiring all food business operators to notify the appropriate food authority when setting-up a food business.
Remedial Action	A notice served by an Authorised Officer of the

Notices (RAN)	local authority under Regulation 9 of the Food Hygiene (Wales) Regulations 2006 (as amended) on a food business operator to impose restrictions on an establishment, equipment or process until specified works have been carried out to comply with food hygiene requirements.
Risk rating	A system that rates food establishments according to risk and determines how frequently those establishments should be inspected. For example, high risk hygiene establishments should be inspected at least every 6 months.
Service Plan	A document produced by a local authority setting out their plans on providing and delivering a food service to the local community.
Trading Standards	The service within a local authority which carries out, amongst other responsibilities, the enforcement of food standards and feedingstuffs legislation.
Trading Standards Officer (TSO)	Officer employed by the local authority who, amongst other responsibilities, may enforce food standards and feedingstuffs legislation.
Unitary authority	A local authority in which all the functions are combined, examples being Welsh Authorities and London Boroughs. A Unitary authority's responsibilities will include food hygiene, food standards and feedingstuffs enforcement.
Unrated business	A food business identified by an authority that has not been subject to a regulatory risk rating assessment.
Wales Heads of Environmental Health (WHoEH)	A group of professional representatives that support and promote environmental and public health in Wales.

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Cllr. Ieuan Williams
Isle of Anglesey County Council
Council Offices
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LL77 7TW

Reference C15203
Date 30 Nov 2015
Pages **1** of **2**

Dear Cllr. Williams

Annual Audit Letter – Isle of Anglesey County Council 2014-15

This letter summarises the key messages arising from the Auditor General for Wales' statutory responsibilities under the Public Audit (Wales) Act 2004 and reporting responsibilities under the Code of Audit Practice.

Isle of Anglesey County Council complied with its responsibilities relating to financial reporting and use of resources

It is the Council's responsibility to:

- put systems of internal control in place to ensure the regularity and lawfulness of transactions and to ensure that its assets are secure;
- maintain proper accounting records;
- prepare a Statement of Accounts in accordance with relevant requirements; and
- establish and keep under review appropriate arrangements to secure economy, efficiency and effectiveness in its use of resources.

The Public Audit (Wales) Act 2004 requires the Auditor General for Wales to:

- provide an audit opinion on the accounting statements;
- review the Council's arrangements to secure economy, efficiency and effectiveness in its use of resources; and
- issue a certificate confirming the completion of the audit of the accounts.

Local authorities in Wales prepare their accounting statements in accordance with the requirements of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom. This code is based on International Financial Reporting Standards. On 30 September 2015, the Auditor General for Wales issued an unqualified audit opinion on the accounting statements confirming that they present a true and fair view of the

Council's financial position and transactions. This report is contained within the Statement of Accounts. The key matters arising from the accounts audit were reported to members of the Audit and Governance Committee in the Audit of Financial Statements report on 23 September 2015, and a more detailed report will follow in due course.

The Auditor General for Wales is satisfied that the Council has appropriate arrangements in place to secure economy, efficiency and effectiveness in its use of resources

The Auditor General for Wales' consideration of the Council's arrangements to secure economy, efficiency and effectiveness has been based on the audit work undertaken on the accounts as well as placing reliance on the work completed as part of the Improvement Assessment under the Local Government (Wales) Measure 2009. The Annual Improvement Report will highlight areas where the effectiveness of these arrangements has yet to be demonstrated or where improvements could be made.

The Auditor General for Wales issued a certificate confirming that the audit of the accounts had been completed on 30 September 2015.

Work to date on certification of grant claims and returns has not identified significant issues that would impact on the 2015-16 accounts or key financial systems

A more detailed report on grant certification work will follow in 2016 once this year's programme of certification work is complete.

The financial audit fee for 2014-15 is currently expected to be in line with the agreed fee set out in the Annual Audit Outline.

Yours sincerely

Lynn Pamment
Partner, PricewaterhouseCoopers LLP

For and on behalf of the Auditor General for Wales

cc. Dr. Gwynne Jones, Chief Executive

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Certificate of Compliance

Audit of the Isle of Anglesey County Council's assessment of 2014-15 performance

Certificate

I certify that, following publication on 26 October 2015, I have audited the Isle of Anglesey County Council's (the Council) assessment of its performance in 2014-15 in accordance with section 17 of the Local Government (Wales) Measure 2009 (the Measure) and my Code of Audit Practice.

As a result of my audit, I believe that the Council has discharged its duties under sections 15(2), (3), (8) and (9) of the Measure and has acted in accordance with Welsh Government guidance sufficiently to discharge its duties.

Respective responsibilities of the Council and the Auditor General

Under the Measure, the Council is required to annually publish an assessment which describes its performance:

- in discharging its duty to make arrangements to secure continuous improvement in the exercise of its functions;
- in meeting the improvement objectives it has set itself;
- by reference to performance indicators specified by Welsh Ministers, and self-imposed performance indicators; and
- in meeting any performance standards specified by Welsh Ministers, and self-imposed performance standards.

The Measure requires the Council to publish its assessment before 31 October in the financial year following that to which the information relates, or by any other such date as Welsh Ministers may specify by order.

The Measure requires that the Council has regard to guidance issued by Welsh Ministers in publishing its assessment.

As the Council's auditor, I am required under sections 17 and 19 of the Measure to carry out an audit to determine whether the Council has discharged its duty to publish an assessment of performance, to certify that I have done so, and to report whether I believe that the

Council has discharged its duties in accordance with statutory requirements set out in section 15 and statutory guidance.

Scope of the audit

For the purposes of my audit work I will accept that, provided an authority meets its statutory requirements, it will also have complied with Welsh Government statutory guidance sufficiently to discharge its duties.

For this audit I am not required to form a view on the completeness or accuracy of information. Other assessment work that I will undertake under section 18 of the Measure may examine these issues. My audit of the Council's assessment of performance, therefore, comprised a review of the Council's publication to ascertain whether it included elements prescribed in legislation. I also assessed whether the arrangements for publishing the assessment complied with the requirements of the legislation, and that the Council had regard to statutory guidance in preparing and publishing it.

The work I have carried out in order to report and make recommendations in accordance with sections 17 and 19 of the Measure cannot solely be relied upon to identify all weaknesses or opportunities for improvement.

Recommendations under the Local Government (Wales) Measure 2009

No recommendations

HUW VAUGHAN THOMAS

AUDITOR GENERAL FOR WALES

CC: Leighton Andrews, Minister for Public Services

Jeremy Evans, Manager

Andy Bruce, Performance Audit Lead

Isle of Anglesey County Council

Performance work programme update for Audit Committee 8 December 2015

Local Government Studies – Update August 2015

This part of the briefing provides an update on progress on delivering the all Wales Local Government studies programme and other centrally managed projects. Each study relates to local government only unless the commentary below specifically references work on National Parks and/or Fire and Rescue Authorities.

1. 2014-15 Local Government Studies

Independence of older people

The report was published on 15 October 2015. It is available at - http://www.audit.wales/publications/Independence-of-Older-People

Delivering with Less – Leisure

The report is due for publication in early December 2015.

2. 2015-16 Local Government Studies

Community Safety

Fieldwork is complete. The North Wales fieldwork sites are Conwy/Denbighshire, Wrexham, North Wales Police and Crime Commissioner and the North Wales Safer Communities Board. The national report is planned for winter 2016.

The strategic approach of councils to income generation and charging

This study is being delivered under our annual "delivering with less" programme and the study will involve an audit of councils' strategic approach to charging; the approval process for setting and reviewing charging within a council; the impact of charging on services and service users; and the legislative basis for charging.

The project brief has been distributed and the study is being delivered under a contract with Grant Thornton. Anglesey is not a fieldwork site.

Council funding of third-sector services

Again, under the theme of delivering with less, this study will look at the level of investment in voluntary sector services to benchmark findings against an LGDU reviews conducted on behalf of the WCVA dating from 2001-02. The review will include the measures used to judge the effectiveness of funding in a tracer area, which will be agreed with the WCVA; review decision making processes to determine whether the principles of good governance in funding third sector services are being followed. The project brief has been distributed and Anglesey is not a fieldwork site.

3. 2016-17 Local Government Studies

We are in the process of developing and finalising a list of potential study topics for consultation on our future programme of work. The draft programme will be discussed with engagement teams in forthcoming round of team meetings. Following this, local authorities will be consulted.

4. Improvement audit assessment work for 2015-16

This part of the briefing provides an update on progress on delivering the audit and assessment work at Anglesey (some studies will also include other North Wales and Welsh councils).

Assessment of performance audit

The certificate was issued in November and the Council's Performance Report complies with Welsh Government guidance and the LG Measure.

Financial resilience review

The review is complete and informal feedback was provided to the Section 151 officer. A local report has been drafted and following feedback from the Council, the report will be published in December/January.

Governance review

This work will focus on areas identified as being in need of improvement in the Corporate Assessment report. Timing – December 2015 to March 2016.

Performance management review

A study across all six North Wales councils on benchmarking social services costs against performance. The study includes CSSIW involvement and discussions with council staff. Timing – September to December 2015. A meeting between WAO, Council lead officers and CSSIW has been scheduled for the 21 December to discuss potential outcomes from an analysis of the indicators.

Locally determined review(s)

Follow-up of aspects identified as being in need of improvement in the Corporate Assessment report. Timing – December 2015 to March 2016. This will stem from the Corporate Assessment following discussion with the Council.

Annual Improvement Report

Annual summary and assessment by the Auditor General and other regulators. Timing – December 2015 to March 2016.

5. Improvement audit assessment work for 2014-15

Corporate Assessment

The final report was published on 2 December and will be presented to the Council on 9 December 2015.

6. Follow up on national recommendations

The Wales Audit Office is following up on recommendations made in national studies reports published during 2014-2015 by way of a survey to all councils in the autumn of 2015. This will enable the evaluation of progress on recommendations at each council, inform local planning for 2016-2017, and give a national picture of the implementation of WAO recommendations.

7. National Value-for Money studies

A separate table has been produced which identifies the national studies the Wales Audit Office has produced or is planning through the 2015-16 period.

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ISLE OF ANGLESEY COUNTY COUNCIL	
REPORT TO	**AUDIT AND GOVERNANCE COMMITTEE**
DATE	**8 DECEMBER 2015**
SUBJECT	**PROGRESS REPORT ON INTERNAL AUDIT 01 APRIL 2015 TO 31 OCTOBER 2015**
LEAD OFFICER	**HEAD OF INTERNAL AUDIT – MIKE HALSTEAD**
CONTACT OFFICER	**AUDIT MANAGER - SIONED PARRY**
Nature and reason for reporting - To comply with the requirements of the UK Public Sector Internal Audit Standards and the CIPFA UK Standards which came into force on 1st April 2013, whereby the Head of Audit is required to report periodically to the Audit & Governance Committee on the Internal Audit Service's performance relative to the 2015/16 Audit Plan and consider Internal Audit performance measures on a quarterly basis.	

1. INTRODUCTION

1.1 This report is produced in compliance with the Terms of Reference of the Audit and Governance Committee, whereby the Committee should review progress in delivering the Internal Audit Plan and Internal Audit Strategy through the receipt and consideration of quarterly progress reports.

1.2 The report analyses the performance of the Internal Audit Service for the period 1st April 2015 to 31st October 2015 and is supported by **Appendices A to E** detailing progress against performance targets for 2015/16 and the work undertaken by the Service during this period.

1.3 A revised Strategic Plan for the three year period 2015/16 to 2017/18 was submitted and approved by the Audit and Governance Committee at a meeting on the 27 July 2015. The resulting 2015/16 Operational Plan provides a more balanced plan; which spreads audit coverage more widely and enables the examination of a number of areas which have not been subject to audit review in recent years.

2. RECOMMENDATION

2.1 Members are asked to consider and provide comment on the assurance provided to the Audit and Governance Committee in this report regarding the internal control, risk management and corporate governance processes that are in place to manage the achievement of the Authority's objectives.

3. BACKGROUND INFORMATION

3.1 Internal Audit Performance 1/4/15 to 31/10/15

3.1.1 An analysis of the work and performance of the Internal Audit Service has been undertaken for the period 1/4/15 to 31/10/15. There were 10 audit projects of varying complexity in respect of 2014/15 that were not completed or issued by 31/03/15 and constitute work in progress as follows:

- Cash Receipting System
- Council Tax
- Housing Benefits
- Housing Rents
- Main Accounting System
- NNDR
- Payroll
- Sundry Debtor
- Treasury Management
- Stock Check DLO

3.1.2 The amount of work allocated to work in progress during 2015/16 to the end of August accounts for 5.5 days and will be met from closure of previous year's work contingency.

3.1.3 A schedule of performance targets for the period ending 31/10/15 is attached in **Appendix A**. It should be noted that the performance indicator in respect of audits performed during this period is reduced due to the need for the Service to concentrate on completing all work in progress in respect of 2014/15. Progress has also been hampered by a higher than expected level of sickness within the Audit Team and the fact that the Team is carrying a vacancy.

3.2 Additional Unplanned Work

3.2.1 There was 1 additional unplanned audit performed during the period 1/4/15 to 31/10/15. This amounts to 2.2 days work and is documented on the attached schedule at **Appendix B**. Unplanned grant certification work previously undertaken by external audit has also been undertaken and amounts to 34 days.

3.3 Statement of Assurance

3.3.1 The Head of Audit is required to provide the Audit and Governance Committee with an opinion on the overall adequacy and effectiveness of the Authority's governance, risk management systems and internal control environment. In compliance with the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note. The overall opinion is one of the assurances used by the Authority in preparing the Annual Governance Statement required under the Accounts and Audit Regulations.

3.3.2 The audit opinions on the assignments performed during the year to date have been categorised as follows:

- Substantial Assurance
- Reasonable Assurance
- Limited Assurance
- Minimal Assurance

3.3.3. In support of the audit opinions, the recommendations made during the year have been categorised as High, Medium and Low priority, as was approved by the Audit and Governance Committee on the 27 July 2015. Definitions of the risk ratings of recommendations and the audit opinions are attached in **Appendix C**. Consideration will be given to align the Internal Audit recommendation risk ratings with the Authority's Risk Management Matrix further embedding the risk management process in the Authority. Committee approval will be sought at a future date.

3.3.4 A summary of all audit assignments completed during the year to date including work in progress from 2014/15 is attached in **Appendix D**. The schedule summarises the audit

opinions and recommendations in respect of each area reviewed and will form the basis of the opinion contained in the Annual Statement of Assurance of the overall adequacy and effectiveness of the Authority's governance, risk management and internal control framework for 2015/16. Since the 1 April 2015, ten final reports have been issued from the 2014/15 Internal Audit Operational Plan and five from the 2015/16 Operational Plan.

3.3.5 The Risk Management Framework & Top 5 Risks audit and the Information Governance – Compliance Audit completed during September and October, 2015 respectively, both resulted in '**Reasonable**' levels of assurance. Details of the audits are summarised in **Appendix D.**

3.4 Audit Follow Ups and Recommendation Tracking

3.4.1 The UK Internal Audit Standards require Internal Audit to follow up management actions arising from its assignments. The implementation of agreed audit recommendations is the responsibility of management not Internal Audit. Internal Audit's responsibility is to report the status position.

3.4.2 The data is currently compiled from a self-assessment by the relevant services and is currently not subject to confirmation by Internal Audit until a subsequent audit review is undertaken in the same area. In the interim it is for managers to explain why recommendations have not been implemented. **Table 1** below summarises the implementation of recommendations as at 9 November 2015:

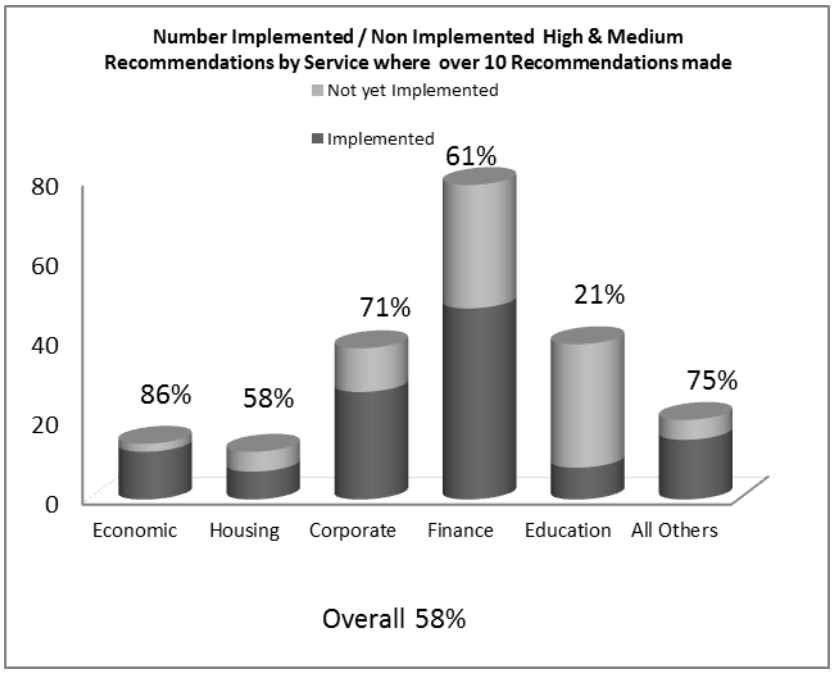
Table 1 - Status of agreed recommendation as at 09-11-2015

Status	High	Medium	Total	%
Complete	24	93	117	58%
Outstanding	8	77	85	42%
Total	32	170	202	100%

3.4.3 Recommendations are currently rated as high, medium or low according to the perceived risk as outlined in **Appendix C**. Those rated low are not subject to formal follow up by Internal Audit and are not included in this analysis. The percentage implementation rate as at 9 November 2015 was 58% of 'high' and 'medium' recommendations having been recorded as implemented.

3.4.4 A graph showing the breakdown of recommendation implementation by Service is provided in **Table 2** below:

Table 2



3.4.5 A report by the previous Interim Audit Manager to the Audit and Governance Committee on 27 July 2015 identified that work is required to improve the monitoring and reporting of progress in implementing agreed recommendations. The introduction of a Follow Up and Monitoring Process is addressed elsewhere on your agenda under the Revision of the Internal Audit Protocol to include Follow Up Audits.

3.4.6 **Referrals**

3.5.1 In addition to the assurance services agreed with and provided to assist management in meeting the objectives of the Authority, Internal Audit also undertake a range of referrals/ consultancy services which include:

- Advice and guidance to management in respect of a range of issues, including system implementation, compliance with policies regulations and procedures and internal control requirements;
- Training;
- Special investigations including fraud related work.

3.5.2 The number of planned days for referrals/consultancy during the year amounts to 205 days with 113.81 days spent on this work up to the end of October 2015.

3.5.3 A summary of special investigations undertaken by Internal Audit during the period 1 April 2015 to 31 October 2015 is included in **Appendix E** and amounts to 48 days.

3.6 Sickness Absence

3.6.1 The Service manages sickness absence in compliance with the Authority's Sickness Absence Policy. Sickness accounted for 73 days absence up to the period ending 31 October 2015 against an annual target of 45 days. This was primarily due to the long term sickness absence of 2 officers in the first quarter, which accounted for 59.81 days absence.

4. INTERNAL AUDIT FORWARD WORK PROGRAMME

Scheduled Review Title	Service Area	Current Status
Partnerships Governance & Performance	Corporate	Draft Reviewed
Building Regulation Fees	Sustainable Development	Work in Progress
Contract Audit – Capital Expenditure	Corporate	Work in Progress
Fleet Management	Sustainable Development	Draft Reviewed
Human Resources – Policies & Practices for Managing the Workforce	Transformation	Work in Progress
Ysgol Talwrn	Lifelong Learning	Work in Progress
Ysgol Brynsiencyn	Lifelong Learning	Work in Progress
Ysgol Cemaes	Lifelong Learning	Work in Progress
Ysgol Gynradd Bodedern	Lifelong Learning	Work in Progress
Affordable Housing, Houses into Homes and Self-build Loan Scheme	Community	Draft to be reviewed
Housing Strategy	Community	Work in Progress
NDR & Council Tax	Resources	Work in Progress

5. CONCLUSION

5.1 An analysis of the Internal Audit Service's performance for the period 1 April 2015 to 31 October 2015 demonstrates that performance levels are more or less on target. However, the ability of the Service to achieve the 2015/16 Operational Plan will be dependent on the level of demand for audit resources in respect of referrals, unplanned work prior to the year end and sickness absence levels.

INTERNAL AUDIT PERFORMANCE TARGETS 2015-16 **APPENDIX A**

Description	IOAC Actual 2013/14	IOAC Actual at 31/3/15	IOAC 2015/16 Target	IOAC Actual at 31/10/15	Wales Average 2013/14
1. % Planned Audits Completed	81%	92%	80%	32.20%	80%
2. Number of Audits	51	46	60	19	126
3. % Clients responses 'Satisfied'	100%	100%	100%	Nil Return	97%
4. % Recommendations accepted	100%	100%	100%	90%	99%
5. % Implementation of High & Medium Recommendations at Follow up audits	46%	49%	85%	58%	N/A
6. % Audits completed within planned time	N/A	N/A	90%	84.21%	71%
7. % Directly chargeable time against total available	N/A	N/A	70%	73.30%	68%
8. Average days from closing meeting to issue of draft report	N/A	N/A	6 days	8.6 days	9.5 days
9. Average days between response to draft and final report issue	N/A	N/A	2 days	2.4 days	2.4 days
10. Average actual cost per directly chargeable audit day	£245	£238	£250	£250	£225
11. No. Audit Staff	5.5	5.6	5.68	5.68	9.3
12. % staff leaving	0	0	0	0	22%

AUG 2015

APPENDIX B

ANGLESEY COUNCIL
INTERNAL AUDIT

ANALYSIS OF ADDITIONAL UNPLANNED WORK PERFORMED DURING 1st APRIL 2015 TO 31st OCTOBER 2015

	AREA	NATURE OF THE WORK	AUDIT DAYS
1	Bryn Trewan	The Audit Committee requested that Internal Audit look at original documentation in relation to the re-charge of sewage cost in relation to 60 properties at Bryn Trewan, Caergeiliog.	2.20
2	Grant Certification – European Social Fund	Final Certification.	4.30
3	WG Pupil Deprivation Grant 2014/15	Internal Audit was informed in September 2015 that the Pupil Deprivation Grant Authority Allocation Certificate and an Internal Audit Report had to be submitted to WG by 331 October 2015.	4.80
4	WG Welsh In Education Grant 2014/15	Internal Audit informed in August 2015that the WEG Authority Allocation Certificate and an Internal Audit Report had to be submitted to WG by 31 October 2015.	2.70
5	WG 14 - 19 Learning Pathways Grant 2014/15	Internal Audit was informed in September 2015 that the 14-19 Learning Pathways Grant Authority Allocation Certificate and an Internal Audit Report had to be submitted to WG by 31 October 2015.	13.18
6	WG School Effectiveness Grant 2014/15	Internal Audit informed in August 2015 that the SEG Authority Allocation Certificate and an Internal Audit Report had to be submitted to WG by 31 October 2015.	9.05
	TOTAL DAYS		**36.20**

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APPENDIX C

AUDIT RECOMMENDATIONS AND THE AUDIT OPINION

1. DEFINITIONS OF ASSURANCE RATINGS

New assurance level definitions for 2015/16 are clearer and more precise and bring into play the priority of recommendations made. They are:

LEVELS OF ASSURANCE	DEFINITION
SUBSTANTIAL ASSURANCE	Arrangements for governance, risk management and internal control are good. No or only low impact management action is required. **No high and a maximum of 2 medium priority recommendations are made.**
REASONABLE ASSURANCE	Arrangements for governance, risk management and/or internal control are reasonable. Management action of moderate to low impact is required. **No high priority recommendations are made.**
LIMITED ASSURANCE	Arrangements for governance, risk management and internal control are limited. Management action of high to moderate impact is required. **A number of high and/or medium priority recommendations are made.**
MINIMAL ASSURANCE	Arrangements for governance, risk management and internal control are significantly flawed. High impact management action is required in a number of areas. **A significant number of high priority recommendations are made.**

2. Definitions of Recommendation Priorities

Definitions of the priorities used for recommendation have been made to improve consistency within the audit team and help the level of understanding by the report recipient. They are:

RECOMMENDATION PRIORITY	DEFINITION
High	Significant action required relating to the absence if or non-compliance with fundamental control processes creating the potential for significant governance issues, malpractice, risk or error to go undetected.
Medium	Important action required to bring the internal control system up to an acceptable standard or eliminate an unacceptable level of non-compliance with existing control processes.
Low	Action which would improve the internal control in general but which is not vital to the overall control system.

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Summary of Recommendations and Assurance Levels 1-4-15 to 31-10-15 APPENDIX D

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
1	Cash Receipting System WIP 2014/15	April 15	Resources	4	An audit of Cash Receipting System was undertaken as part of the approved internal audit periodic plan for 2014/15. The receipting of cash amounts is currently undertaken via manual input to the Cash Receipting system from bank statements. A recommendation included in the 2013/14 Cash Receipting report related to the implementation of an auto feeder bank statement should be progressed in 2015/16 to assist in ensuring that bank reconciliation can be carried out promptly from period end. This and the three further recommendations in the 2013/14 Cashiers Final Report have not been implemented. **Opinion:** Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed and consistently applied.	Substantial
2	Debtors WIP 2014/15	April 15	Resources	22	An audit of Sundry Debtors was undertaken as part of the approved internal audit periodic plan for 2014/15. In 2013/14 the number of invoices raised was 20,287 with a value of £16.3M. The value of cancelled invoices plus credit notes raised in the period was £462k. An Aged Debt Summary Report dated 14 January 2015 reported a total amount of sundry debt outstanding to be £3,192,488.54.	Limited

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					The Council introduced a new CIVICA financials system in April 2013 including the Sundry Debtors module which is used as the Council's main record of debtors. The Sundry Debtor review for 2013/14 included six Medium and eleven Low category recommendations. The 2014/15 audit showed that the six Medium category recommendations made have not been implemented. These relate to the prompt and effective recovery of outstanding debt, regular review of aged invoice, regular review of write offs, suppressions, reconciliation of the financial ledger to the Sundry Debtor system and responsibilities relating to the nomination of officers for the entering and authorising invoices and debtor details within the system. Two of the Low category recommendations have been implemented. The remaining nine Low category recommendations are re-iterated. These relate to the review of system access rights, supporting documentation for debtor invoices, review of fees and charges, duplicate debtor detail, cancelled debts, debit of cost codes when evident that debts cannot be recovered, debtor performance indicator reports and the reporting of performance in relation to targets. **Opinion:** Taking account of the issues identified, whilst the Council can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, and consistently applied, action needs to be taken to ensure this area is managed.	
3	Council Tax WIP 2014/15	April 2015	Resources	8	An audit of Council Tax was undertaken as part of the approved internal audit periodic plan for 2014/15. Council Tax is	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					administered by the Revenue and Benefits Service. There were 34,553 properties (excluding unbanded properties) as at March 2013. The total debit raised for Council Tax in 2013/14 (net of exemptions, reliefs and council tax benefits) was £30.8m of which the in year collection rate was 97.1% of this total. The Council Tax report for 2013/14 included one Medium and six Low categorised recommendations. The 2014/15 audit found that the Medium recommendations relating to reconciliation to the Postal Docket has not been implemented. Four Low recommendations have been assessed as not implemented and one Low recommendation was seen to be part-implemented. The recommendations relate to single person's discount, debt recovery procedures, accounts on pending write-off status, review of suppressed accounts and void visits. **Opinion:** Taking account of the issues identified, the Council can take reasonable assurance that the controls upon which the organisation relies to manage these risks are suitably designed, consistently applied and effective. However we have identified issues that, if not addressed, increase the likelihood of the risks materialising.	
4	NNDR WIP 2014/15	April 2015	Resources	8	An audit of NNDR was undertaken as part of the approved internal audit periodic plan for 2014/15. The total number of properties (excluding unbanded properties) as at 31 March 2014 was 2,707. The total debit raised for NNDR in 2013/14 (net of refunds) was	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					£13.6m of which the in year collection rate was 97.9% of this total. The average reported tax collection rate for all Unitary Authorities in Wales was 97.1%. The NNDR report for 2013/14 included two Medium and eight Low categorised recommendations. Our follow up work in 2014/15 has found that the Medium recommendations relating to reconciliation of total value of bills to the number of rateable hereditaments and clearing write offs that have been on the system for more than twelve months have not been implemented. One Low category recommendation has been actioned and two superseded; the remaining five Low category recommendations have been assessed as not implemented. These recommendations relate to prompt processing of write-offs on the system, carrying out exempt property visits, consistent application of recovery procedures, prompt referral of debts to Enforcement Agents and review of suppressed accounts. **Opinion:** Taking account of the issues identified, the Council can take reasonable assurance that the controls upon which the organisation relies to manage these risks are suitably designed, consistently applied and effective. However we have identified issues that, if not addressed, increase the likelihood of the risks materialising.	
5	Housing Benefits WIP 2014/15	April 2015	Resources	11	An audit of Housing Benefit - Key Controls was undertaken as part of the approved internal audit periodic plan for 2014/15. The total amount of Housing Benefit paid in 2014/15 for the period 01-04-2014 to 11-02-2015 in respect of private tenants was approximately £8.5m and for LA tenants £7m. The total amount	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					awarded under the Council Tax Reduction scheme was approximately £5m. The total case load recorded up to January 2015 for Housing Benefit Claims was 49,230 and for Council Tax Reduction were 65,638. The Benefits Service is within target for time taken to process change in circumstances, on receiving all information required for decision within 14 days of new claim and on accuracy checks undertaken in the period. However, the Service has not reached set targets in relation to the processing of new claims and for the identification of cases for which the calculation of the amount of benefit due is correct. The most significant area in which the Service has been ineffective in the period is in the recovery of benefit overpayments which have increased during the period. The Housing Benefit 2013/14 Internal Audit report included 5 Medium and 6 Low categorised recommendations. Follow up work in 2014/15 found that at the time of review the 4 Medium and 5 Low priority recommendations were implemented. The 2 recommendations assessed as not implemented relate to the non-recoverable write offs and reconciliations and the segregations of duties between the roles of allocations and recovery. **Opinion:** Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.	

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
6	Housing Rents WIP 2014/15	April 2015	Resources	4	An audit of Housing Rents was undertaken as part of the approved internal audit periodic plan for 2014/15. At the time of reporting the Council's Housing Service managed 3798 dwellings, 767 garages and 12 leased properties across the County. The estimated rental income for 2014/15 was reported to be £13.8M. **Opinion:** Taking account of the issues identified during the course of the audit, the Council can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.	Substantial
7	Stock Check DLO WIP 2014/15	May 2015	Housing	N/A	An annual stock check undertaken by the Authority's Internal Audit Service at the BMU Depot on 28th of March 2015. The total closing stock value identified in April 2015 was £157,493.13. **Opinion:** The stock records maintained at the depot are sufficiently accurate and provide a reliable record of the stock levels at the year end.	Substantial
8	Treasury Management WIP 2014/15	May 2015	Resources	2	An audit of Treasury Management was undertaken as part of the approved internal audit periodic plan for 2014/15. The Treasury Management function operates within the approved Treasury Management Strategy and the Annual Investment Strategy which is approved by the full Council each year. The Current Treasury Management position (for quarter 3) was reported to the Audit Committee in February 2015. The review of Treasury Management in 2013/14 resulted in a Green audit opinion and three medium category recommendations being made. Follow up work as part of this year's review found that the previous recommendations have yet to be fully implemented. The previous recommendations relate to: • Access rights within the HSBC net system and deletion of	Substantial

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					any users that no longer need access; • Ensuring two authorising signatories (segregation of duties) are obtained in order to carry out fund transfers within the Authority; • To maintain an audit trail and to provide assurance over segregation of duties signatures evidencing checking, authorising or approving should be in the name of the individual carrying out relevant action and not 'pp'd' in the name of an absent officer. Treasury Management processes and procedures should be fully, clearly documented and dated in order to set out who can approve, documentation required and segregation of duties. **Opinion:** Taking account of the issues identified, the Council can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.	
9	Payroll Key Controls WIP 2014/15	May 2015	Resources	6	An audit of Payroll - Key Controls was undertaken as part of the approved internal audit periodic plan for 2014/15. The Payroll system currently in use is 'Resourcelink' provided by Northgate and is an integrated Human Resources and Payroll system. There were 3,850 live payroll records at the end of March 2015 and 2,333 paid records in the month. There were 415 new starters on the payroll and 444 leavers processed during the 2014/15 financial year. Key findings from the review highlighted a lack of formally documented procedures, issues in relation to secure storage of	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					payroll records and system access controls do not enforce segregation of duties between HR establishment functions and payroll functions. The lack of segregation of controls has been highlighted in a previous payroll audit report and in a separate review of Logical Access & Segregation of Duties. **Opinion:** Taking account of the issues identified, the Council can take reasonable assurance that the controls upon which the organisation relies to manage these risks are suitably designed, consistently applied and effective. However, issues have been identified that, if not addressed, increase the likelihood of the risks materialising.	
10	Main Accounting System WIP 2014/15	June 2015	Resources	6	An audit of the Main Accounting System - CIVICA was undertaken as part of the approved internal audit periodic plan for 2014/15. At the time the audit was undertaken the CIVICA team was in the process of conducting a re-launch of the system. The re-launch was initiated due to a number of perceived weaknesses in the way the system had been introduced and subsequently used by the services. Administration of the system was also lacking mainly as a result of poor procedural documentation. It is envisaged that the re-launch of CIVICA will be substantially complete by the end of the current calendar year and all issues raised within the audit dealt with as part of that action. **Opinion:** Arrangements for governance, risk management and/or internal control are reasonable. An overall Reasonable Assurance audit opinion resulted from the review with four Medium category and two Low category recommendations being agreed with	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					management.	
11	ICT Disaster Recovery	July 2015	Resources	13	This audit was undertaken as part of the approved Internal Audit plan for 2015/16. Internal Audit carried out a review in 2012/13 of the management arrangements for Business Continuity and ICT Disaster Recovery. Internal Audit's opinion at that time was that the Council could not take assurance that the controls upon which it relies to manage these areas were suitably designed, consistently applied or effective (a MINIMAL assurance level). Recommended actions were agreed but Internal Audit was informed that little action has been taken since. The 2015/16 audit report only deals with ICT Disaster Recovery plans. A separate report has been produced covering Business Continuity. The main key findings in the 2015/16 report identified that: • The Council does not have a formal approved ICT Disaster Recovery Plan in place • The Council does not have a dedicated disaster recovery facility located away from the ICT Suite • Services need to complete up to date business plans to feed into future ICT Disaster Recovery Plans • There is no regular restores of system and data backups • Scheduled restores are not carried out in live and test environments to ensure backups can be used to restore promptly and reliably in a disaster scenario • Responsibility of maintenance of the environmental control and fire suppression systems are not formally documented	Minimal

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					and monitored by ICT • The current UPS is not fit for purpose and the Council does not therefore have an operating UPS in the event of an electrical failure. **Opinion:** Arrangements for governance, risk management and internal control are significantly flawed. High impact management action is required in a number of areas. **Recommendations are predominantly high priority**	
12	Markets Administration & Rents Income	July 2015	Public Protection & Planning	4	An audit of Market Administration and Rents Income was undertaken as part of the revised internal audit plan for 2015/16. The service area has not been subject to audit review since 2006. The key findings from the audit identified that operational procedures had not been reviewed and updated to reflect recent changes in market operations and banking arrangements. It was also evident there is no systematic monitoring to ensure that all market traders maintain and produce evidence of adequate public liability insurance cover. **Opinion:** An overall Reasonable Assurance audit opinion resulted from the reviews with three Medium category and one Low category recommendations being agreed with management.	Reasonable
13	Business Continuity	July 2015	Corporate	7	An audit of Business Continuity was undertaken as part of the approved internal audit periodic plan for 2015/16. BCM is a statutory duty for local authorities as well as being a key part of governance processes. It is a requirement of the Civil Contingencies Act 2004 that plans are prepared and put in place	Limited

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					to ensure that services, particularly those that are statutory services, can continue. The main findings of the review identified the Interim Business Continuity Plan is, in its current draft form, not sufficiently complete to ensure proper efficient and effective recovery of the Council's data and processes should a disaster event occur. Responsibilities of the Senior Leadership Team and Heads of Services in relation to Business Continuity are not clearly stated within the Business Continuity Plan and Business Continuity is currently not reported and managed at the highest level. The work to establish a Business Continuity Management and Emergency Planning Working Group should continue and the comprehensive Corporate Business Continuity Plan should incorporate Building Recovery Management arrangements. **Opinion:** Arrangements for governance, risk management and internal control are limited. An overall Limited Assurance audit opinion resulted from the reviews with five High category and two Medium category recommendations being agreed with management.	
14	Risk Management Framework & Top 5 Risks	Sept 2015	Corporate	3	This audit was undertaken as part of the approved Internal Audit periodic pan for 2015/16. A review of the application of the Risk Management Framework was commissioned by the SLT in the summer of 2014 and found the following:	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					• The application of risk across the Council was inconsistent • It is not clear how the service and corporate risk registers relate • A lack of clarity regarding process fro escalation or feedback; and • Risk is not well aligned with the planning and performance management processes. The Policy and processes have been revised and training delivered to senior officers and staff. Service Risk Registers are being reviewed and incorporated into the Business Planning Process and Revised Corporate Risk register in place by the end of the first Quarter 2015. The main findings of the review identified that Service Delivery Plans are not always submitted promptly and within deadlines with all sections having been completed including links to the Risk Registers. Evidence of existing controls relating to the Corporate Risk Register were not always available. **Opinion:** An overall Reasonable Assurance audit opinion resulted from the reviews with two Medium category and one Low category recommendations being agreed with management.	
15	Information Governance – Annual Review of Compliance	Oct 2015	Corporate	7	An audit of Information Governance – Annual Review of Compliance was undertaken as part of the approved Internal Audit periodic plan for 2015/16. Key findings from the review are:	Reasonable

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					• Third party contractors processing personal data on behalf of the Council have not been identified to ensure that an appropriate Data Processing Agreement has been implemented and Data Processing Agreements re not available for every 'Category 1' Contracts. • No new systems, projects or processes had been implemented during the audit review and therefore no evidence of Privacy Impact Assessments undertaken were available for review by the auditor. • Not all Information Asset Owners (IAOs) were able to give assurance that appropriate measures are in place for the secure storage, movement, retention and disposal of records within remote establishments (those outside of the HQ) • The Council lacks procedures for managing electronic records containing confidential data • No assurance can be given as to whether random information sharing of personal data had been assessed as a lack of data was available for testing. • Not all staff comply with the Clear Desk Policy implemented by management • The Council's privacy notices issued by each service are not clear, consistent and available for the gathering , processing and sharing of data • No central log exists of all privacy notices and no evidence was seen of privacy notices transferred to the corporate privacy notice template • No formal written report has been presented to the SLT of data security incidents, its cause and effectiveness of	

	Report Title	Date	Service	Total Audit Recomm-endations	Key Messages	Assurance Level
					response as per the Data Security Incident Policy. It was acknowledged that incidents have been verbally reported to SLT to date. **Opinion:** An overall Reasonable Assurance audit opinion resulted from the reviews with five Medium category and two Low category recommendations being agreed with management.	

ANGLESEY COUNCIL
INTERNAL AUDIT SECTION

Appendix E

SUMMARY OF SPECIAL INVESTIGATIONS - 1 APRIL 2015 TO 31 OCTOBER 2015

Job No.	Type of Incident	No. of Days	Comment / Result
1955.14/15	School – alleged financial irregularities	4.70	Recommendations made to address poor financial record keeping.
2006.14/15	Recycling Unit -	0.34	It is considered that procedures to counter theft from the site are adequate and there is good CCTV coverage. Nothing further can be done regarding anonymous allegation.
005	Missing £100 Cash	4.53	The Police investigation into the incident has now been closed. Weaknesses identified by management and measures to strengthen the procedures have been immediately implemented.
010	School - Theft of Cash	7.03	Perpetrator resigned and investigation closed.
014	Depot – Theft of Diesel	3.11	Ongoing Police investigation.
017	WG Referral – Disabled Student Allowance – Ineligible Payments	5.36	Draft Stage - No recommendations have been made in relation to this referral as the LA no longer administers the DSAs.
022	Unauthorised opening of visitor attraction	18.31	Enquiry concluded. Report currently being prepared.
031	Employee undertaking paid work whilst off sick	0.20	Insufficient information to warrant further investigation. E-mail address only indication of additional employment.
032	Theft of personal monies from school classroom	2.64	Ongoing Police enquiry. CCFO liaising with Police regarding further action.
	Potential data breach – hand delivered mail	1.82	CCFO liaising with Corporate Information Officer and Reception Staff in relation to adopting some form of recording of private/confidential hand delivered mail.
TOTAL DAYS		**48.00**	

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ISLE OF ANGLESEY COUNTY COUNCIL	
REPORT TO	**AUDIT AND GOVERNANCE COMMITTEE**
DATE	**8 DECEMBER 2015**
TITLE OF REPORT	**REVISION OF THE INTERNAL AUDIT PROTOCOL TO INCLUDE FOLLOW UP AUDITS**
LEAD OFFICER	**HEAD OF INTERNAL AUDIT – MIKE HALSTEAD**
CONTACT OFFICER	**AUDIT MANAGER - SIONED PARRY**
Nature and reason for reporting – To comply with the requirements of the UK Public Sector Internal Audit Standards and the CIPFA UK Standards which came into force on 1st April 2013, whereby the Head of Audit is required to follow up management actions arising from its assignments.	

1. INTRODUCTION

1.1 The Internal Audit Service has in place an Internal Audit Protocol agreed with senior management which sets out the various stages of Internal Audit engagements and the timescales for undertaking these.

1.2 This Internal Audit Protocol document sets out an agreed methodology and timescales for the planning, performance and communication of results from Internal Audit reviews in line with the Public Sector Internal Audit Standards. The Protocol sets out what is required from both the Internal Audit Service and its clients in order to best achieve the set audit objectives.

1.3 The Interim Head of Internal Audit in a report to the Audit and Governance Committee 27 July 2015 identified work needed to be done to improve the process for collecting the data concerning agreed recommendations raised and how progress in implementation is monitored in order to be able to report accurately to the Senior Leadership Team and provide assurance to the Audit and Governance Committee.

1.4 No enhancement of the internal control framework can be made or reductions in associated risks until recommendations are implemented in full. A Follow Up and Monitoring process to provide assurance that the agreed recommendations are implemented within the timescales set out in the Final Report Action Plan is set out in Paras. 10 and 11 of the attached Internal Audit Protocol. The Follow Up procedures for establishments (Elderly and Children's Homes, Day Care Centres, Leisure Centres, Libraries, Museums etc.) are the same apart from school audits which is outlined in Page 13, Para. 6.

1.5 The Protocol has been reviewed and updated in line with current regulation and practices.

2. RECOMMENDATION

2.1 The Internal Audit Protocol is presented here for the information and comment of the Audit and Governance Committee.

CYNGOR SIR
YNYS MÔN
ISLE OF ANGLESEY
COUNTY COUNCIL

Title:	INTERNAL AUDIT PROTOCOL
Last Reviewed:	AUDIT COMMITTEE – 8 December 2015
Next Review Due:	AUDIT COMMITTEE – April 2017
Author:	AUDIT MANAGER

PROTOCOL FOR INTERNAL AUDIT

Introduction
The Relevant Internal Audit Standard Setters (RIASS) adopted a common set of Public Sector Internal Audit Standards (PSIAS) from 1 April 2013. The PSIAS encompass the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF). The Relevant Internal Audit Standard Setters for local government in the United Kingdom is the Chartered Institute of Public Finance and Accountancy (CIPFA). **(PSIAS – Framework Overview)**

Purpose of the Protocol
The Council has adopted the Public Sector Internal Audit Standards (PSIAS) and all Internal Audit activities must comply with these standards. The Public Sector Internal Audit Standards include, among many others, standards relating to the following;

- Engagement Planning (PSIAS 2200) which covers the areas of Engagement Objectives, Scope, Resources and Work Programmes (PSIAS 2210; 2220; 2230 & 2240).

- Performing the Engagement (PSIAS 2300) which covers Engagement Supervision (2340).

- Communicating Results (PSIAS 2400) which includes the Criteria for Communicating (2410) and the Dissemination of Results (2440).

- Monitoring Progress (PSIAS 2500) which covers the establishment of a follow-up process to monitor and ensure management actions have been effectively implemented (2500 A1) and monitor the disposition of results of consulting engagements (2500 A2).

This Internal Audit Protocol document sets out an agreed methodology and timescales for the planning, performance and communication of results from Internal Audit reviews in line with the PSIAS. The Protocol sets out what is required from both the Internal Audit Service and its clients in order to best achieve the set audit objectives.

Definition of Internal Audit

Internal Audit is defined within the Public Sector Internal Audit Standards as follows:

"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes." **(PSIAS – section 3)**

Audit Objectives

The objective of all audits is to assist and support management in identifying strengths and weaknesses in systems and to improve the systems for governance, risk management and of internal control. In order to achieve this common goal there needs to be communication and co-operation between both parties throughout the process in order to ensure that the audit meets the needs of the client department and the organisation as a whole. The purpose of this protocol is to provide a model system for both Auditors and Clients to follow and to ensure input into the process by the Client Department. It is possible that circumstances may justify a departure from this model system.

This protocol only relates to planned audits identified in the audit programme and not to any special investigation, or audits which require the auditor to visit unannounced.

1. Audit Planning

1.1 The Public Sector Internal Audit Standards make the chief audit executive responsible for developing a risk-based plan. The chief audit executive takes into account the organisation's risk management framework, including using risk appetite levels set by management for the different activities or parts of the organisation. If a framework does not exist, the chief audit executive uses his/her own judgment of risks after consideration of input from senior management and the Audit and Governance Committee. The chief audit executive must review and adjust the plan, as necessary, in response to changes in the organisation's business, risks, operations, programs, systems, and controls. **(PSIAS 2010 – Planning)**

1.2 The audit planning process is carried out annually in January and February and is produced by carrying out a risk assessment of all the organisational areas. The relevant extract of the audit plan is agreed with each individual Service prior to

each the start of each financial year. This process results in each senior manager being informed of each area, under their control, that the Internal Auditor intends to audit during the forthcoming year.

This planning process is a chance for discussion between Internal Audit and the Services to identify any areas of particular change or concern in the areas to be reviewed. The issues discussed will be fed into the assignment planning stage for these reviews. The active involvement of the Council's senior management in this process is vital to ensure that reviews are designed to add the most value to each area.

The planning stage will also involve discussion on broad indications of dates for the undertaking of reviews in order to avoid peak times for the Services and to cause the least disruption to their work. Where possible Internal Audit will design the Audit Schedule around these broad dates. However, in order to fit in with the requirements of the External Auditor, or to ensure that any specific skills necessary to complete some reviews are available, agreed timings may require amendment following discussion with Services.

In order for any review to fully support management and to add value it is imperative that management and Internal Audit work together and that the Internal Auditor on site has access to the right people and the right information at the right time.

1.3 When the Auditor is in a position to commence a particular audit identified in the Audit Plan, the relevant senior manager will be notified by memorandum **at least 7 days prior to the proposed date of the scoping meeting.** The memorandum should give a brief description of the proposed terms of reference, although instances may arise where it is not possible for the Auditor to draw up a proposed terms of reference at this stage (e.g. a new system which has not been audited previously). If possible a proposed date for commencement should also be given.

1.4 As a first stage in carrying out the audit a scoping meeting will take place between the Auditor and the Head(s) of Service (or designated key audit contact) **at least 7 days prior to the issuing of the Audit Planning Sheet**. The purpose of this meeting is to discuss the areas which the Auditor has assessed as being of sufficient risk to require inclusion in the audit and also to consider the concerns and priorities of the client and to feed these areas into the planning process in order to agree a final terms of reference for the audit.

However it should be noted that in drawing up the terms of reference, the Auditor must maintain his / her independence and clients cannot insist that areas are removed from the terms of reference if the Auditor's assessment of risk identifies that the particular area should be included. In this respect Internal Audit will need to include areas that are required for External Audit and other stakeholders to take assurance from their work.

1.5 The scoping meeting will also identify the person who will act as the main contact during the audit. The nominated Contact Officer can be the senior manager or a manager within the Service responsible for the area under review.

1.6 This scoping meeting will also allow the Auditor and the client to identify useful sources of information that the Auditor can use during the review.

1.7 The final point to be agreed at the scoping meeting will be the timescale for the audit, i.e. when it will start, how long it is expected to take and when the closure meeting will take place. The timescale will depend on the type and complexity of the audit to be undertaken and it must be emphasised that the days specified will not be consecutive working days as the work will be undertaken in conjunction with other audit projects and work.

1.8 For audits of a corporate nature, which address authority wide issues, the initial memorandum will be e-mailed to the Chief Executive and it is for them to decide which senior manager will act as the lead on behalf of the Council. The Assignment Planning Sheet will be agreed with this lead senior manager.

1.9 The results of the scoping meeting will be entered into the Internal Audit working papers and will be issued to the client as an Audit Planning Sheet (Audit Brief) **within 7 days of the scoping meeting**. This document sets out the objectives of the review and the limitations to its scope. The start and anticipated end days of audit field work are also included. This document must be agreed with, and signed off by, the senior manager or nominated Contact Officer prior to the start of the field work.

1.10 The Audit Planning Sheet will contain details of the key information and data that will be required by the Auditor at the start of the review. This may include copies of relevant procedure notes, organisation charts, various system reports, copies of minutes of meetings etc. Adequate time should be allowed from the issue of the Audit Planning Sheet and the start of the Audit field work to allow management to produce and collate this information for the day of commencement of the field work.

1.11 Information provided by management should be provided electronically where possible as the Internal Audit Service will produce electronic audit files and working papers wherever possible.

2. Undertaking the Audit

2.1 The audit will then be undertaken with any queries and general feedback being directed through the Contact Officer.

2.2 If the initial findings of the audit identify significant areas of risk, problems or unexpected factors, then these will be referred back to the relevant senior manager and any additional work necessary will be discussed. If significant control weaknesses are identified which require immediate action then an **interim report** detailing these weaknesses and a course of action to mitigate or eliminate them will be issued by the Audit Manager.

2.3 The Auditor will complete audit tests and the work will be reviewed by the Audit Manager or a Senior Internal Auditor to ensure that all the work identified in the Assignment Planning Sheet has been carried out satisfactorily and that the standard of the audit is in accordance with the requirements of the Audit Manual and the Public Sector Internal Audit Standards.

2.4 The Auditor will keep the Contact Officer informed on the general progress of the review and in particular whether the Auditor is experiencing delays or is expecting the audit to be significantly delayed for any reason. Agreement can then be reached on a new date for the closure meeting.

3. Debrief Meetings

3.1 Unless indicated by the relevant senior manager, at the initial meeting, a debrief meeting will be held between the Auditor, the senior manager and any other officer nominated by the senior manager (normally the Contact Officer) **within 7 days of the completion of the Audit field** work to discuss the findings, conclusions and recommendations. The senior manager need not attend the meeting if he / she wishes and can delegate the debrief process to the Contact Officer.

3.2 Debrief meetings are designed to provide feedback on the results of the audit and for management to review the work undertaken and to discuss with the Auditor any identified factual errors or misunderstandings in the work undertaken. Debrief meetings are also used to review the recommendations and to ensure that they are suited to the way in which individual Services and sections operate. The Auditor should ensure that they have the audit file with them including evidence to support their findings as appropriate. Debriefs should ensure that there are no surprises for management in the draft report and make it easier for management to respond when the draft is issued. An indication of the final RAG opinion for the report will also be provided at the debrief meeting.

3.3 If management believes that they can provide further information relating to issues raised at the debrief meeting then this information will be taken into account by Internal Audit before the production of the draft report. However, the additional information must be relevant to the issues raised and made available to Internal Audit to allow compliance with the timeframe set for the issuing of the draft report (i.e. within 14 days from the date of the debrief meeting).

3.4 At the end of the debrief meeting the management representatives senior manager and / or Contact Officer) present will be asked to sign the debrief sheet prepared by Internal Audit to the effect that the issues contained therein have been discussed at this meeting. The management representative is signing to confirm the issues discussed and no agreement to their accuracy and content is required at this point.

3.5 It may become apparent at the closure meeting that further field work is required by the Auditor in order to verify the points raised or to refer to further information identified by management. In such instances the Auditor will undertake the additional testing required and amend the review findings as necessary. The client will be given the opportunity to decide whether they wish to receive feedback on these extra points through a second debrief meeting or by means of the formal draft report.

4. Draft Reports

4.1 The Internal Audit Section will issue a draft report of the findings, conclusions and recommendations, to the individuals identified in the Assignment Planning Sheet **within 14 days of the initial debrief meeting**.

4.2 For those audits, identified as corporate audits, the debrief meeting will be between the Auditor and the lead senior manager. It is noted that this Officer may not be in a position to provide a response on all the points raised and may

require consulting with other Services. This consultation process will be reflected in a longer timescale for responding to the draft report.

5. Providing Responses

5.1 It is expected that management responses including timescales and the nominated responsible employee for implementation be returned to the Audit Section **within 14 days of the issue date on the draft report.** If it is not possible to achieve the deadline set, the relevant senior manager, or agreed Contact Officer should contact the Audit Manager to discuss the matter and to agree a revised deadline.

5.2 It is the intention of the Audit Manager to agree all reports issued and clients will be given every opportunity and support in order that a response is provided. In order for this process to work, it is important that those who will be responding to the draft report are present at the debrief meeting.

5.3 As the Auditor also has a responsibility to inform and provide assurance to the Council's S.151 Officer on the standard of internal controls operating within systems, a **copy of draft reports** of any audit given a 'Red Assurance' audit opinion under **Internal Audit's RAG methodology** will be sent to the S.151 Officer. If the findings of the audit indicate unlawful activities, or activities which may equate to maladministration, a copy of the report will also be sent to the Council's Monitoring Officer. In some cases it may be necessary to refer reports to other officers with specific responsibility for areas covered in the report.

5.4 Audit Reports should be treated as documents confidential to the service and whilst the report is in draft stage the Auditor will not release it to any other person apart from those identified as recipients of the draft report, unless access to another officer is agreed between the Auditor and the appropriate senior manager. However the S. 151 Officer or Monitoring Officer do have the right to receive copies of draft reports. In such cases they will also be provided with copies of any responses already received from Services.

5.5 Where a specific finding and / or recommendation relates to issues concerning the systems or internal controls operated by another Service/s then the background to, and a copy of, the specific finding and / or recommendation will be sent to that Service for a response. Such responses will then be included in the Final report. The confidentiality of audit reports must be respected by these Services.

5.6 Clients should also ensure that access to the report is limited to the recipients identified and to other officers whose input is required in order for the Service to provide a response. Draft reports are work in progress at this point and should not be circulated widely by management.

5.7 The client will be given every opportunity and assistance to provide a response to draft reports but if no response is forthcoming a final reminder copied to the relevant senior manager will be issued and non-responses will be reported to the Chief Executive and to the Audit and Governance Committee.

5.8 The Audit and Governance Committee has requested that a report be included in the Audit Manager's Progress Report of all draft reports that have not been responded to within three months of the issue of a draft report.

6. Issuing Final Reports

6.1 A **Final report will be issued within 7 days following receipt of all management responses** to draft reports. The Final report will be issued only to those identified on the Assignment Planning Sheet.

6.2 Although it is the intention of the Audit Manager to agree the contents of the final report with the client Service there may be instances where this is not possible. Where cases arise where the report cannot be agreed, the reasons why the client Service does not agree with the findings, conclusion or recommendations made will be shown in the report. Any disagreements will also be noted in the Management Action Plan where the Audit Manager will detail why he believes a significant and / or material risk remains if no management action is taken to mitigate or eliminate the weakness identified.

6.3 Final Reports are issued to the relevant senior management and / or the appropriate manager(s) identified at the outset of the audit within the Assignment Planning Sheet, and to the S.151 Officer. In addition a summary of all reports is included in the Audit Manager's progress report to the Audit Committee. The Executive Summary of all reports given a 'Red Assurance' opinion will also be included in progress reports. The progress report is a public document and therefore the Executive Summary may eventually come into the public domain.

6.4 Copies of all Internal Audit system reviews and Establishment reports (not referrals) are available to Audit and Governance Committee members on request to the Audit Manager. Internal Audit reports are provided for the sole use of the Member and not for further publication or re-issue.

6.5 Copies of Final Internal Audit reports may also be requested by the External Auditor in order that they can review the standard of work carried out. This evaluation will determine if the External Auditor takes assurance from the work of Internal Audit.

6.6 **Audit Opinions –** New assurance level definitions for 2015/16 are clearer and more precise and bring into play the priority of recommendations made. They are:

LEVELS OF ASSURANCE	DEFINITION
SUBSTANTIAL ASSURANCE	Arrangements for governance, risk management and internal control are good. No or only low impact management action is required. **No high and a maximum of 2 medium priority recommendations are made.**
REASONABLE ASSURANCE	Arrangements for governance, risk management and/or internal control are reasonable. Management action of moderate to low impact is required. **No high priority recommendations are made.**
LIMITED ASSURANCE	Arrangements for governance, risk management and internal control are limited. Management action of high to moderate impact is required.

	A number of high and/or medium priority recommendations are made.
MINIMAL ASSURANCE	Arrangements for governance, risk management and internal control are significantly flawed. High impact management action is required in a number of areas. **A significant number of high priority recommendations are made.**

7. Quality Control

7.1 The Public Sector Internal Audit Standards require the Audit Manager to develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity. The quality assurance and improvement programme must be designed to enable an evaluation of the internal audit activity's conformance with the Definition of Internal Auditing and the Standards and an evaluation of whether internal auditors apply the Code of Ethics. The programme also assesses the efficiency and effectiveness of the internal audit activity and identifies opportunities for improvement. **(PSIAS standard 1300)**

7.2 In order to allow the standard of the service to be monitored and to identify improvements which can be made a quality questionnaire will be issued to the relevant senior manager with each Final report. The completion and return of this questionnaire should be **within 7 days of the issue of the Final report.**

8. Complaints

8.1 A complaints procedure is offered to clients in those circumstances where the client is of the view that the level of service provided in a specific case is below that which would be expected.

8.2 The complainant is initially expected to discuss the complaint informally with the Audit Manager to see if any issues of concern can be satisfactorily resolved without the need for formal steps.

8.3 Where it is not possible to resolve the matter informally, the complainant (or their line manager) should make a written complaint to the Audit Manager explaining the nature of the complaint and the client's expectation. Where the complaint is about the work of the Audit Manager the complaint shall be made to the Chief Executive.

8.4 Within a reasonable time, as communicated to the complainant, Audit Manager (or the Chief Executive) will consider the complaint and, as needs be, discuss the matter with the complainant, members of staff of the Service, or any other appropriate officer.

8.5 Within the appointed time the Audit Manager (or the Chief Executive) will respond to the complaint in writing. This response will explain any steps to be taken in response to the complaint or explain why no specific steps will be taken.

8.6 Where the complainant, or their line manager, is unhappy with the result of the complaint following step 8.5 above, the complainant, or their line manager, may

make an appeal against that decision. The appeal shall be made in writing to the Chief Executive, setting out the reasons for appeal and steps 8.4 and 8.5 shall be followed by the Chief Executive in dealing with the appeal. The Chief Executive's decision on the appeal shall be final.

9. Audit and Governance Committee

9.1 The Audit and Governance Committee receives an Internal Audit Progress report at each of its meetings and an Annual report of the Audit Manager. This allows the Audit and Governance Committee to monitor the performance of Internal Audit against the Operational Plan during the year.

9.2 The Audit and Governance Committee has requested that all draft reports that do not receive management responses within three months of the issue of the latest draft be reported to them.

9.3 The Audit and Governance Committee also receives details of all Final Internal Audit reports issued that have received a 'Red Assurance' audit opinion.

10. Audit Follow Ups

10.1 The Internal Audit process needs to go beyond the issue of a Final Report and to provide assurance that the agreed recommendations are implemented within the timescales set out in the Final Report Action Plan. No enhancement of the internal control framework can be made or reductions in associated risks until recommendations are implemented in full.

10.2 Each audit report contains a schedule setting out an agreed action plan for management to implement. This will form the basis of the follow up review or visit aimed at reviewing the implementation of the agreed recommendations.

10.3 A follow up will normally take place **within 6 months of the issue of the final report** and will assess managerial action taken and establish its effectiveness. The Section needs to maximise its resource and target resources where they are most needed. As a result it has been agreed to implement the new follow up process as follows:

LEVELS OF ASSURANCE	NEW PROCESS
SUBSTANTIAL ASSURANCE	No follow up will be undertaken.
REASONABLE ASSURANCE	Generally only those recommendations ranked yellow and higher will be reviewed (Medium and High Priority). However, this is not rigid, as a number of green (Low) risks together could increase the overall risk rating. The recommendations should be discussed and those recommendations to be reviewed at the follow up stage should be agreed with the Principal Auditor/Audit Manager when the audit is reviewed.
LIMITED ASSURANCE	A full in depth follow up will be undertaken.

MINIMAL ASSURANCE	A full in depth follow up will be undertaken.

10.4 Wherever possible, follow ups should be conducted from the desk to minimise resources.

10.5 The results of follow ups should be recorded in the appropriate column of the action plan and should be conveyed to the client by memo.

10.6 Where management has failed to implement recommendations as agreed, a formal process will be followed to report these findings to senior management, and to the Audit and Governance Committee. A **second follow-up** audit may be necessary in the event of a failure by management to implement a significant number of recommendations contained in the original report. Where a number of recommendations remain outstanding at the second follow up stage and there are no obvious reasons to account for the lack of progress, the matter will be referred to the Audit and Governance Committee for consideration. This will require a responsible officer to attend the Audit and Governance Committee to explain the lack of progress.

10.7 Subsequent to the completion of the follow up and an assessment of the number of recommendations implemented and identified as outstanding it is necessary to, where appropriate, provide a revised audit opinion. The revised audit opinion should be reported to management.

10.8 A copy of the follow-up memo must be retained on the 'shared' drive for reference purposes.

11. Monitoring of Audit Follow Ups

11.1 At the beginning of each year management complete a 'Schedule of Follow-Up Audits' as attached in **Appendix A**, which lists all the audit follow ups due in the current year. The Schedule details the following information:

- A description of the audit
- File ref
- The auditor
- Audit date
- Follow up due date

11.2 Subsequent to the completion of the follow-up, the respective auditor completes the remaining information on the follow up schedule:

- Actual follow up date
- The number of recommendations made
- The number of recommendations outstanding

- The revised audit opinion

The schedule is maintained on the 'G' drive – 'Audit Follow-Up Schedules Folder'.

11.3 In addition to the completion of the 'Schedule of Follow-Up Audits' the responsible auditor must complete the Performance Indicator Schedule, which requires the recording of the number of recommendations implemented (**See attached at Appendix B**). This schedule is held on the 'G' drive – PI Schedules Folder.

12. Distribution of Audit Follow Ups

12.1 The follow up memo or report should be distributed to the same officers who were on the distribution list for the original audit report issued in final format.

ESTABLISHMENT REVIEWS

Establishment Audits involve the auditing of individual Council establishments (Schools, Elderly and Children's Homes, Day Care Centres, Leisure Centres, Libraries, Museums etc.) These audits follow a standard audit programme developed for each establishment.

1. Preparation for the Audit

1.1 Prior to the start of each financial year, a copy of the relevant audit programme will be sent to the relevant senior manager in the Service. The senior manager should contact the Audit Manager to discuss any additions or amendments to the programme.

1.2 Prior to the commencement of each audit the senior Service manager and individual establishment manager will be contacted and informed that the audit is planned. Arrangements for carrying out the visit will be made with the individual establishment manager.

2. Carrying Out the Audit

2.1 Audit work will be carried out in the normal manner with the intention of minimising the time spent at the establishment.

2.2 At the end of the visit a debrief meeting will be held with the individual establishment manager to discuss the findings of the audit.

3. Agreeing Draft Reports and Providing a Response

3.1 Given the need for audit reports to follow the internal checking process within the Audit Section it is not possible for "draft" audit reports to be provided to the individual establishment manager during the visit, nor is it normally practical for Auditors to return to establishments to discuss the "draft" report (it would be costly, time consuming and increase the disruption for establishments.). Only in exceptional cases, where any additional work carried out following the visit or the

review by the Audit Manager has resulted in the findings of the draft report being significantly different from those discussed at the closure meeting, will the Auditor return to the establishment to discuss the draft report. Therefore in the majority of cases establishment audits will follow the current process whereby a draft report is issued to the relevant senior Service manager or individual establishment manager.

3.2 The senior Service manager or individual establishment manager will be given 14 days in which to provide a response to the issues raised in the draft report.

3.3 The process for amending and agreeing reports is as for all audit reports.

3.4 Failures to respond will be dealt with in the same manner as all other reports i.e. the client will be given every opportunity and assistance to provide a response but if no response is forthcoming a final reminder copied to the relevant senior manager will be issued and non-responses will be reported to the Audit and Governance Committee.

4. Issuing Final Reports

4.1 The process for issuing final reports will be the same as for all other reports.

5. Quality Control

5.1 The procedures for quality control are the same as for all other reports.

6. Audit Follow Ups

6.1 The procedures for follow ups are the same for all other reports apart from school audits whereby any audits where a head teacher has failed to implement recommendations as agreed, a formal process will be followed to report these findings to Education Department senior management, the Chair and the local authority representative of the Board of Governors. A **second** follow-up audit may be necessary in the event of a failure by the school's head teacher and Governing Body to implement a significant number of recommendations contained in the original report.

6.2 Where a number of recommendations remain outstanding at the second follow up stage and there are no obvious reasons to account for the lack of progress, the matter will be referred to the Audit and Governance Committee for consideration. This will require a head teacher/Chair of Governors and a senior manager from the Education Department to attend the Audit and Governance Committee to explain the lack of progress.

SUMMARY OF INTERNAL AUDIT PROCESSES AND TIMESCALES

Ref	Process Description	When	Responsible Person	Reference in Protocol
1	Annual Audit Planning	February / March	Audit Manager / Relevant senior managers	1.1 to 1.2
2	Initial Notification Memorandum	At least 7 days prior to the proposed date of the scoping meeting.	Audit Manager / Senior Internal Auditors	1.3
3	Scoping Meeting	At least 7 days prior to the issuing of the Audit Planning Sheet.	Audit Manager / Relevant senior managers	1.4
4	Issue of Audit Planning Sheet	Within 7 days of the scoping meeting	Audit Manager / Senior Internal Auditors	1.9
5	Production and collation of information and data required by Auditor and specified in the Audit planning Sheet	Prior to start date for field work stated in Audit Planning Sheet.	Heads of Service / Nominated Contact Officer	1.10
6	Undertake audit and results reviewed within Internal Audit.	Within number of days specified in Audit Planning Sheet	Internal Auditor / Audit Manager / Senior Internal Auditor	2.3
7	Debrief Meeting	Within 7 days of the completion of the Audit field work	Audit Manager / Senior Internal Auditor / Auditor/ Relevant senior managers / Nominated Contact Officer	3.1 to 3.5
8	Issue of Draft Report	Within 14 days of the initial debrief meeting	Audit Manager / Senior Internal Auditors	4.1 to 4.2
9	Management Responses	Section within 14 days of the issue date on the draft report.	Heads of Service / Nominated Contact Officer	5.1
10	Issue of the Final Report	Within 7 days following receipt of all management responses.	Audit Manager / Senior Internal Auditor	6.1
11	Completion and return of Internal Audit Quality questionnaire	Within 7 days of the issue of the Final report.	Heads of Service / Nominated Contact Officer	7.2
12	Follow Up Audit	Usually within 6 months of the issue of the final report.	Audit Manager / Senior Internal Auditor / Auditor/ Relevant senior managers / Nominated Contact Officer	10.3

Follow ups Register 2015/16

Follow up Register 2015/16

	Auditable Area Description	Service	Report Date	Number of Recommendations						Audit Opinion	Follow ups Date
				High	Medium	Low	Suggestion	Total	Agreed by Mgmt		
1	Cash Receipting System 2014/15	Resources	Apr-15	0	2	2	1	5	5	Green	N/A
2	Council Tax WIP 2014/15	Resources	Apr-15	0	4	4	0	8	8	Green Amber	Oct-15
3	Housing Benefits WIP 2014/15	Resources	Apr-15	0	5	6	1	12	12	Green Amber	Oct-15
4	Housing Rents WIP 2014/15	Housing	Apr-15	0	2	3	1	6	6	Green	Oct-15
5	Main Accounting System WIP 2014/15	Resources	Jun-15	0	4	2	2	8	8	Green Amber	Dec-15
6	NNDR WIP 2014/15	Resources	Apr-15	0	4	4	0	8	8	Green Amber	Oct-15
7	Payroll WIP 2014/15	Resources	May-15	0	4	6	0	10	8	Green Amber	Nov-15
8	Sundery Debtor WIP 2014/15	Resources	Apr-15	0	10	12	4	26	25	Red Amber	Oct-15
9	Treasury Management 2014/15	Resources	Apr-15	0	3	2	2	7	7	Green	N/A
10	Bryn Trewen Debt Position	Housing	May-15	0	0	0	0	0	0	7 Issues Raised	Nov-15
11	Business Continuity Management	Democratic Services	Jul-15	5	2	0	0	7	7	Red Amber	Feb-16
12	LSB ESF Grant Certification	Resources	May-15	0	0	0	0	0	0	N/A	N/A
13	ICT Disaster Recovery	Resources	Jul-15	8	5	0	0	13	13	Red	Feb-16
14	Market & Rent Income	Planning & Public Protection	Jul-15	0	3	1	0	4	2	Green Amber	Feb-16
15	Risk Management	Corporate	Sep-15	0	2	1	0	3	3	Reasonable	Mar-16
16	Informaiton Governance - Annual Review oif Compliance	Corporate	Oct-15	0	5	2	0	7	7	Reasonable	Apr-16
17											
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19											
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22											
23											
24											
25											

APPENDIX B

SCHEDULE OF FOLLOW UP AUDITS 2015/2016

	Description	Auditor	Audit Date	Follow up Date	No. Recs	Recs Outstan-ding & WIP	High	Medium	Low	Original Audit Opinion	Revised Audit Opinion
1											
2											
3											
4											
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	TOTALS										

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