Title of meeting:	Governance & Audit & Standards Committee
Date of meeting:	3rd February 2017
Subject:	Audit Performance Status Report to 3rd January 2017
Report by:	Chief Internal Auditor
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Summary

1.1 Four new "No Assurance" audits and 1 Critical Risk exception from the 2016/17 Audit Plan are highlighted in this report.

1.2 There are now 130 planned audits for 2016/17 made up of 103 new reviews and 27 follow up audits. Of these, 102 (78%) have been completed or are in progress as at 3rd January 2017. This represents 49 audits (38%) where the report has been finalised, 6 audits (5%) where the report is in draft and 47 audits (35%) currently in progress.

1.3 In addition to the planned audits there are 11 areas of on-going work and 4 continuous audits which contribute to risk assurance.

1.4 Areas of Assurance are shown in Appendix A. Results of completed follow up audits can be found within Appendix B.

2. Purpose of report

2.1 This report is to update the Governance and Audit and Standards Committee on the Internal Audit Performance for 2016/17 to 3rd January 2017 against the Annual Audit Plan, highlight areas of concern and areas where assurance can be given on the internal control framework.

3. Recommendations

3.1 That Members note the Audit Performance for 2016/17 to 3rd January 2017.

3.2 That Members note the highlighted areas of control weakness for the 2016/17 Audit Plan.

3.3 That Members approve the proposed Audit and Counter Fraud Strategy for the use of Audit resources for 2017/18

4. Background

4.1 The Annual Audit Plan for 2016/17 has been drawn up in accordance with the agreed Audit Strategy approved by this Committee on 29th January 2016 following consultation with the Chief Executive, Deputy Chief Executive, Directors and the previous Chair of this Committee.

5. Audit Plan Status 2016/17 to 3rd January 2017

Percentage of the approved plan completed

5.1 78% of the annual audit plan has been completed or is in progress as at 3rd January 2017. Appendix A shows the completed audits since the last meeting. Appendix B shows the completed follow up audits since the last meeting.

The overall percentage figure is made up as follows:

- 42 new reviews (32%) where the report has been issued, 3 in draft form (2.5%) and 40 (31%) where work is in progress
- 7 planned follow ups (5%) where the report has been issued, 3 in draft form (2.5%) and 7 (5%) where work is in progress

5.2 As requested by Members of the Committee a breakdown of the assurance levels on completed audits is contained in Appendix A. Where specific parts of the control framework have not been tested on an area (because it has been assessed as low risk for example) it is recorded as NAT (No Areas Tested) within the Appendix.

Changes to the 2016/17 Audit Plan

5.3 One audit has changed scope since the last meeting. Five full audits and one follow up audit have been removed.

5.3.1 Young Carer's - This audit has been changed to cover the Wellbeing Service. After discussion with the then Director of Public Health it was agreed that an audit of this area would provide more value as it was new service and was of a higher risk than the Young Carer's service.

5.3.2 The follow up audit of Pupil Premium funding was removed as this area is now being covered during full school audits. 10 school audits have been completed this year none of which raised any concerns over Pupil Premium funding.

5.3.3 The full audit of Emergency Planning (Corporate) has been removed as the service is now managed through a shared manager with Southampton City Council. The shared management started in December 2016 so this area will now be reviewed as part of the 2017/18 Audit Plan and in quarter 1.

5.3.4 The full audit of Income Dues at the Port has been removed. The Port have recently undertaken work with the ferry company to put in place new controls as a result of previous issue. To allow these controls to take effect and be fully tested an audit will be carried out as part of the 2017/18 Audit Plan.

5.3.5 The full audit of Strategic Project Management has been deferred until 2017/18. A review in 2015/16 was carried out which did not raise any major concerns. In addition project progress is now reported as part of the quarterly performance management reports from Directorates to this committee.

5.3.6 The full audit of Work Place Mental Health has been deferred to 2017/18 as this is a new area and an audit would be more meaningful once the service is more established.

5.3.6 The full audit of Budget Estimates for Capital Schemes has been removed as the area was covered in the Realisation of Budget Savings audit.

5.3.7 Changes have been made to the Audit Plan as Internal Audit has seen a significant increase in external work. An additional 81 days have been secured throughout the year bring a new total of 323 days for 16/17 compared to 120 during 15/16. In addition to this one of the Counter Fraud Officer within team has been absent through long term sickness.

5.3.8 Taking into account the changes above the overall audit coverage remains within the acceptable tolerance level in order for the Chief Internal Auditor to provide an annual audit opinion.

5.4 **External Clients**

Internal Audit has now secured 323 days of audit work for external clients during 2016/17. 52% of the days for this work have now been completed.

5.5 **Reactive Work**

Reactive work completed by Internal Audit in 2016/17 includes:

- 27 corporate fraud investigations
- 28 items of advice

As well as the following unplanned reviews/work:

- Channel Shift Programme
- Copyright Audit

Exceptions

5.6 Of the full audits completed so far this year the number of exceptions within each category have been:

- 2 Critical Risk
- 79 High Risk
- 16 Medium Risk

- 7 Low Risk (Improvements)

5.7 The table below is a comparison of the audit status figures for at this time for this financial year and the previous two years.

	2014/15	2015/16	2016/17
% of the audit plan progressed	72%	81%	74%
No. of Critical exceptions	4	1	2
No. of High risk exceptions	79	53	79

Ongoing Areas

5.8

The following 11 areas are on-going areas of work carried out by Internal Audit;

- Regulation of Investigatory Powers Act (RIPA)- authorisations and training
- Anti-Money Laundering, includes processing of activity reports, review of the policy and staff training.
- Investigations
- Financial Rules waivers
- National Fraud Initiative (NFI) to facilitate national data matching carried out by the Audit Commission
- National Anti-Fraud Network (NAFN) bulletins and intelligence follow up
- Counter Fraud Programme
- Policy Hub project to ensure that all Council policies are held in one place and staff are notified of the policies relevant to them
- G&A&S Committee reporting and attendance and Governance,
- Audit Planning and Consultation
- Risk Management

Continuous Audit Areas

5.9 The following 4 areas are subject to continuous audit (i.e. regular check to controls) and feed into overall assurance;

- Legionella Management
- Asbestos Management
- Key risks management in services
- Performance Management

6. Areas of Concern & Updates

New Areas of Concern

6.1 **Property & Housing - Resident Development**

6.1.1 The audit of Resident Development was given a "No Assurance" rating as 6 high risk exceptions were raised. Previously known as the Resident Participation Service, the Resident Development team work with Portsmouth City Council residents to help them get back into employment.

6.1.2 The 6 high risk exceptions and agreed actions are summarised below:

Exception	Agreed Action
Inadequate record keeping in regard to Resident Development Plans, i.e. 76% tested held no evidence of the objectives, progress or measures. This makes it difficult to assess whether any actions taken achieve the desired outcome and are beneficial to the resident.	Processes are to be implemented to ensure a consistent approach to both the delivery of resident development plans and their recording.
The service does not have clear business objectives for this service provision or how the work that is undertaken aligns to services provided elsewhere. Without a clear objective or vision the service may suffer from inefficient working practices and duplication of efforts with other Council services.	The service is currently under review, this process will involve setting business objectives to be included within the 2017/18 Property & Housing business plan.
Outcomes for the team's caseload are not reported or measured. This means that management are unable to accurately establish if resources are appropriately allocated and distributed to ensure service delivery is effective.	As part of the process review noted above, outcomes will be measured in future against the defined objectives of the service. Actions taken against each case and evidence to support those actions will now be retained.
Inconsistent approach taken to recording financial information for each case. This makes it difficult to assess the effectiveness of the support provided or assurance that the financial support given was appropriate. 90% of the cases tested showed inconsistencies.	The service will adopt the grant process when administering funds to residents. This will record any financial information between the service and the residents and allowing the documentation to be signed.
Failure to adequately monitor spending against budget allocations, meaning inappropriate or fraudulent spending could go undetected. The budget allocation in this area is £50,000.	The adoption of the grant process will make budget monitoring more transparent and allow for spot checks and reconciliations to take place
No inventory is kept of equipment used by Resident Development Officers or	The whole service has been required to submit the identification numbers for

residents. This is a breach of Financial Rules and without an inventory should any items become damaged, lost or stolen the Authority may not be able to make a claim.	all PC's and equipment in their possession to create an inventory

6.1.3 A follow up in this area will be carried out as part of the 2017/18 Audit Plan

6.2 **External - St. Paul's RC Primary School**

6.2.1 The audit of St. Pauls RC Primary School was given a "No Assurance" rating after 8 high risk exceptions were raised.

6.2.2 The 8 high risk exceptions and agreed actions are summarised below:

Exception	**Agreed Action**
Testing noted a failure to keep an electronic summary of banking documents which can be cross checked with the bank paying in stub. This puts the School and its finance officers in a vulnerable position in the event of loss or theft of money.	A summary of banking sheet will now be produced and checked to the total amount banked. Spot checks will be undertaken on a termly basis
Purchase orders were found to be have been raised retrospectively which is against PCC Financial Rules as expenditure is not being duly authorised prior to commitment.	All staff are to be reminded of the requirement to raise a purchase order before committing the expenditure
The school's Business Continuity Plan was not compliant with best practice. It was not evident who had approved the plan or whether staff were aware of its contents. In the event of an emergency the school may not have the required resources or awareness of a strategy to resolve the issue presented.	A compliant plan will be put in place and approved by the full Governing Body
The school does not have a CCTV policy in place, this is non-compliant with Information Commissioners Office (ICO) Code of Practice and other legislation and could result in a fine for the school.	The Resource Management Governors will review and ratify a CCTV policy at their November 2016 meeting
MIDAS certificates for mini bus drivers could not be evidenced in 2 cases. Using a non MIDAS driver may negate the insurance policy in the event of an accident. In addition and in some instances 52/1963 miles the odometer	A copy of all current MIDAS certificates will be retained on file. The journey log sheets will be checked on a termly basis

readings were not sequential which could be a result of private/unauthorised use of the minibus.	
The inventory of assets did not contain adequate detail in order to identify an asset in the event of an insurance claim. This increases the chance of loss or theft going undetected and may result in any insurance claims being rejected.	Controls will be put in place to ensure the school's inventory complies with PCC Financial Rules. A termly spot check of inventory items will be carried out.
DBS application documents were being held on file in breach of the DBS Code of Practice and Data Protection Act leaving the school open to potential enforcement action from the ICO.	Any disclosure information held in employee's files will be shredded and moving forward the school will only retain documentation which proves the individual's right to work in the UK.
The school's Unofficial, Building and PTA funds were not being submitted annually to the Full Governing Body in accordance with the Scheme for Financing Schools. The Governing Body should have financial oversight over the operation of the PTA Account.	The Governing Body will monitor the operation of the Unofficial, Building and PTA fund moving forward.

6.2.3 At the request of the Head Teacher a follow up audit will take place in Quarter 4 of 2016/17 to ensure that the agreed actions have been fully implemented.

6.3 **External - Craneswater Junior School**

6.3.1 The audit Craneswater Junior School was given a "No Assurance" rating after 9 high risk exceptions were raised

6.3.2 The 9 high risk exceptions and agreed actions are summarised below:

Exception	**Agreed Action**
Governors were not being offered the opportunity to declare any pecuniary interests before meetings of the Full Governing Body which contradicts the Schools Financial Value Standards (SFVS).	The clerk will ensure Governors are afforded the opportunity to declare any interests at the beginning of every meeting
Staff have not completed the staff competencies matrix as declared on their SFVS statement. The Governing Body are responsible for ensuring this statement is accurate and that the skills mix is appropriate.	Staff competencies are to be reviewed as part of the Performance Development Review process
No signed hire agreement form was in	A hire form agreement will be

place for an ongoing let of the school hall. In addition there was no evidence that the hirer holds a current public liability certificate. Without an agreement there is no documented evidence of the conditions of the hire should they be needed to resolve a dispute. If the hirer doesn't have insurance any claims may become the responsibility of the school.	completed annually and a current insurance certificate attached to each form.
At the time of audit testing the cash held in the safe exceeded the insurance limit of £3000 (£5394). This could negate the School's insurance policy in the event of a theft/loss.	Controls will be put in place to ensure the limit is not breached. The Finance Officer will undertake spot checks to confirm the balance held within the safe is not over the £3000 limit.
Petty cash reconciliations were not being undertaken on a monthly basis which is a breach of PCC Financial Rules and does not enable the identification of errors or other inaccuracies which may then require correction.	Petty cash statements will now be reconciled on a monthly basis.
The School's 'Emergency Management Plan' was found to be non-compliant with best practice. It was not clear who had written the plan, when it was written, who approved it and how often it would be reviewed. In the event of an emergency the school may not have the required resources or awareness of a strategy to resolve the issue presented.	An appropriate plan will be put in place and signed off by the Full Governing Body on an annual basis
7 of 18 MIDAS certificates required to operate the minibus were found to have expired. Using a non MIDAS driver may negate the insurance policy in the event of an accident.	A summary of the copy of the MIDAS certificates will be retained on file as evidence that all drivers are a member of the scheme and when their renewal is due.
The information held on the asset inventory was found not to comply with PCC Financial Rules. Items were found within a classroom that had not been security marked or added to the inventory. In the event of assets being lost or stolen the insurance company may reject claims submitted.	Controls will be put in place to ensure compliance with PCC Financial Rules in relation to the administration and control of the School's assets including uniquely numbering assets, security marking for identification purposes and spot checks carried out and clearly evidenced by a person who is independent from the administration and control of the inventory.
A review of the governing body	The Governing Body will monitor the

minutes showed that the governors had not been presented with an audited statement of accounts for Parent Teacher Association (PTA) fund as required by Scheme for Financing Schools. The Governing Body should have financial oversight over the operation of the PTA Account.	operation of the PTA Funds to ensure an Audited Statement of Account is submitted within the expected deadline in the future.

6.3.3 A follow up audit has been scheduled for Quarter 1 of 2017/18

6.4 **Property & Housing - Emergency Procedures**

6.4.1 The audit of Emergency Procedures was given a "No Assurance" rating after 3 high risk exceptions were raised.

6.4.2 Details of the 3 high risk exceptions and the agreed actions can be found below:

Exception	**Agreed Action**
Testing found that a sample of relevant staff did not have a copy or were aware of PCC's Emergency Planning document. If staff are not aware of the processes and protocols to follow in an emergency situation services may be ineffective or non-operational and staff/residents placed in danger.	The Emergency Planning Master document will be reviewed and disseminated to all staff
The Housing and Property service does not maintain centralised records of actions taken relating to emergency incidents. It is not therefore possible to evaluate whether responses to the emergency were correctly implemented against the Emergency Planning document or whether there are lessons to be learnt. i.e. staff training or revising the Emergency Planning procedures.	The Assistant Housing Manager has advised that the Emergency Planning document is a useful guideline, however that staff are encouraged to be flexible, and would not necessarily be expected to make reference to it in an emergency situation. The Assistant Housing Manager does not believe that it would be of use to the service to evaluate the responses of staff against such a document, and accepts the risk of not doing so.
No central records are kept detailing the type or frequency of emergency incidents that have occurred. Failure to log incidents does not enable patterns or trends to be identified and actioned relating to other properties or buildings, which could help prevent future incidents.	The Assistant Housing Manager has accepted the risk in this area for the same reasons as detailed above.

6.4.3 A follow up audit in this area will form part of the 2017/18 Audit Plan

6.5 **HR, Legal & Performance - Staffing Off Contract**

6.5.1 A critical risk exception was raised in this audit as testing found issues with regard to the reviewing of Disclosure and Barring Service (DBS) checks of temporary workers provided by Staff 2000 (used by Adult Social Care, although not under contract as part of PCC's temporary appointment framework). Where an employee has had a DBS check carried out in previous employment within the past 12 months this should be reviewed to ensure there are no issues before they commence work for the agency. Once work is commenced the agency will carry out a new DBS check.

6.5.2 Full details of the exception and agreed action can be found below.

Exception	Agreed Action
A sample of 19 workers was tested, of which 14 (73%) had been allowed to commence work on the basis of a DBS check carried out under previous employment. However for 9 of the 14 employees, the agency couldn't evidence that a review of this previous DBS check had occurred prior to employment at PCC. For the remaining 5 employees, these DBS checks were reviewed after employment commenced, which is a breach in policy. Checks were then conducted on the current DBS certificates for the 19 workers. There was no record on file that a DBS check had been done for 4 workers (21%) and the certificate for 1 worker (5%) was not seen until after employment with PCC started even though they had not previously had a DBS check carried out. If an incident was to occur and it was found that the temporary employee had not been DBS checked a claim could be made against both the agency and the Authority which could result in a financial loss and reputational damage.	• Residential Homes have been instructed to check DBS and record the certificate number for all agency staff entering the home for the first time. • Contract officers to follow up on the checks by carrying out a minimum of 2 follow-up visits between January and March 2017. If Staff 2000 continue to be used then further visits will be carried out from April 2017. • Reduce use of agency staff through continuing appointment of apprentices and the development of a peripatetic team to cover absence of care staff.

6.5.3 A follow up audit of this area will be conducted as part of the 2017/18 Audit Plan.

Updates to previously raised concerns

6.6 **Information Governance - Security Sweeps - Unresolved**

6.6.1 Two security sweeps were conducted by Internal Audit. The first took place in October at the Somerstown Hub, whilst the second took place in November and covered the Civic Offices.

6.6.2 Across the two sweeps the following was found. The results from the initial 2015/16 sweep of the Civic Offices and Chaucer House are in brackets.

- 32 (52) unsecured laptops
- 1 (0) unlocked room containing keys to PCC Housing properties at the Hub
- 3 (22) instances of sensitive data
- 1 (1) unlocked controlled stationery cupboard
- 2 (1) unlocked key cabinets

The results show an improvement from previous year in the two key areas of sensitive data and unsecured laptops.

6.6.3 Emails were sent to each Director with a breakdown of the results for their area of responsibility. A request was made that they respond to the Deputy Chief Executive detailing what action would be taken to resolve the issues highlighted during the sweeps.

6.6.4 The Deputy Chief Executive has not requested any further security sweeps to take place this financial year. The assurance rating for the audit has moved from "No Assurance" to "Limited Assurance"

6.7 **Finance & Information Service -Data Archiving Modern Records & Application Archiving - Unresolved**

6.7.1 An audit of Data Archiving Modern Records was conducted in 2014/15 and subsequently an audit of Application Archiving was conducted in 2015/16. Both audits highlighted risks relating to the corporate management of data in Portsmouth City Council. The agreed actions to mitigate the risks identified in both audits were to be included in a project relating to data management. A follow up audit reviewing the 4 high risk exceptions raised across the two audits was completed in 2016/17.

6.7.2 The exception from the Application Archiving audit was raised after testing found that data from 4 key applications (Oracle EBS, Northgate Revs and Bens, Northgate Housing and W2) was not being archived or deleted meaning that the Authority could be in breach of the Data Protection Act 1998.

6.7.3 Follow up testing confirmed that research has been conducted to try to resolve the issue of holding data longer than required. However, no solutions have been

identified as PCC do not have the in house skills to create a solution and require the assistance of the software manufacturer. As a result the exception remains open and the relevant teams will continue to look for solutions in this area.

6.7.4 The first high risk exception from the Data Archiving Modern Records audit was raised as testing found that the Corporate Retention Schedule was not dated and did not contain sufficient detail as to why data was being retained for the periods noted.

6.7.5 Follow up testing confirmed that a part time Archivist and Records Manager has been appointed to lead a project in relation to improving the Authority's data management. The Authority is also using a consultant to update the Corporate Retention Schedule and they are working with the Archivist and Records Manager to ensure legislative changes are reflected. The aim is for this project to be completed by the summer of 2017.

6.7.6 The second high risk exception from the Data Archiving Modern Records audit was raised as testing found that files were being stored on the W:/ drive corporate filing system that were past their retention dates. This could result in a breach of the Data Protection Act 1998.

6.7.7 This is another area that the data management project ending is 2017 is due to cover. Follow up testing found that research had been completed as to how many files are contained on the corporate W:/ drive (12m some as old as 1990). In order to reduce this figure individual departments would need to cleanse their area of the drive but this is not planned at the current time. Moving forward a file naming convention was to be rolled out to staff in the first quarter of 2017 which will aid with future monitoring of files. The issue of mass deletion of files is to be tabled at the next meeting of the Corporate Information Governance Panel for discussion.

6.7.8 The final exception from the Data Archiving Modern Records audit was raised as testing found that files were being kept in Modern Records past their retention dates. This could result in a breach of the Data Protection Act 1998.

6.7.9 Follow up testing confirmed that the process the Modern Records service follows when files reach their retention date has now changed. Permission from the data owner to dispose of the files is no longer sought. Instead data owners are asked if they wish to retain the documents and why. If no response is received the files are disposed of. This exception has been closed.

6.7.10 The assurance level for the audit remains at "No Assurance".

6.8 **MMD - Navision Access - part resolved**

6.8.1 The 2015/16 audit of MMD Main Accounting highlighted an issue with the Navision financial system that had been previously raised in earlier audits. Navision is unable to produce a report which details the permission settings and

levels for staff. As a result Internal Audit could not provide any assurance that staff had appropriate access permissions within the system.

6.8.2 This issue was revisited as part of the follow up audit of MMD Accounts Payable. Meetings with the Port's IS service confirmed that reviewing and reporting on individual accesses within Navision was a large and complicated undertaking. During these discussions it was noted that Navision keeps an audit log of changes made by users within the system.

6.8.3 In order to provide some assurance in this area the audit log for 6 months (01/04/2016 - 06/10/16), which contained 440,000 lines of data where each line represented a change in Navision were extracted for review. Areas reviewed included invoice and credit note creation, supplier records, user records and supplier bank details. The results of the analysis were checked with the Systems Development Manager in order to highlight any irregular or unexpected entries. Overall testing found there had not been any irregular entries for the areas tested. Therefore whilst testing cannot provide assurance that access within Navision is suitably restricted, reasonable assurance can be given that within the last 6 months there have not been any changes made to records by anyone without the authority to do so. However this is not an ongoing control and assurances cannot be provided for any period prior to or after the 6 months between 1/4/16-6/10/16.

6.8.4 Moving forward MMD will now review the Navision Audit log on a quarterly basis to ensure that no inappropriate access has occurred. As assurance is built up the frequency of those checks can then reduce. This area has therefore moved from "No Assurance" to "Limited Assurance".

6.9 **Human Resources, Legal & Performance - Assessed and Supported Year in Employment (ASYE) - part resolved**

6.9.1 The 2016/17 audit of ASYE resulted in one critical risk exception being raised. An in year follow up has now been completed to confirm the agreed action has been carried out.

6.9.2 The critical risk exception was raised with regard to the financial controls surrounding the funding provided for newly qualified Social Workers, in order for them to complete their professional training. The funding (provided externally) should be used to purchase resources for the Social Workers, as additional support such as bespoke courses or core training and to pay for the certification of 'Developing Professional Specialist Practice' from Bournemouth University once the ASYE programme has been completed. Testing was unable to identify how the funding is being monitored and found no management trail to confirm what the funding was being used to purchase. An action was agreed whereby Social Worker's progress through the supported year in employment would be documented on a tracking spreadsheet so spend could be recorded and monitored. The option of the ASYE Co-ordinator applying for a purchase card would also to be explored.

6.9.3 An action was agreed whereby Social Worker's progress through the supported year in employment would be documented on a tracking spreadsheet so spend could be recorded and monitored. The option of the ASYE Co-ordinator applying for a purchase card would also be explored.

6.9.4 Follow up testing confirmed that expenditure data is now being captured within the tracking spreadsheet. In addition monthly budget meetings have been taking place since October 2016 in order to facilitate the accurate allocation of funds and expenditure. The option of using a purchase card was explored but was not deemed a viable option due to capacity concerns. At the time of testing funding amounts were not being input into the tracking spreadsheet, this is to be resolved in early 2017. As a result of testing reasonable assurance can now be given in this area.

7. Comments on the plan to date

7.1 The 2016/17 Audit Plan is on course to be completed by 31st March 2017. The percentage completed or in progress (74%) is lower than the 2015/16 level. However this is due to the increased number of audits in the 2016/17 plan and higher levels of income generating external work being undertaken.

8. Equality impact assessment (EIA)

8.1 The contents of this report do not have any relevant equalities impact and therefore an equalities assessment is not required.

9. Legal Implications

9.1 Legal Services have considered the report and are satisfied that the recommendations are in accordance with the Council's legal requirements and the Council is fully empowered to make the decisions in this matter.

9.2 Where system weaknesses have been identified he is satisfied that the appropriate steps are being taken to have these addressed.

10. Finance Comments

10.1 There are no financial implications arising from the recommendations set out in this report.

10.2 The S151 Officer is content that the progress against the Annual Audit Plan and the agreed actions are sufficient to comply with his statutory obligations to ensure that the Authority maintains an adequate and effective system of internal audit of its accounting records and its system of internal control.

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Signed by: Elizabeth Goodwin, Chief Internal Auditor

Appendices:

Appendix A – Completed audits from 2016/17 Audit Plan
Appendix B - Completed Follow Up Audits
Appendix C - Audit & Counter Fraud Strategy 2017/18

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document		**Location**
1	Accounts and Audit Regulations	http://www.legislation.gov.uk/uksi/2011/817/contents/made
2	Audit Strategy 2016/17	http://democracy.portsmouth.gov.uk/documents/s9962/Final%20Audit%20Performance%20Report%20to%2016th%20December%202015.pdf
3	Previous Audit Performance Status and other Audit Reports	Refer to Governance and Audit and Standard meetings –reports published online http://democracy.portsmouth.gov.uk/ieListMeetings.aspx?CommitteeId=148

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by: