Portsmouth CITY COUNCIL

Title of meeting:	Governance & Audit & Standards Committee
Date of meeting:	30th June 2017
Subject:	Annual Internal Audit Report for the 2016/17 Financial Year
Report by:	Chief Internal Auditor
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Summary

1.1 In 2016/17 Internal Audit raised 6 Critical Risk exceptions. A further 4 audits have been given no assurance since the last meeting and are detailed in Section 6. This brings a total of 12 no assurance audit opinions for 16/17.

1.2 The final audit plan contained 92 full audits and 33 follow up audits. 3 of the audits were removed from the 2016/17 plan, details as follows:

- Mayfield School has been moved to the 2017/18 audit plan
- The Partnership fraud checks work was covered under the audit undertaken by Gosport Borough Council
- Cash collection was covered under a number of establishment reviews already carried out during 16-17

1.3 100% of the revised 2016/17 Audit Plan (89 audits) has been completed.

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

1.5 Areas of Assurance are shown in Appendix A.

1.6 During 2016/17 Audit carried out 361 days for external clients across 12 client groups.

1.7 A total of £255,455 has been raised in overpayments relating to Housing and Council Tax Benefit and Council Tax Support frauds with 95 cases being closed in 2016/17 resulting in 29 implemented sanctions. Further details are provided in section 9.

2. Purpose of report

2.1 This report is to give the Annual Audit Opinion on the effectiveness of the control framework, based on the Internal Audit findings for 2016/17 and highlight areas of concern.

2.2 To advise Members of the Audit Plan for 2017/18.

2.3 To provide a summary of the Counter Fraud cases investigated and sanction results. Details of corporate cases investigated are contained within exempt Appendix D.

3. Recommendations

3.1 That Members note the Audit and Counter Fraud Performance for 2016/17.

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

3.3 Members note the Annual Audit Opinion on the effectiveness of the system of internal control for 2016/17.

3.4 Members endorse the Audit Plan for 2017/18

3.5 Consider any additional actions to be taken in response to matters raised within this report relating to the reviews undertaken.

4. Background

4.1 The Annual Audit Plan for 2017/18 has been drawn up in accordance with the agreed Audit Strategy approved by this Committee on 3rd February 2017 following consultation with Directors and the previous Chair of this Committee. The Plan will be revised quarterly to take account of any changes in risks/ priorities, in accordance with the Strategy.

4.2 From the 1st April 2015 officers within PCC's Benefit Counter Fraud Team moved across to Internal Audit, pending the transfer of Housing Benefit cases only to the Department of Works & Pensions (DWP) as part of the Governments 'Single Fraud Investigation Service' initiative. This transfer has been completed and since 1st April 2016 all new Housing Benefit claim investigations have been dealt with by the DWP.

4.3 The Counter Fraud team retain powers to investigate Sub-Letting and Council Tax Support Fraud. These include Social Housing Fraud Act 2013 and Council Tax Reduction Schemes (Detection of Fraud & Enforcement) Regulations 2013/ Local Government Finance Act 1992.

4.4 During 2016/17 Internal Audit has had a significant increase in external client work, going from 120 days across 4 clients in 2015/16 to 361 across 12 clients. For 2017/18 these will increase to 1005 days and as a result of additional income, additional resources have also been employed.

5. Audit Plan Status 2015/16

Percentage of the approved plan completed

5.1 100% of the annual audit plan has been completed. Appendix A shows the completed audits for 2016/17. Appendix B shows the completed follow up audits for 2016/17.

The overall percentage figure is made up as follows:

- 89 (73%) new reviews where the report has been issued.
- 33 (27%) planned follow ups where the report has been issued

5.2 As requested by Members of the Committee a breakdown of the assurance levels on completed audits since the last meeting 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.

Reactive Work

5.3 Reactive Work undertaken by Internal Audit in 2016/17 includes:

- 31 special investigations (excludes Benefit and Council Tax Support cases)
- 35 items of advice, (where the advice exceeds an hours work)

As well as the following unplanned reviews

- Channel Shift Programme
- Copyright audit

Exceptions

5.4 Of the 2016/17 full audits either completed or at the draft report stage the number of exceptions within each category have been:

- 6 Critical Risk
- 128 High Risk
- 50 Medium Risk
- 11 Low Risk (Improvements)

5.5 The table below is a comparison of the audit status figures for this financial year and the previous two years

	2014/15	**2015/16**	**2016/17**
% of the audit plan	100%	100%	100%

completed			
No. of Audits Completed for the year	150	116	122
No. of Critical exceptions*	11	1	6
No. of High risk exceptions	196	103	128

5.6 In order to provide a more meaningful comparison the table below reflects the audit figures

exceptions per audit is in brackets

	2014/15	**2015/16**	**2016/17**
No. of Full Audits Completed for the year	85	76	74
No. of Critical exceptions	11	1	6
No. of High risk exceptions	91 (1.071)	98 (1.289)	84 (1.135)

There has been an increase in the number of critical risk exceptions raised in 2016/17 but a decrease in the number of high risk exceptions.

Ongoing Areas

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

- Regulation of Investigatory Powers Act (RIPA) - authorisations
- Anti-Money Laundering monitoring and reporting
- Investigations
- Financial Rules Waivers
- National Fraud Initiative (NFI) to facilitate national data matching carried out by the Cabinet Office
- 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

5.8 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

New areas of concern

6.1 **Culture & City Development - Safety signage**

6.1.1 The audit of Safety Signage was given no assurance as testing resulted in one critical and two high risk exceptions.

6.1.2 The exceptions and agreed actions are summarised in the table below.

Exception	Agreed Action
Critical - There is no evidence of formal and periodic assessments being carried out for large areas of open/inland water under the council's responsibility. Exceptions to this have been limited to areas of the seafront and Paulsgrove Lake which were most recently assessed by the Royal National Lifeboat Institution (RNLI) in 2016, recommendation actions of which are still outstanding as at 09/01/2017. Audit site visits noted old, non-compliant safety signage - if any - present at 5 areas tested. Half of the eight sites visited across the city appear not to have been checked recently as audit checks on 12/12/2016 noted poorly maintained signage. Safety practices may be deemed insufficient without formal and robust risk assessments being carried out of water areas in public open spaces. This could ultimately contribute towards injury/death of members of the public. The lack of risk assessments could also result in the Authority being held liable in any related legal challenge resulting from injury/death.	The RNLI has been commissioned to carry out further risk assessments across a broader range of areas throughout the city. The RNLI currently has a three month lead time. Outcomes are likely to be further signage, rescue equipment and regular checks being carried out. It is proposed that the cost of initial assessment and remedial work to signage and equipment is requested to be funded from the Council's contingency reserve, subject to approval. Officers will identify potential ongoing resource requirements and review the options for delivery and funding of these.
High - There is no corporate accountability for water safety generally and safety signage specifically. There is no defined lead to water safety in the city and the subject is not explicitly addressed at a constitutional level in the terms of	A provisional lead has been proposed in the form of Culture and City Development. This Service has the requisite knowledge, skills and experience in the area having responsibility for the Seafront and other associated areas.

reference for any cabinet members. There is no corporate water safety policy and by extension safety signage - across all public open spaces areas for which the council is responsible. Without corporate oversight to water safety the risks to the public may not be dealt with appropriately or consistently increasing the likelihood of successful legal action / reputational damage against the council in the event of death/injury.	
An inspection of 8 areas across Portsmouth found that the majority of signage across the Seafront/Old Portsmouth meets the latest British Safety standards, with the exception of those noted by the RNLI in 2016. The recommendations made by the RNLI have yet to be addressed. Signage at all other locations appeared to be old, with several in a poor state, and are non-compliant with national standards. Signage which is in a poor state or does not meet national/EU standards are more likely to be unclear as to their meaning and ultimately may not provide sufficient warning in any cases of negligence/breach of statute brought against the council.	As part of the aforementioned review, the RNLI will highlight signs which do not meet requirements and will make recommendations accordingly. Any remedial work necessary will need to come out of the new proposed funding.

6.1.3 A follow up audit of Safety Signage will be conducted in Quarter 1/2 as part of the 2017/18 audit plan.

6.2 **Port - Closed Circuit Television (CCTV)**

6.2.1 The audit of Port CCTV was given no assurance as testing resulted in two critical and one high risk exceptions.

6.2.2 The exceptions and agreed actions are summarised in the table below.

Exception	**Agreed Action**
Critical - Testing was carried out to	The Duty Port Manager has assumed

confirm whether Principle 4 (designated individual with responsibility for the development and operation of a surveillance camera system and adequate governance arrangements) and Principle 5 (clear rules, policies and procedures must be in place before a surveillance camera system is used) of the Surveillance Camera Commissioner's Code of Practice are being complied with. The following issues were highlighted: • There was no defined management lead to camera operations at the Port. • There was no clearly defined accountability structure in place to provide and display effective governance, clarity, organisation and communication. • There was no current policy with complimentary procedures in place. Without transparent accountability lines and a suitable surveillance camera policy to steer the Port's surveillance camera operations it may not be complying with the law and could face legal challenges on prosecutions or by data subjects resulting in fines and reputational damage. Without up to date supporting procedures CCTV staff are less likely to fulfil duties in accordance with internal and external requirements.	temporary responsibility for CCTV operations whilst work is made towards compliance. A wider discussion is necessary to establish whether a Senior Responsible Officer at PCC should be made the Single Point of Contact (SPOC) for CCTV operations throughout those areas in which PCC is ultimately responsible. Once this is complete a formal accountability structure for CCTV operations will be established. A Code of Practice for Portsmouth International Port's CCTV System is being developed following completion of the privacy impact assessment. This will be available to view on the Portsmouth International Port web site, circulated to staff and signed off as read and reviewed annually. Consideration will be given to a PCC-wide CCTV Code of Practice subsequent to senior management approval. Work Instructions on the use of the CCTV systems and the processing of data are to be developed together with the CCTV Code of Practice.
Critical - Further testing was carried out against Principles 1 and 2 of the Code of Practice. Principle 1 of the surveillance camera code of practice states that the 'use of a camera system must always be for a specified purpose which is in pursuit of a legitimate aim and necessary to meet an identified pressing need'. As part of this the CCTV system must have clear objectives. At the start of the audit on	Objectives of the camera system have now been defined and will form part of the new CCTV Code of Practice. Annual reviews of the system will be undertaken in the form of 'pressing needs' and privacy impact assessments. An annual surveillance camera systems audit will also be carried out to ensure the objectives of the system are still being met and the system itself is complied with.

29th November the Port had not articulated its surveillance camera objectives. Principle 2 states the 'use of a surveillance camera system must take into account its effect on individuals and their privacy, with regular reviews to ensure its use remains justified.' Annual reviews of the Port's CCTV system have not been formally carried out. A privacy impact assessment has been carried out during this audit which needs to better reflect the ICO's Privacy Impact Assessment (PIA) Code of Practice and link into a broader 'pressing need' justification. Annual reviews and PIAs are not published which Principle 2 of the code suggests as best practice. Documented justification in the form of a 'pressing need' review and PIA specifically for body worn video (BWV) is lacking. The Data Protection Register on the Information Commissioner Office's web site also holds redundant information as to the current use of CCTV at the Port. This does not appear to have been updated since 2000. Non-compliance with the code's principles can lead to legal challenges and enforcement action. Failure to update the Data Protection Register with current personal data handling practices breaches legislation and could result in fines and/or legal challenges.	Justification for body worn video will be further developed and evidenced as part of the above process. The Data Protection Register will be updated to further detail the current use of surveillance cameras at the Port
High - Training requirements as per the Code of Practice was also tested. It was found that: • Staff are not all necessarily aware of all of their responsibilities when it comes to surveillance camera operations	A formal training matrix for any staff associated with CCTV operations will be developed as a priority. Training to National Operating Standards for both operational and management staff began in January 2017 and will continue to be rolled out through to

and there has been no formal CCTV training. • Some operational staff have control over surveillance cameras beyond their remit. They are able to control cameras when they should only have view-only access and also in locations beyond their sphere of responsibility. Without adequate training, system users may not have the necessary skills and knowledge to use or manage the surveillance system resulting in legal challenges and/or fines should it be used inappropriately.	March 2017. Physical access and system controls are currently being put in place to ensure staff are not able to control cameras when they have viewing rights only. This process will also ensure access is limited to only the areas that they have responsibility for.

6.2.3 A follow up audit of Port CCTV will be conducted in Q1/2 as part of the 2017/18 audit plan.

6.3 **Mainland Market Deliveries (Shipping Services) (MMD) - Insurance and Claims**

6.3.1 The audit of MMD Insurance & Claims was given no assurance as testing resulted in two high risk exceptions.

6.3.2 The exceptions and agreed actions are summarised in the table below.

Exception	Agreed Action
High - Employer Liability (EL) Claims: The Health & Safety Manager advised that there had been 46 employer liability claims since 2012. However he was only able to provide accident reports relating to 2 claims that are currently ongoing. Therefore it was not possible to undertake full sample testing. **Error Cost Corrections:** MMD receives claims for damaged goods or equipment. As many of these claims do not exceed the insurance excess of £10,000, they are investigated and resolved directly by MMD. A sample of 10 was tested, and issues were found for all 10 cases.	**EL Claims** From the 03/01/17 the new Health & Safety Manager has a comprehensive process for recording claims and associated paperwork. This process will be documented into a flow diagram, implemented and monitored. **Customer Claims** The spreadsheet for recording customer claims has been amended to better capture the information in one central place and to improve management information and reporting. The investigation paperwork is to be reviewed to ensure all relevant details

There were inconsistencies found in the way that Error Cost Corrections are investigated, with varying levels of detail, authorisation and supporting evidence. Without clear records relating to the cause, progress and resolution of claims, it is not possible for MMD to effectively mitigate the risk of incidents being repeated.	are being recorded and actioned. Once complete they will be held centrally and reviewed by the General Manager to ascertain whether any further action or any changes to processes need to be implemented
High - It was not possible to obtain a sample to show action taken in response to accidents that resulted in employer liability claims. This was due to the fact that records were not traceable in the format in which they had previously been stored, and because definitive actions had not been taken in all instances. There were sixteen of these claims from 2014-2016, with £9364.99 paid, and a reserve of £92,217 for claims not yet settled. If action is not taken to address the cause of an accident, it increases the likelihood that that it will recur. This may result in staff injury, lost working time and ultimately, an increased insurance premium for these types of claims.	The Health & Safety Manager has contacted MMD's insurer for a list of employer liability claim details. He will use this information to populate a spreadsheet, which will be used to ensure that additional control measures are put in place to prevent a recurrence of incidents.

6.3.3 A follow up audit of MMD Insurance and Claims will be conducted as part of the 2017/18 audit plan.

6.4 **Housing & Property - Compliance with Fire Policy**

6.4.1 The audit of Compliance with Fire Policy was given no assurance as testing resulted in one critical and one high risk exceptions.

6.4.2 The exceptions and agreed actions are summarised in the table below.

Exception	**Agreed Action**
Critical - The PCC Fire and Asset Management policies state that each property should have a full fire risk assessment (FRA) every ten years, and that these must be reviewed	The Property & Housing service has advised that FRAs are now to be completed when required, as opposed to as part of a planned maintenance schedule.

<table>
<tr><td>regularly. Properties over 6 storeys are classed as 'high risk' and must be reviewed every two years. Properties below 6 storeys as required by PCC policy, should be reviewed every three years.

PCC has 39 properties that are six storeys or over. Testing confirmed that seven blocks of flats (18%) were established as missing a current FRA, and fifteen blocks (38%) were shown to have an expired FRA.

Of the 712 properties which are 5 storeys or lower, analysis found that 280 (39%) had no recorded FRA date, and 171 (24%) blocks were overdue a review.

If PCC has not carried out a Fire Risk Assessment for all of its properties subject to The Regulatory Reform (Fire Safety) Order 2005, it may be putting its residents at risk of serious harm in the event of a fire. Not fulfilling this responsibility under the Act constitutes a summary offence, subject to a £1000 fine, or, upon indictment, a fine and/or imprisonment not exceeding two years.</td><td>All high-risk blocks are to have a current FRA in place by April 2017. All other properties requiring one should receive a compliant FRA by April 2019.

The policy is to be updated to show that the requirement to review high-risk properties every two years is will be replaced with a timescale that is decided by the competent person undertaking the assessment.</td></tr>
<tr><td colspan="2">A review of the critical-risk exception has been carried out in June 2017, in order to highlight PCC's current position. For the purpose of comparison with the 2016/17 figures, blocks of flats have been separated into two categories: those with six storeys and above, and those with five storeys and below.

All seven blocks of six storeys and above, previously identified as missing a Fire Risk Assessment, now have a current assessment uploaded to the database entry.

Of the fifteen properties of six storeys and above identified as requiring an FRA review, fourteen have had a review undertaken. Although Mill Gate House (1-76) FRA date of 13/6/17 is yet to be uploaded to the system.

The final property, Wilmcote House (1-113), is currently undergoing extensive renovations which began in 2014. The Assistant Director of Property and Housing has advised that, in such situations, it is the responsibility of the contractor on site to assume responsibility for the management and production of evacuation/ fire safety plans for both residents and workmen while they are in control of the building.</td></tr>
</table>

The Asset Manager has confirmed that the consultants managing the scheme and the contractor review, throughout the duration of the project, health and safety on site including the contractor fire risk assessment. Health and Safety is reported in the regular monthly project reports submitted to PCC and is an agenda item at the monthly project board and contractor site meetings. Evidence has been sighted by Internal Audit confirming that the contractor has carried out monthly reviews, the last of which was conducted on the 2nd June 2017. The PCC Fire Safety Officer has visited the site several times and is due to undertake a review of the contractor fire risk assessment on the 23rd June 2017. Progress is being made regarding Fire Risk Assessments to properties of five storeys and below and the Asset Manager has updated the action and stated that no properties will not have an FRA by mid-July 2017 and no blocks will have a review outstanding by the end of August 2017. A verbal update will be given by the Asset Manager at the committee meeting of the 30th June 2017. Moving forward and to conclude this a follow up audit of compliance with fire safety will be conducted during Q3 by Internal Audit who will report a final position on all areas identified for the next committee meeting.	
High - PCC has landlord responsibility for 14,821 properties. Of these, 13,064 have a gas supply. Testing found that 143 of these did not have a gas certificate in line with Gas Safety (Installation and Use) Regulations 1998 s.36 (2) & (3). Action had not been taken to address this situation for 11 cases (<1%). Failure to properly maintain a tenant's gas equipment may ultimately result in a loss of life, or damage to PCC property. In constituting a breach of regulations, it could lead to prosecution. If referred to the Crown Court, the potential outcomes include imprisonment and an unlimited fine. Although the number of outstanding properties represents a very small percentage of the overall population, the exception has been rated as high-risk, as expired certificates constitute a breach of the legislation.	All eleven non-compliant properties identified within the December extract have since received gas safety checks.

Updates

6.5 **Children's Social Care** - **Through Care Team - no progress since original audit**

6.5.2 The 2015/16 audit of the Through Care Team resulted in no assurance being given. A follow up audit was conducted as part of the 2016/17 audit plan.

6.5.3 5 high risk exceptions were raised as part of the original audit. The results of the follow up testing are detailed in the table below.

Exception	Follow Up Results	Further Agreed Action
Checks undertaken on a sample of care leaver's grants identified discrepancies between Finance and Social Care records for 36/ 82 (44%) of the transactions tested. There is a potential that over or underpayments may be made to care leavers, resulting in either financial losses or reputational damage.	Further testing of 55 transactions relating to 5 care leavers was undertaken. Discrepancies were found for 31 transactions (56%)	Prepaid cards will be introduced for care leavers grants. Operational processes will be developed to support this. Reconciliations will be carried out for existing Care Leavers, in order to confirm the remaining grant available to be paid to them. Reports will be produced and retained within the team, one showing spend on the Care Leavers cards and the other showing what has been loaded to the Care Leavers Cards. Both will be reviewed and retained.
A duplicate payment of £470.59 was found for one care leaver. An overspend of £85.33 was also found for one care leaver. Over payments made to care leavers, may result in either financial losses or reputational damage.	No duplicate payments were identified in further testing carried out.	Agreed actions as above.
Inadequate record	No issues were found in	Agreed action as above.

keeping in relation to care leavers' grants was found for 13 out of the 18 logs reviewed (72%). The risk exposure is the same as those mentioned above.	terms of the records kept on the 5 further logs tested.	
Pathway plans were not completed and in place within the required timescale for 8 out of the 12 (67%) young people tested. If a Pathway Plan is not completed and reviewed in a timely manner a young person's ambitions and needs may not be identified. This could potentially affect the planned outcome of them becoming independent.	Pathway plans were not completed in the required timescale for 2 out of the 5 (40%) young people tested.	A new report has been introduced to capture all young people when they reach 15 years and 9 months old to confirm that their Pathway Plan has commenced and is completed by the time the young persons is 16 years and 3 months. Where delays occur these will be chased with the relevant managers.
Leaving Care Assessment of Needs were either not completed or were late in being completed for 10 out of the 12 (83%) young people tested. The risk exposure is the same as those mentioned above.	Needs assessments were not found for 2 out of 5 (40%) young people tested	All Pathway Plans within the team have been reviewed to ensure each care leaver has a current plan in place.

6.5.4 Pathway planning will be covered as part of a full audit planned for 2017/18.

6.6 **Corporate** - **Closed - Circuit Television (CCTV) - partially resolved**

6.6.1 The 2015/16 audit of the CCTV resulted in no assurance being given. A follow up audit was conducted as part of the 2016/17 audit plan.

6.6.2 4 high risk exceptions were raised as part of the original audit. The results of the follow up testing are detailed in the table below.

Exception	**Follow Up Results**	**Further Agreed Action**
PCC's CCTV Policy has	A redrafted CCTV Code	The redrafted Policy will

not been shared or adopted by other Services. The Services managing their own CCTV do not have any policy relating to its use (apart from Body Worn Videos). Where CCTV is not covered by the CCTV Policy, Services may not be complying with the Law and could face legal challenges on prosecutions or by data subjects resulting in fines and reputational damage.	of Practice has been written by the CCTV Operations Manager but yet to be published. This is due to the Surveillance Camera Commissioner (SCC) soon to be issuing new guidance that will supersede existing arrangements. A Senior Responsible Officer (SRO) for CCTV operations has yet to be appointed.	be updated, put on PolicyHub and staff training organised by the CCTV Operations Manager following the issue of new guidance by the Surveillance Camera Commissioner. A Senior Responsible Officer will be appointed to take accountability for CCTV operations, ensuring all Services comply with a Central Code of Practice.
Where individual services manage their own CCTV a number of non-compliance issues around pressing need, signage, viewing, siting and maintenance were identified. This appears to be due to service staff not being aware of the PCCs CCTV Policy, various Codes of Practice or related DPA and Human Rights issues. There is a risk of enforcement action or fines from the ICO; Legal challenge resulting in fines and reputational damage.	The CCTV Operations Manager has met with appropriate services and provided advice, signage has been improved and viewing is now limited to dedicated personnel only. Children's Homes now being supported by Housing - and hence managed by the Corporate Control Room - so new systems will be added in due course. Libraries' systems and signage is now in place and staff now aware of responsibilities.	Comprehensive assessments to take place in March-April 2017 by the CCTV Operations Manager for Services employing surveillance cameras.
The CCTV Code of Practice and Protection of Freedoms Act (POFA) Codes of Practice (Principle 4) requires that there are regular proactive checks or audits carried out to	Self-assessments were sent out by the former Chief Internal Auditor, and returned. Full annual assessments will be carried out by the CCTV Operations Manager.	An SRO to be appointed and backed up by regular assessments of all Services going forward

ensure that procedures are complied with. There is currently no corporate oversight so these checks are not happening. The risk exposure is covered in the previous issue.		

6.6.3 At present there are no plans for a further follow up audit in this area.

6.7 **Children's Social Care - Single Assessment Framework - no progress since original audit**

6.7.1 The 2016/17 audit of the Single Assessment Framework resulted in no assurance being given. A follow up audit was conducted later in 2016/17.

6.7.2 3 high risk exceptions were raised as part of the original audit. The results of the follow up testing are detailed in the table below.

Exception	Follow Up Results	Further Agreed Action
A sample of 25 of the 925 single assessments completed since January 2016 was tested. 4 (16%) were not fully complete and 14 (56%) contained little or no information in the child/parent/carer comments section on the assessment. If assessments are incomplete or have not fully involved the child/parent/carer then they may not have considered all areas where a child may have needs. This may require further work by the Social Worker which is not an efficient use of time. This may also impact on the services that are offered to the	Correct working practices were reinforced with the team in June 2016. A further sample of 25 assessments was tested and it was found that 24 (96%) contained little or no information in the child/parent/carer comments section on the assessment.	New report to be devised which will be sent to Service Leads, Practice Leads, and the Head of Assessment and Intervention on a weekly basis. The report will show all assessments authorised in the previous week, by whom authorised, by whom written and what information has been input in the parents/carers and child's comments boxes. The report will also show the Assessment and Progress review details if the assessment is completed in longer than 10 days. Issues where performance is not as required will be followed

child/parent/carer and could impact on whether the family's situation is improved or not. This will ultimately affect the child's long term outcomes.		up by the Service Leads with the Practice Leads and ultimately with the Social Workers to ensure that these are addressed going forwards.
17 of the 25 cases tested took longer than the planned initial 10 day timescale. It was found for 12 (71%) of these that there was no evidence that they had been reviewed at the 10 day stage or authorisation given for the longer timescale. There is a risk that delays have negative impacts on the short and longer term outcomes of children. This could also result in the Authority failing to meet its statutory obligations in safeguarding.	Further testing of progress reviews was carried on 25 cases which had taken longer than the planned 10 day timescale. It was found for 20 cases (80%) that there was no evidence that they had been reviewed at the 10 day stage or authorisation given for the longer timescale	Agreed action as above.
No signed assessments were found to have been scanned into the Client Case Management for the sample of 25 cases tested. If assessments are not signed then there is no clear evidence that the child/parent/carer has actually been involved in the assessment and that the information recorded accurately reflects the current situation. This could affect the services offered and the long term outcomes for the young person.	Testing of the same sample of 25 cases found 1 signed assessment on CCM (4%).	Reinforce requirements for recording with Service Leads and Practice Leads.

6.7.3 At present there are no plans for a further follow up audit in this area.

6.8 **Finance & Information Service - Accounts Receivable - not resolved**

6.8.1 The 2015/16 audit of Accounts Receivable resulted in no assurance being given. The exceptions raised were followed up as part of the annual Accounts Receivable audit in 2016/17.

6.8.2 2 high risk exceptions were raised in the 2015/16 audit, the exception related to credit notes has been raised in the previous 4 annual audits. The results of the follow up testing are detailed in the table below.

Exception	Follow Up Results	Further Agreed Action
514 staff were listed as having Accounts Receivable EBS access. Testing found that 59 users' accounts (11.48%) remained active despite no longer being employed by the Authority. Financial, legislative and operational risk that EBS accounts belonging to staff no longer working for the authority may be accessed by unauthorised parties seeking to exploit system vulnerabilities.	516 staff were listed as having Accounts Receivable EBS access. Testing found that 43 of these staff (8%) were ex-employees who still had access to the system.	Access has been terminated for the 43 staff. A compliance exercise was undertaken in April '16, in which all managers were contacted to verify access requirements for all staff with EBS privileges. They were also advised that, in future, all access rights would be removed when staff members change job role.
Testing confirmed that the agreed actions from the previous audits, which involved the periodic analysis of credit notes and the generation of monthly reports for finance managers to review, have not been implemented. There is no current proposal to alter the authorisation method regarding credit notes. Without verification,	The proposed quarterly review of a sample of credit notes had not been undertaken. A process has since been devised to ensure that future credit note authorisations are subject to appropriate scrutiny.	A 5% sample of credits notes will be taken. A spreadsheet will be maintained showing why the credit was needed and confirmation will be sought from the authoriser that they had actually authorised the credit.

there is a risk that credit note requests may be presented as authorised, without the authoriser's Knowledge, resulting in financial loss to the authority.		

6.8.3 These areas will be covered under the annual Accounts Receivable audit to be undertaken in 2017/18.

6.9 **External - St Paul's Primary School - resolved**

6.9.1 The 2016/17 audit of St Paul's Primary School resulted in no assurance being given. A follow up audit was conducted later in 2016/17.

6.9.2 8 high risk exceptions were raised as part of the original audit. The results of the follow up testing are detailed in the table below.

Exception	Follow Up Results	Further Agreed Action
Sample testing found no evidence of the source documentation used to verify sums banked.	During retesting a proper management trail from receipt to banking was identified as now in place.	No further action required.
From a sample of 6 purchase orders, 2 were raised retrospectively which is a breach of Financial Rules. The total spend on these purchase orders was £3,093.80. Failure to raise purchase orders in advance presents an inaccurate budget position and does not demonstrate appropriate authorisation.	Retesting evidenced that all staff were appropriately reminded of the requirements. In addition a new sample of purchase order were tested and confirmed to have been raised in advance.	No further action required.
The school 'Business Continuity Plan' was found to be non-compliant with best practice; i.e. not frequently reviewed, approved by the Full Governing Body or	Evidence was found during the follow-up to confirm that adequate arrangements are now in place.	No further action required.

communicated to all staff. There is a risk that the school will not have an effective and current plan in place to minimise risk and disruption in the event of an emergency.		
Governors have not adopted a CCTV Policy as required by the Information Commissioner's Office (ICO) CCTV Code of Practice. Non-compliance with the ICO Code of Practice, Regulation of Investigatory Powers Act (RIPA) and the Data Protection Act could result in a potential fine to the School.	Governors have agreed that the CCTV system does not provide value for money and is not financially viable to maintain. It was agreed that the cameras will remain as a deterrent but that they will not be operational, which negates the requirement for a CCTV Policy.	No further action required.
The MIDAS certificate file was examined for nine employees who have driven the mini buses for the period April 2016 to the date of the audit. Testing confirmed there were seven current certificates on file, one certificate had expired in January 2016 and one certificate was not on file. Using a non-MIDAS qualified driver as required by PCC insurance policy may negate the policy in the event of a claim. 52 miles (3%) of those reviewed could not be accounted for. Possible unauthorised / private use of a mini bus	Evidence was found during the follow-up to confirm that adequate arrangements and checks are now in place.	No further action required.

will result in increased fuel costs.		
Insufficient data was held in relation to the inventory, i.e. description of the items held. This could negate insurance cover if full asset details are not recorded. Assets also could be lost or stolen and go undetected.	Evidence was found during the follow-up to confirm that adequate arrangements and checks are now in place.	No further action required.
During initial testing it was noted that DBS application documents (i.e. Bank / Building Society statements) had been retained on file for (3) individuals tested, which is a breach of the DBS Code of Practice and Data Protection Act. This could result in a financial penalty for the Authority.	Evidence was found during the follow-up to confirm that adequate arrangements and checks are now in place.	No further action required.
Testing found no evidence that the Unofficial Fund and the PTA fund (Friends of St Pauls) had been audited and presented to the Governing Body.	Evidence was found during the follow-up to confirm that adequate arrangements and checks are now in place.	No further action required.

7. Annual Audit Opinion

7.1 Due to the number of critical and high risk exceptions raised under the audits carried out, the Audit opinion for 2016/17 is that only limited assurance on the effectiveness of the control framework can be given.

7.2 Whilst this opinion is the same level as the previous years the direction of travel is deteriorating not improving. Four audit opinion levels are now in place as agreed in the 2016/17 Audit and Counter Fraud Strategy and these are: no assurance, limited assurance, reasonable assurance and full assurance. Where there are mainly medium or low risk exceptions the annual audit opinion would be reasonable or full assurance.

7.3 There is still a significant level of high risk exceptions raised this year, a number of which are a result of failure by managers to carry out checks either previously performed centrally by support services or where they have differing priorities and capacity issues. In addition the level of investigation involving staff has not subsided, which may be indicative of the reduced resources and control layers, needed following the austerity measures. The results of follow up work also show that only 39% of agreed actions have been implemented again showing a decline. Some of the reasoning for this is capacity or proposed solutions that did not mitigate the risks identified.

7.4 Internal Audit is concerned that the overall effectiveness of the control framework position is declining and will continue to work with Directors, the Deputy Chief Executive and the Chief Executive to improve on specific areas of control, risk management and governance weaknesses.

7.5 Any significant corporate weaknesses and agreed actions will be reflected in the Annual Governance Statement. The impact of the Internal Audit work for 2016/17 may affect that year's work for External Audit. It may also inform their work for 2017/18 and where they consider there are weaknesses in control that could materially affect the accounts they may need to carry out further work to gain the necessary audit assurance required for a true and fair view of the financial position and compliance with professional codes of practice.

7.6 Internal Audit has carried out a self-assessment and confirms that they are compliant with the Public Sector Internal Audit Standards (PSIAS).

8. 2017/18 Audit Plan

8.1 The Audit Plan planned coverage for 2017/18 has been drawn up using the Strategy approved by Members of this Committee at their 3rd February 2017 meeting.

8.2 Meetings have been held with all Directors and the Chief Executive and the previous Chair of the Governance & Audit & Standards Committee who have all been consulted on the areas planned and the overall Audit Plan.

8.3 The 2017/18 Audit Plan is attached as Appendix C to this report. There are 105 audit items although this may increase once preliminary audit work commences on areas such as grants as and when they are required. In addition to this a quarterly review will be carried out to take account of changing risks & priorities, all of which will be reported back to this Committee.

8.4 As at the 5th June 2017 1005 days have been purchased by external clients for Internal Audit work, this is an increase of 644 days from the previous year.

9. Counter Fraud Performance

9.1 Below is a table summarising the work completed by the Corporate Counter Fraud Team during 2016/17

Case Type	Number Cautioned	Number Prosecuted	Admin Penalty	Sanctioned Fraud Overpayment	Total Overpayment Raised
Housing Benefit (HB) only	0	6	0	£163,517.17	£210,640.84
Council Tax Support (CTS) only	6	2	1	£20,094.98	£30,738.90
Council Tax Benefit (CTB) only	0	0	0	£7,699.16	£14,075.66
Joint HB & CTS	0	10	0	Included in above figures	Included in above figures
Joint HB & CTB	0	2	0	Included in above figures	Included in above figures
Joint HB, CTS, CTB	0	2	0	Included in above figures	Included in above figures

9.2 Corporate investigations that have exceeded all appeal time limitations are detailed in Appendix D.

9.3 A caution is a warning given in certain circumstances as an alternative to prosecution to a person who has committed an offence. A caution can only be considered when there is sufficient evidence to justify instituting criminal proceedings and the person has admitted the offence during an Interview under Caution.

9.4 An administrative penalty: is an alternative to prosecution and only applies where it appears to the Secretary of State and/or a local authority that the making of an overpayment was attributable to an act or omission by the claimant and that there are grounds for instituting proceedings for an offence.

9.5 The administrative penalty is payable in addition to any recoverable overpayment. The Department for Work and Pensions are now responsible for issuing Administrative penalties relation to Housing Benefit.

9.6 A Caution and Administrative penalty can only be offered where the Local Authority has established sufficient evidence to prosecute. These sanctions are offered as an alternative to prosecution but the claimant is not obliged to accept and may decide to proceed to court.

9.7 A sanctioned overpayment relates to cases that have either been cautioned, prosecuted or have had an administrative penalty applied, i.e. an offence was identified. The total overpayment contains an element of cases where no offence has been identified.

9.8 The total value of the 1 administrative penalty was £809.26. Investigations into sub-letting also resulted in 3 properties being recovered.

9.9 Overall 61 cases were referred to the Counter Fraud Team during 2016/17 of which 51 (84%) were investigated following a risk assessment on the intelligence received.

9.10 In 2016/17 there were 29 sanctioned cases. The breakdown of the sanctioned cases is as follows:

- 22 prosecutions
- 6 cautions
- 1 administrative penalties

10. Equality impact assessment (EIA)

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

11. Legal Implications

11.1 The City Solicitor has considered the report and is 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.

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

12. Finance Comments

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

12.2 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 A - Municipal Year 201617
Appendix B - Completed follow up audits from 2016/17 Plan
Appendix C - 2017/18 Audit Plan
EXEMPT Appendix D - Corporate Investigations

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	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: