Internal Audit Progress Report
Audit Committee (March 2024)

Pendle Borough Council

Contents

Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards and conforms with the International Standards for the Professional Practice of Internal Auditing.

1 Introduction

This report provides an update to the Accounts & Audit Committee in respect of the progress made in against the Internal Audit Plan for 2023/24 and brings to your attention matters relevant to your responsibilities as members of the Accounts & Audit Committee.

This progress report provides a summary of Internal Audit activity and complies with the requirements of the Public Sector Internal Audit Standards.

Comprehensive reports detailing findings, recommendations and agreed actions are provided to the organisation, and are available to Committee Members on request. In addition, a consolidated follow up position is reported on a periodic basis to the Audit Committee.

This progress report covers the period 31st October 2023 to 7th March 2024.

2 Key messages for Accounts & Audit Committee

Since the last meeting of the Accounts & Audit Committee, there has been the focus on the following areas:

Audit Reviews

The following reviews have been finalised:

- **Food Safety** (Moderate Assurance)
- **Housing Inspections** (Moderate Assurance)
- **Planning applications** (Substantial Assurance)
- **Mandatory Training** (Substantial Assurance)
- **Risk Management** (Substantial Assurance)

Refer to Appendix C for details of Key Areas and Actions to be delivered.

The following reviews are at draft report stage:

- **Budget setting & monitoring**
- **Third party suppliers (Liberata)**
- **IT Information Security**

The remaining 23/24 reviews below are currently in progress:

- **IT Cyber security/IT resilience** (fieldwork)
- **Performance reviews (staff)** (fieldwork)
- **Finance deep dives** (planning)
- **Revenue & Benefits** (planning)

Follow up of previous internal audit recommendations

A summary of the current status of follow-up activity is included in Appendix D, however, we would draw the committee's attention to the following:

Of the 100 recommendations set out in Appendix D, 77 of these have been fully actioned. The remaining recommendations are either in progress (10) or are not due yet for action (13). There are no critical or high priority recommendations outstanding.

Audit Plan Changes

Audit Committee approval will be requested for any amendments to the original plan and highlighted separately below to facilitate the monitoring process.

There are no proposed changes to the Audit Plan.

MIAA Quality of Service Indicators

MIAA operate systems to ISO Quality Standards. Public Sector Internal Audit Standards (PSIAS) require MIAA to 'develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity.' This programme must include internal and external assessments.

External assessments must be conducted at least once every five years. Our last external assessment was completed in 2020 and concluded MIAA fully complies with PSIAS (as previously reported to Audit Committee).

We also undertake regular internal assessments to ensure our ongoing compliance with requirements. We have recently completed our annual self-assessment of compliance with PSIAS and can confirm full compliance with PSIAS.

Added Value

Briefings

Our latest briefings/blogs are:

- 23/24 Through the Audit Committee Lens Series - Data Quality - Board Reporting
- 23/24 MIAA Insight Series - Driving Efficiency and Value

Appendix A: 2023/24 Contract Performance

The Public Sector Internal Audit Standards (PSIAS) state that 'The chief audit executive must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement. Below sets outs the overview of delivery for your Head of Internal Audit Opinion for 23/24:

HOIA Opinion Area	TOR Agreed	Status	Assurance Level	Audit Committee Reporting
Core/Mandated Assurances				
Risk Management Core Controls	✓	Final Report Issued	Substantial	March 2024
Finance Systems Deep Dive		Q4 - Planning		
Revenue & Benefits		Q4 - Planning		
Risk Based Assurances				
Third party suppliers		Draft report stage		
Budget Setting & Monitoring (was Transformation Programme)		Draft report stage		
Planning applications	✓	Final Report issued	Substantial	March 2024
Housing inspections	✓	Final report issued	Moderate	March 2024
Food Safety	✓	Final report issued	Moderate	March 2024

HOIA Opinion Area	TOR Agreed	Status	Assurance Level	Audit Committee Reporting
Mandatory Training	✓	Final report	Substantial	March 2024
Performance Management - Appraisals	✓	Fieldwork		
IT Cyber Security/IT resilience	✓	Fieldwork		
IT information security	✓	Draft report stage		
2022/23 reviews				
Housing Benefits	✓	Final report	Substantial	November 2023
Council tax & NNDR	✓	Final report	Substantial	November 2023
Procurement	✓	Final report	Moderate	November 2023
Key Financial Systems	✓	Final report	Substantial	November 2023
Follow Up				
Qtr 1	N/A	Complete	N/A	July 2023
Qtr 2	N/A	Complete	N/A	November 2023

HOIA Opinion Area	TOR Agreed	Status	Assurance Level	Audit Committee Reporting
Qtr 3	N/A	Complete	N/A	March 2024
Qtr 4	N/A	Complete	N/A	March 2024

Appendix B: Performance Indicators

The primary measure of your internal auditor's performance is the outputs deriving from work undertaken. The following provides performance indicator information to support the Committee in assessing the performance of Internal Audit.

Element	Reporting Regularity	Status	Summary
Delivery of the Head of Internal Audit Opinion (Progress against Plan)	Each Audit Committee	Green	We are on track to be able to provide the Council with a Head of Internal Audit Opinion in line with the required timescales.
Issue a Client Satisfaction Questionnaire following completion of every audit.	Each Audit Assignment	Green	Questionnaire issued with each audit report.
Percentage of recommendations raised which are agreed	Each Audit Committee	Green	Actions agreed by the Council on all recommendations raised.
Qualified Staff	Annual	Green	MIAA have a highly qualified and diverse workforce which includes 75% qualified staff. The Senior Team delivering the Internal Audit Service to the Council are CCAB/IIA qualified.
Quality	Annual	Green	MIAA operate systems to ISO Quality Standards. The External Quality Assessment, undertaken by CIPFA, provides assurance of MIAA's compliance with the Public Sector Internal Audit Standards. MIAA conforms with the Public Sector Internal Audit Code of Ethics.

Appendix C: Key Areas from our Work and Actions to be Delivered

Report Title (Assurance Level)	**Food Safety (Moderate Assurance)**			
Executive Sponsor	Director of Place			
Objective	To provide assurance that the food safety function was operating effectively to manage the statutory obligations of the Council.			
Recommendations	0 x Critical	1 x High	4 x Medium	0 x Low
Summary	At the beginning of the financial year 2034/24 there were 790 food premises within the Council's catchment area. All the premises reviewed in this audit had Food Hygiene Rating Scheme scores assigned following inspections and these were recorded on the Food Standards Agency (FSA) website. One application for an approved business had been received in the preceding 12-month period and this was reviewed and inspected in accordance with the regulations satisfactorily. The review found that whilst procedures were in place, they were not always consistently followed. Improvements are required to further strengthen the control environment. A high priority issue has been raised relating to one business which has not been compliant with the standards since October 2022 but no enforcement action had been taken by the Council. (This has since been actioned). **(High priority)** There were 43 Standard Operating Procedures (SOPS) in place and the majority had recently been reviewed, but two need to be reviewed and updated. **(Medium priority)** Export certificates for food licences were not stamped with the officers unique "Certifying Officers" stamp including their registration number in two instances reviewed and one of these was also signed "pp" using a pasted signature on a word document. **(Medium priority)** Two complaints were noted as having not been concluded in a timely manner. **(Medium priority)**			

	The Continuing Professional Development (CPD) for one officer was not sufficient in the previous two years to comply with requirements of the Food Law Code of Practice. **(Medium priority)**
Key Areas Agreed for Action	• Business inspected on 26/10/23. Structural issues non-critical to food safety remain non-compliant with proportionate further formal action to be taken, with a scheduled revisit for 28th November 2023. HACCP requirements now completed and compliant. (High priority, now actioned) • The Enforcement policy to be reviewed and updated within 4 months. All SOP's will be reviewed, updated within 4 weeks. A procedure for scheduling and reviewing SOP's to be introduced within 4 weeks. **(Medium priority, action by 31 March 2024)** • A procedure for reviewing CPD on a regular basis will be introduced within 4 weeks. We will ensure that any new officers employed meet the CPD requirement prior to employment. **(Medium priority, action by 31st January 2024)** • We are currently reviewing how Export Health Certificates are produced with automatic signatures produced on Idox. All Export Health Certificates go out in pdf document, with this format to be reviewed to prevent fraudulent use. The business has been refunded for the overpayment and we are migrating fees for Export Health Certificates to online. **(Medium priority, action by 31 March 2024)** • Complaint investigations on occasions do take time due to their complex nature. Regular 6 monthly reviews currently take place, with these to be now to be documented. **(Medium priority, action by 30th June 2024)**
Key Risks Highlighted with No Agreed Action	N/A

Report Title (Assurance Level)	**Housing Inspections (Moderate assurance)**			
Executive Sponsor	Director of Place			
Objective	To provide assurance that the council has controls in place to ensure rental properties meet statutory requirements and do not endanger residents.			
Recommendations	0 x Critical	1 x High	4 x Medium	1 x Low
Summary	The key findings from this review were: • From a sample of Houses of Multiple Occupation (HMO's) and tenant housing complaints, it was found that evidence to support inspections, licenses and enforcement letters were not consistently retained in either physical files or on IDOX. **(High priority)** • Whilst there was an enforcement policy and housing complaints procedure in place, there was no clear definition of the roles and responsibilities of the housing team. The housing complaints procedure did not provide any timescales for each action to be taken and furthermore, the enforcement policy could expand on guidance on the enforcement action that staff should take. **(Medium priority)** • Monthly performance indicators (PIs) are produced including some that relate to Private Sector Housing and are presented to the performance clinic quarterly. Red/Amber rated PIs are then reported to Executives. However, the PIs could be expanded and there is no documented governance structure in place including reporting and monitoring up to Council level. since June 2023 PIs are reported by exception to Executives. **(Medium priority)** • The council responded to the request made by the DLUCH in a timely manner. This included action to be taken to address the specific issues of damp & mould in privately rented properties. It was however noted that there was no formal action plan in place to monitor progress. **(Medium priority)** • Testing also found that although the council has a process in place for prioritising urgent complaints, and sample testing did not raise any concerns about urgent complaints reviewed, there are a large number of complaints logged since January 2023 that have not yet been closed. **(Medium priority)**			

	• The council website links to comprehensive government guidance for private renting tenants; however, it does not include a clear link on the housing section of the website allowing tenants to make a complaint. **(Low priority)**
Key Areas Agreed for Action	• This issue has arisen due to an agency member of staff not completing records correctly on IDOX. The department has already reviewed and implemented changes around record keeping particularly around HMO's. Settings have been changed on IDOX. (**High priority, action completed)** • The housing complaints procedure is being reviewed and will include timescales for each stage along with roles and responsibilities. Staff used the HHSRS enforcement guidance and all HHSRS scores and enforcement actions are checked and signed off by a manager/supervisor. **(Medium priority, action by 31 March 2024)** • The enforcement policy is due for review in 2024 as part of an overall enforcement review and performance indicators will be raised as part of the annual PI review. **(Medium priority, action by 31 July 2024)** • The action points in the DLUCH letter were implemented at the time that the letter was sent (November 22) which is why there isn't a current action plan in place. **(Medium priority, action already taken)** • This recommendation links to previous recs around governance & reporting as this will flag issues to senior staff outside of the housing team to raise awareness around the capacity issues. Updated procedure will improve complaint handling. (**Medium priority, action by 31 March 2024)** • Link added to Housing/Tenant webpage. **(Low priority, action completed)**
Key Risks Highlighted with No Agreed Action	N/A

Report Title (Assurance Level)	**Planning applications (Substantial assurance)**			
Executive Sponsor	Director of Place			
Objective	To identify and evaluate the controls in place to manage key risks which would affect the effective operation of the Council's system for handling and oversight of planning applications.			
Recommendations	0 x Critical	0 x High	2 x Medium	2 x Low
Summary	Overall, our review noted that there was a good system of internal control in place for the handling and oversight of planning applications, however we have identified some areas for further improvement. All of the Council's planning applications are managed on the IDOX system. The Council received 608 planning applications between January and October 2023. In the same period 79 pre planning applications were received. The Council's website was found to contain extensive guidance for public on planning applications. At the time of our audit there were 123 applications to be completed of which 43 were overdue. A subsequent review of the overdue applications at the conclusion of the audit fieldwork, showed a significant reduction in the number overdue. **(Medium priority)** The Council aims to respond to pre planning applications within four weeks of receipt, but this has not always been achieved. **(Low priority)** A reconciliation of Webpay transactions for planning payments is undertaken but not formally recorded. **(Low priority)** The executive committee receive quarterly reports on the KPIs from across the Council including Planning in the form of the Strategic monitoring reports, although the first quarters report was not presented to the Executive until October 2023. **(Medium priority)**			
Key Areas Agreed for Action	• The number of cases until the end of September is now 26. Of these, 3 have been deferred at Committee, 3 are with the Chairman having been written up, one is being written up, and the			

	remaining 19 are awaiting more information or in negotiation. Cases are actively managed, and backlogs are significantly down. Active monitoring is taking place and will continue. Cases are now almost up to date and as far as feasible will be up to date by the end of November 2023. Case management is an ongoing and happens with the manager each week. Review resources at the quarterly performance clinics. **(Medium priority, action completed)** • Review the process notes for Pre-application Inquires to ensure more consistency of capturing information. Applications are dealt with as effectively and quickly as feasible within the resources that are available. The focus has mainly been on planning application performance. That is now to an acceptable level. We will now focus more on pre-applications. (**Low priority, action completed)** • A log of confirming the webpay information has been reviewed to be created. Webpay is checked several times a week. **(Low priority, action completed)** • The timescales are set by the CE as is the review framework which involves compiling the information, going through performance clinics and then reporting to Committee. There would need to be a corporate change to alter this. The matter will be brought to the Senior Management Team for review. **(Medium priority, action completed)**
Key Risks Highlighted with No Agreed Action	N/A

Report Title (Assurance Level)	**Mandatory Training (Substantial assurance)**			
Executive Sponsor	Director of Resources			
Objective	The overall objective was to provide assurance on the systems and processes in place to define, record and report on compliance with mandatory training requirements and report on assurances through the Council's governance structures.			
Recommendations	0 x Critical	0 x High	5 x Medium	0 x Low
Summary	The Council has four main areas of mandatory training, each separately managed. The Health and Safety department manage training relevant to the health and safety of the staff and public, this is done comprehensively using the iHASCO system and is governed by an internal procedure note with clear records of training offered and undertaken, reminders are generated to staff and their managers for any incomplete training noted on the system. Equally the IG training system, KnowBe4, is well managed with training offered to all who require it and compliance recorded on the system, again with emails generated for non-compliance to staff and management. The compliance training rates for iHASCO for September 2023 were 81.6% and for KnowBe4 83%. The safeguarding training is required by all staff every three years, this was carried out last year face to face with the extended managerial team who then cascaded the training to their teams. Equality and diversity training is also mandated and face to face training has recently been rolled out to all staff in the Fleet Street Depot. The whole system does not have an overarching policy or any central control to ensure compliance and conformity **(Medium priority)**, there was previously a centrally managed spreadsheet of compliance, but this is not currently in use **(Medium priority)**. The system would benefit from an overall training needs matrix being developed and being centrally managed to ensure that all staff have the required levels of training to carry out their allocated roles. **(Medium priority)** Councillors receive only Safeguarding training they have not received any health and safety training on iHASCO and are not offered training in respect of Information Governance on KnowBe4. **(Medium priority)**			

	The system in place for monitoring mandatory training in HR is currently not being completed for Health & Safety and Information Governance. A spreadsheet of compliance is completed if HR are aware of the training taking place but pro-active work in this area is currently on hold as the post holder is currently on Maternity leave and this work has not been reallocated. Whilst general emails are sent to all staff in respect of HR training such as equality and diversity and safeguarding, they are not monitored centrally with personal reminders sent to staff or Managers to follow up any non-compliance. **(Medium priority)** Whilst reports are generated from the KnowBe4 and iHASCO systems and training compliance is reported and discussed at the Corporate Governance Steering Group there is currently no reporting in respect of Safeguarding and Equality and Diversity compliance. **(Medium priority)**
Key Areas Agreed for Action	• The mandatory training requirements are to be reviewed and identified. Using this as a start position the policy is to be developed and implemented. The learning and development officer post is being brought in-house. The appointee will be responsible for recording and monitoring all mandatory training and for assisting with the work in respect of training identification and drafting the policy. **(Medium priority, action by 30 June 2024)** • The learning and development officer to be appointed will be responsible for recording all aspects of mandatory training. A training Needs Assessment will be completed including the Mandatory Training elements once the appointee is in post. **(Medium priority, action by 30 June 2024)** • The councillors are not on the council network therefore the risk to the council is minimal and so currently do not receive the training that is rolled out through the systems. Any training offered will be on a face to face basis as this delivery method is one that the councillors prefer and will encourage compliance. Following the local elections to be held in 2024 and the appointment of councillors to roles the Mandatory Training requirements of each will be assessed and the councillors requested to complete all those assigned. **(Medium priority, action by 30 September 2024)** • The learning and development officer post is being brought in-house. The appointee will be responsible for recording and monitoring all mandatory training and for assisting with the work in respect of training identification and drafting the policy. **(Medium priority, action by 30 June 2024)**

	• This reporting will be undertaken by the newly appointed learning and development officer when in post. Once the mandatory training has been identified, the policy adapted and the training rolled out and monitored compliance reports will be prepared and presented to the Corporate Governance Steering Group for their information. **(Medium priority, action by 31 July 2024)**
Key Risks Highlighted with No Agreed Action	N/A

Report Title (Assurance Level)	**Risk Management (Substantial assurance)**			
Executive Sponsor	Director of Resources			
Objective	The overall objective of the review was to provide assurance on the design and operating effectiveness of the Council's risk management processes.			
Recommendations	0 x Critical	0 x High	1 x Medium	1 x Low
Summary	Overall, it was found that there is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in areas reviewed. The council has recently reviewed its Risk Management Strategy and has now migrated its Strategic Risk Register over to Pentana. The Strategy sets out roles and responsibilities of employees of the council staff and the Corporate Governance Steering Group (CGSG). The Corporate H&S Policy sets out the role of the Risk Management Working Group (RMWG) however this is not reflective of current arrangements. There are no separate Terms of Reference for the CGSG and RMWG. **(Medium priority)** The Accounts and Audit Committee have received updates in year on Risk Management, updating of the RM Strategy and the management of the new Strategic Risk Register via Pentana. Quarterly updates on the progress of actions linked to the Strategic Risk Register are reported to the CGSG.			

	Further staff training is planned for March 2024, however this is not in line with the RM Strategy that states there should be annual refresher training provided. **(Low priority)**
Key Areas Agreed for Action	• The Council will ensure that defined ToR for CGSG & RMWG are to be developed in line with the recommendation above. **(Medium priority, action by 31st May 2024)** • Current and future training being arranged in line with Risk Management Strategy. (Low priority, action by 31st May 2024).
Key Risks Highlighted with No Agreed Action	N/A

Appendix D: Follow up of previous audit recommendations

AUDIT TITLE (YEAR)	NO OF RECS MADE	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
Client Function (2020/21)	6	Substantial	4	2	-	-	-	-	1	1	The review of service provision and governance arrangements which the Council and Liberata have been undertaking is still ongoing but is drawing to a conclusion. The next Joint Partnership Board will take place on 7/3/24.
Conflicts of Interest (2021/22)	11	N/A	11	-	-	-	-	-	-	-	All recommendations either actioned or were not accepted.
Client Function – Liberata (2021/22)	4	Substantial	3	1	-	-	-	-	1	-	Partially implemented recommendation relates to the format of reports, which will be considered after the framework is agreed.
Joint Ventures (2021/22)	5	Substantial	3	2	-	-	-	-	2	-	Two medium priority recommendations in progress, expected to be completed by 31 March 2024. These relate to putting in place terms of reference for the working groups and receipt of information in line with section 6 of shareholders agreement.
ICT Strategy (2021/22)	5	Limited	5	-	-	-	-	-	-	-	All recommendations actioned.
Cyber Security Remote working (2021/22)	5	Moderate	5	-	-	-	-	-	-	-	All recommendations actioned.

AUDIT TITLE (YEAR)	NO OF RECS MADE	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
Key Financial Controls (2021/22)	7	Moderate	6	1	-	-	-	-	1	-	The outstanding recommendation which is in relation to consolidating and updating finance procedure notes is in progress with a revised implementation date of 30/6/24.
IT Payroll CHRIS system	4	Limited	4	-	-	-	-	-	-	-	All recommendations actioned.
Payroll (2022/23)	5	Moderate	5	-	-	-	-	-	-	-	All recommendations actioned.
Budgetary Control (2022/23)	2	Substantial	2	-	-	-	-	-	-	-	All recommendations actioned.
Nelson Town Deal (2022/23)	10	Moderate	10	-	-	-	-	-	-	-	All recommendations actioned.
Procure ment (2022/23	5	Moderate	5	-	-	-	-	-	-	-	All recommendations actioned.
Council Tax and NNDR (2022/23)	3	Substantial	2	1	-	-	-	-	1	-	One medium priority recommendation outstanding with revised date of 31 May 2024. The outstanding recommendation relates to production of a write off procedure.
Housing Benefits (2022/23)	4	Substantial	2	2	-	-	-	-	1	1	Two recommendations in progress with revised date 31/3/24.

AUDIT TITLE (YEAR)	NO OF RECS MADE	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
Key Financial Systems (2022/23)	2	Substantial	1	-	-	1	-	-	-	1	One low priority recommendation outstanding with revised date of 31/3/24.
Food Safety (2023/24)	5	Moderate	2	1	-	2	-	-	3	-	Outstanding recommendations not due for follow up.
Planning applications (2023/24)	4	Substantial	4	-	-	-	-	-	-	-	All recommendations actioned.
Mandatory Training (2023/24)	5	Substantial	-	-	-	5	-	-	5	-	Recommendations not due for follow up.
Risk Management (2023/24)	2	Substantial	-	-	-	2	-	-	1	1	Recommendations not due for follow up.
Housing Inspections (2023/24)	6	Moderate	3	-	-	3	-	-	3	-	Remaining recommendations not due for follow up.
Totals	**100**	**-**	**77**	**10**	**-**	**13**	**-**	**-**	**19**	**4**	

Key to recommendations:

✓/S	Implemented or Superseded
P	Partially implemented/recommendation in progress

X	Recommendation not implemented
ND/FUIP	Not due for follow up

C	Critical priority recommendation
H	High priority recommendation
M	Medium priority recommendation
L	Low priority recommendation

Appendix E: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

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