ITEM 11

AUDIT and GOVERNANCE COMMITTEE
20 SEPTEMBER 2023

INTERNAL AUDIT 2023/24 PROGRESS REPORT

Report by the Director of Finance

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   Note the progress with the 2023/24 Internal Audit Plan and the outcome of the completed audits.

Executive Summary

2. This report provides an update on the Internal Audit Service, including resources, completed and planned audits.

3. The report includes the Executive Summaries from the individual Internal Audit reports finalised since the last report to the May 2023 Committee. Since the last update, there have been no ed reports issued. There are currently no outstanding red reports.

Progress Report:

Resources:

4. A full update on resources was made to the Audit and Governance Committee in May 2023 as part of the Internal Audit Strategy and Plan for 2023/24. One of our Senior Auditors has been successfully appointed to the post of Senior Counter Fraud Officer. This leaves us with two Senior Auditor vacancies which we are working closely with HR to recruit to.

5. We continue to support team members to compete professional training. We are supporting a member of staff to complete the Certified Internal Audit Qualification. We also have two current apprenticeship posts within the team, one for Counter Fraud and one for Internal Audit.

2023/24 Internal Audit Plan:

6. The 2023/24 Internal Audit Plan, which was agreed at the May 2023 Audit & Governance Committee, is attached as Appendix 1 to this report. This shows current progress with each audit and any amendments made to the plan. The plan and plan progress is reviewed quarterly with senior management.

7. There have been 10 audits concluded since the last update, summaries of findings and current status of management actions are detailed in Appendix 2. This includes seven audits from 2022/23, that at the time of reporting to the May 2023 committee were still at draft report stage. The completed audits are as follows:

Final Reports 2022/23:

Directorate	**2022/23 Audits**	**Opinion**
Children's	Primary School 2	Amber
Environment & Place	Capital Programme – Major Infrastructure	Amber
HR	Employee Relations	Green
Environment & Place	Street Lighting Contract Management	Green
Children's	Young People's Supported Accommodation	Amber
Adults	Shared Lives	Amber
Adults	Providers Quality Assurance	Amber

Final Reports 2023/24:

Directorate	**2023/24 Audits**	**Opinion**
Cross Cutting	Business Continuity (including Pandemic Preparedness)	Amber
Environment & Place	Parking Contract Management	Green
Finance	Pensions Administration – IT Applications Review	Amber

PERFORMANCE

6. The following performance indicators are monitored on a monthly basis.

Performance Measure	Target	% Performance Achieved for 23/24 audits (as at 08/08/23)	Comments
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc)	100%	Previously reported year-end figures: 2022/23 71% 2021/22 59% 2020/21 50%
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	100%	Previously reported year-end figures: 2022/23 89% 2021/22 86% 2020/21 88%
Elapsed Time between receipt of management responses to draft report and issue of final report.	10 days	100%	Previously reported year-end figures: 2022/23 92% 2021/22 66% 2020/21 80%

The other performance indicators are:

- % of 2023/24 planned audit activity completed by 30 April 2024 - reported at year end.

- % of management actions implemented (as at 08/08/23) – 73% of actions have been implemented. Of the remaining 27% there are 4% of actions that are overdue, 5% partially implemented and 18% of actions not yet due.

  (At May 2023 A&G Committee the figures reported were 82% implemented, 3% overdue, 7% partially implemented and 8% not yet due)

- % of repeat findings/actions (relative to the number of actions raised within the year) – reported at year end.

- Extended Management Team satisfaction with internal audit work - reported at year end.

Appendix 3

The table in Appendix 3 lists all audits with outstanding open actions, it does not include audits where full implementation has been reported. It shows the split between Priority 1 and Priority 2 actions implemented.

As at 08/08/23, there were 126 actions that are not yet due for implementation (this includes actions where target dates have been moved by the officers responsible), 27 actions not implemented and overdue and 32 actions where partial implementation is reported.

Counter-Fraud

7. The next counter fraud update to Audit & Governance Committee is scheduled for November 2023.

Financial Implications

8. There are no direct financial implications arising from this report

   Comments checked by:
   Lorna Baxter, Director of Finance,
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Legal Implications

9. There are no direct legal implications arising from this report.

   Comments checked by:
   Paul Grant, Head of Legal and Deputy Monitoring Officer,
   paul.grant@oxfordshire.gov.uk

Staff Implications

10. There are no direct staff implications arising from this report.

Equality & Inclusion Implications

11. There are no direct equality and inclusion implications arising from this report.

Sustainability Implications

12. There are no direct sustainability implications arising from this report.

Risk Management

13. The are no direct risk management implications arising from this report.

Lorna Baxter, Director of Finance

Annex:	Appendix 1: 2023/24 Internal Audit Plan progress report Appendix 2: Executive Summaries of finalised audits since last report. Appendix 3: Summary of open management actions.
Background papers:	Nil
Contact Officers:	Sarah Cox, Chief Internal Auditor sarah.cox@oxfordshire.gov.uk

September 2023

APPENDIX 1 - 2023/24 INTERNAL AUDIT PLAN - PROGRESS REPORT

Directorate / Service Area	Audit	Planned Qtr Start	Status as at 10/08/23	Conclusion
Cross cutting	Transformation - Programmes & major projects.	Q3	Not started	
Cross cutting	Business Continuity	Q1	Final Report	Amber
Cross cutting	Strategic Contract Management	Q3	Not started	
Cross Cutting	Risk Management – directorate / service level	Q3	Not started	
Cross cutting	Joint Internal Audit & Counter Fraud proactive review - Procurement Cards	Q2	Fieldwork	
Cross cutting	Joint Internal Audit & Counter Fraud proactive review - Expenses	Q3	Not started	
Childrens	Placements – Contract Management / Quality Assurance	Q1	Fieldwork	
Childrens	Transformation Programme – including Financial Management	Q3	Not started	
Childrens	Independent Reviewing Officers	Q4	Not started	
Childrens	Supported Families	Ongoing / quarterly	Ongoing	-
Adults	Payments to Providers	Q1/Q2	Fieldwork	
Adults	Health Funded Payments	Q2	Scoping	
Adults	Safeguarding	Q4	Not started	
Adults	Income and Debt Recovery	Q3	Fieldwork	

Customers & Organisational Development – Customer Services	Corporate & Statutory Complaints	Q1	Draft Report	
Customers & Organisational Development – Property & FM	Property Health & Safety	Q1	File review	
Customers & Organisational Development – Property & FM	Property Strategy Implementation	Q4	Not started	
Customers & Organisational Development – IT	IT Incident Management	Q3/Q4	Not started	
Customers & Organisational Development – IT	Cyber – Incident Preparedness and Response	Q2	Scoping	
Customers & Organisational Development – IT / Property & FM	Physical Security Systems – Building Access Controls & CCTV System	Q3/Q4	Not started	
Customers & Organisational Development	I-Hub Governance and Project Management	Q3	Not started	

Finance	Pensions Administration	Q3/Q4	Not started	
Finance	Pensions Administration – IT Application Audit	Q2	Final Report	Amber
Finance	Feeder System Controls	Q2/Q3	Fieldwork	
Legal	Case Management	Q3	Not started	
Public Health / Cross Cutting	Pandemic Preparedness	Q1	Combined with Business Continuity Audit	-
Environment & Place	Supported Transport	Q3	Not started	
Environment & Place	Parking Contract – Contract Management	Q1	Final Report	Green
Environment & Place	Local Transport Connectivity Plan	Q3/Q4	Not started	
Environment & Place	S106 – New IT System	Q2	Scoping	
Grant Certification		Ongoing	-	-

APPENDIX 2 - EXECUTIVE SUMMARIES OF COMPLETED AUDITS

Summary of Completed Audits since last reported to Audit & Governance Committee May 2023.

2022/23 – completed audits

School Audit 2 22/23

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance	**R**	**1**	**7**
Financial Planning & Monitoring	**A**	**0**	**5**
Procurement	**A**	**0**	**5**
Income	**A**	**0**	**2**
Assets	**A**	**0**	**1**
Staffing/Payroll	**R**	**1**	**10**
Unofficial Funds	**R**	**0**	**1**
		2	**31**

Opinion: Amber	
Total: 33	Priority 1 = 2 Priority 2 = 31
Current Status:	
Implemented	18
Due not yet actioned	4
Partially complete	1
Not yet Due	10

A governance and financial management audit was undertaken at a primary school, with an overall conclusion graded as Amber. The audit was undertaken following the appointment of an Interim Headteacher and covered the financial management practices under the previous Headteacher as well as the arrangements currently in place and being developed. The audit highlighted issues in relation to some of the governance and financial management practices previously in operation, however acknowledged that the Interim

Headteacher had made good progress in addressing these issues, ensuring improved governance and financial management processes are developed and implemented.

Capital Programme – Major Infrastructure 22/23

Overall conclusion on the system of internal control being maintained	**A**

Opinion: Amber	
Total: 2	Priority 1 = 0 Priority 2 = 2
Current Status:	
Implemented	0
Due not yet actioned	1
Partially complete	1
Not yet Due	0

A corporate review of Capital Programme governance carried out in 2022 resulted in a revised approach to areas such as decision making, thresholds, and roles & responsibilities. A Strategic Capital Board was established to oversee the Capital Programme, and a capital hub created to improve oversight, reporting and monitoring. The Board is becoming more embedded with continuous improvements being made to enhance the quality and timeliness of information being reported at Board level. There are four programme boards reporting into the new Strategic Capital Board: Highways Maintenance, Major Infrastructure, Digital and IT, and Property. This audit sought to provide assurance over the new governance arrangements in relation to Major Infrastructure, which, as of March 2023, accounts for £65.4m of 2022/23 capital expenditure / £740.1m for the 10-year programme.

The overall conclusion of this audit is Amber. This conclusion is based upon the governance in place at scheme level and the effectiveness of escalation processes and documentation of decision making. Through sample testing of three projects within the Major Infrastructure Capital Programme (covering different geographical areas, budgets, and stages), the audit reviewed the governance arrangements in place to confirm that, at an individual project level, project management and risk management arrangements are operating effectively, and, at senior management level, strategic governance arrangements provide sufficient oversight of the delivery of the Council's capital programme. This included review of how issues, concerns, and information is escalated and/or flows through the governance structure. The audit also reviewed the adequacy of guidance in place for staff in relation to the management of capital projects.

The audit recognised the ongoing improvements being made to capital governance in this area, noting the development of the Major Infrastructure dashboard over the previous six months, and subsequent reporting to the Strategic Capital Board to provide greater oversight and visibility of the Major

Infrastructure Capital Programme. It was also noted that as of January, the Major Infrastructure Capital Programme Items for Escalation Meeting, a coordination meeting following the six Programme Boards, took on a more formal approach, with a Terms of Reference drafted and minutes now being taken to document discussions held.

Sample testing found the six Programme Boards (each focusing on a different geographical / high level area) to be working effectively in their role of providing oversight on cost control, timescales, and quality of Major Infrastructure capital projects, and delivery of the capital programme in that area.

From review of evidence available, weaknesses were noted in the timeliness of escalation to the Strategic Capital Board of an arising issue for one of the projects reviewed, however it was reported to Internal Audit that discussions around this were held, although had not been recorded in the meeting's minutes. It is positive to note that the developments in reporting referred to above now mean the Strategic Capital Board has oversight of all Red risks identified within projects, improving the mechanisms in place for flagging early warnings and arising issues.

Inconsistencies were also noted in the way contingency is managed. In one case this resulted in an early warning around a forecast budget overspend being reported in error.

The audit noted the development of an extensive Major Infrastructure dashboard, providing detailed information on each project's RAG rating, timescales, finances (covering budget, spend, and forecasts), and identified risks. This easily available information then informs the exception and summary reporting to the Strategic Capital Board, with the ability to drill down to further information if required.

HR Employee Relations 22/23

Overall conclusion on the system of internal control being maintained	**G**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance Arrangements	**G**	**0**	**0**
B: Operational Processes	**G**	**0**	**2**
		0	**2**

Opinion: Green	
Total: 2	Priority 1 = 0 Priority 2 = 2
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	1

In order to provide assurance and oversight of high-risk employee cases and issues, all cases are RAG rated and recorded on a case management log, with monthly Case Management Risk Group meetings taking place to provide oversight and discuss higher risk cases. Six of these cases were reviewed, covering different service areas, RAG ratings, and case categories, to provide assurance over the processes in place for managing high risk employee relations issues. While weaknesses were noted within some of the cases reviewed, it was positive to note action has already been taken by the new Head of HR Business Partnering & Advisory to strengthen the governance arrangements in place, improving the management and monitoring of cases.

Governance Arrangements

The audit confirmed Case Management Risk Group meetings are taking place on a monthly basis, with appropriate attendance from HR officers as well as representation from OCC's Legal Service. A review of meeting minutes confirmed Amber and Red cases are being discussed as expected, including those sampled as part of the audit.

With regard to the case management log (a spreadsheet maintained to detail all active cases, including their RAG rating, history, and progress updates), sample testing identified some delays in the updating of information and monitoring of cases in 2 of the 6 cases tested.

In discussion with the service, it was reported several new processes have now been implemented to improve oversight and monitoring of cases, including a monthly review of the case management log by the Head of HR Business Partnering & Advisory to identify and escalate any cases that are not progressing as expected, and the automatic regrading of any Green sickness cases to Red, should the sickness exceed three months.

Operational Processes

Sample testing of the six cases taken from the case management log confirmed that, in general, cases are being escalated, monitored, and progressed appropriately. Acknowledging that each case is individual with its own requirements and challenges, exceptions were noted in some instances, including a sickness management case in which a referral to Occupational Health was not made in line with expected timescales, and there was a further delay with the follow up appointment. Another instance noted involved an investigation carried out by an external investigator taking four months (the duration of which the employee's responsibilities were reduced pending the outcome). This was agreed by HR to have taken longer than would be expected. A further instance was also noted in another sickness management

case in which, the employees return to work was delayed pending a manager's availability to carry out the return-to-work interview.

Delays in the resolution of cases were also found to be contributed to by the employee's engagement in two of the cases reviewed. For both of these, employees were asked to complete certain forms (for example a stress risk assessment), however in one case this took six months to be returned, and in the other five weeks. It is noted that while the Council's Managing Sickness Absence Policy it states employees are expected to cooperate with the Council's procedures, there is no further information around how non-engagement will be managed or escalated.

Instances were also identified in which employees on sickness absence reported they had not been made aware of their drop down to half pay, a responsibility of the line manager who is notified via IBC of the payment change date and asked to inform the employee. In one of the instances this resulted in an agreement to continue the period of full pay for an additional two months.

It was noted that reliance has previously been placed on using external parties for legal advice or investigations, however it was reported controls around this have now been tightened, including reviewing at what stage cases should be referred to Legal, and the requirement that any referrals to an external legal party be authorised by the Head of HR Business Partnering & Advisory.

Street Lighting Contract Management 22/23

Overall conclusion on the system of internal control being maintained	**G**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance	**G**	**0**	**0**
Financial Planning & Monitoring	**A**	**0**	**4**
Procurement	**G**	**0**	**0**
Income	**G**	**0**	**0**
		0	**4**

Opinion: Green	
Total: 4	Priority 1 = 0 Priority 2 = 4
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	1
Not yet Due	3

At the time the audit was initially scoped, there were two street lighting contracts in place. A short-term contract focussed on replacement of street lighting on high energy traffic routes and a long-term contract replacing street lighting in residential areas as well as ongoing maintenance. It was reported that there were issues with performance (due to lack of staff / resource to be able to fulfil their responsibilities as part of the contract) with the short-term contractor, which led to the termination of the contractual arrangement at the end of September 2022. The longer-term contractor has since picked up the additional work.

Contract Governance: It was found that there are clear governance structures in place for the management of the contract with fortnightly meetings in relation to operational contract delivery and quarterly strategic level meetings taking place. Roles and responsibilities of OCC staff overseeing delivery of the works under this contract appear clearly understood. There are mechanisms in place which enable the Council staff to oversee delivery of works against what is planned with opportunities for any issues identified to be raised and resolved through the fortnightly meetings if not prior to that. The links between the outputs required from the contract and the Council's strategic objectives and priorities were also found to be clearly defined (including the priority to "put action to address the climate emergency at the heart of our work" and part of the action required in relation to the Climate Action Framework).

Management Information & Performance Reporting: From review of the quarterly reporting provided by the contractor which forms part of the discussion at strategic level contract meetings, it was noted that the format and way in which some of the performance reporting is presented is difficult to interpret and can appear contradictory. This is an area that is in the process of being developed by the service in conjunction with the contractor, with plans to develop comprehensive dashboard reporting.

Although operational contractor performance is being kept under review within the team, it was noted that sample checking undertaken reviewing completed works is not currently documented, it is therefore not possible to evidence the volume of checking, the outcomes, any patterns or trends or that issues identified are being followed up and addressed. Whilst it was reported that issues noted from sample checking would be discussed at fortnightly operational meetings, it was not possible to evidence this explicitly from the minutes available for review.

It was noted that some contract related documentation, specifically minutes from fortnightly meetings where service delivery is discussed, is not always being saved to the shared drive, instead reported to be being held on individuals "one drives".

Risk Identification & Management: There are appropriate arrangements in place for the management of risks in relation to this contract. Contract level risks have been defined, with frequent opportunities to discuss, update and, where necessary, escalate. At service and directorate level, there is a clear process for the identification and management of risk in relation to this service area and specific to the delivery of the street lighting replacement. It is noted that service level risks in this area are due to be reviewed and updated in June

as part of a business delivery session with Heads of Service across the directorate.

Contract Payments: There is a clear process in place for the tracking, management and payment of street lighting works under the contract with review and sign off by the relevant OCC staff prior payments being made. No issues were noted in relation to budget management.

Young People's Supported Accommodation 22/23

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance	**A**	**1**	**3**
Financial Planning & Monitoring	**A**	**0**	**3**
Procurement	**A**	**0**	**4**
Income	**R**	**0**	**8**
		1	**18**

Opinion: Amber	
Total: 19	Priority 1 = 1 Priority 2 = 18
Current Status:	
Implemented	5
Due not yet actioned	2
Partially complete	2
Not yet Due	10

The Young Persons Supported Accommodation (YPSA) service was remodelled, and the new service commenced in October 2020. The new delivery model for services is intended to ensure that vulnerable young people or young people at risk of homelessness are provided with accommodation, whilst being supported to develop their independent living skills, find employment, education or training. The service is intended to be a short-term intervention which enables the young person to move on into independent accommodation.

The Service has already identified issues in relation to governance and the operational delivery of the YPSA service. The key challenges to the service include the commissioning and provision of suitable placements for the young people. This resulted in a workshop taking place in October 2022 which

involved the relevant senior officers. An action plan was developed to address the identified weaknesses and this is in the process of being implemented. Implementation of the Action Plan will address some of the issues identified in the audit.

A: Governance and Risk Management

A number of the issues identified during the audit in relation to governance and risk management arrangements will be addressed by the completion of the actions agreed in the October 2022 Action Plan. The audit noted that improvements are still required in a number of areas including the development of a commissioning strategy for service provision and review and updating of roles and responsibilities in some areas, these issues and the actions required to address them are covered within the October 2022 Action Plan.

It is positive to note that there are appropriate policies and procedures in place across the YPSA Service which are well communicated internally and externally. Documented guidance on processes for contract management and brokerage are currently being developed and agreed.

It was noted that improvements could be made to the operational and strategic oversight of the service. There was previously a YPSA Service Board which is not currently meeting as its remit is under review. Re-establishment of the YPSA Service Board in a more effective format would assist in providing effective oversight of the governance, risk management and operational delivery of the service. The Service Board could also provide the governance mechanism for oversight of implementation of the October 2022 Action Plan.

B: Reporting and Performance Monitoring

There is a lack of meaningful “whole service” management information and there are no KPIs being reported at a senior level to reflect the performance of the YPSA service. Information is collected from providers for contract monitoring purposes but is not currently collated together into “whole service” information, which is a missed opportunity to measure and monitor whole service performance.

C: Contract Management

It was noted that a number of improvements have recently been made to contract management arrangements which include clear contract management ownership, quarterly contract management cycle of activity and ongoing supplier due diligence checks. It was noted that the Quality & Improvement team have developed a comprehensive “Reporting Requirements” document which sets out the reporting and communication requirements for providers to follow, including who to report to in which circumstances, what information to provide, frequency/timescale, contact details and links to the required documents. This has improved performance reporting and communications from providers. There are some further improvements required to strengthen these arrangements, for example improved assurance on the achievement of contractual KPIs, and monitoring progress of the young people in the pathway.

D: Young Person Placements

There are a number of areas identified where arrangements could be strengthened. The correct referral and approval processes are not always being followed, records of meetings are not kept, and external providers' assessments are not routinely shared with OCC officers. Some examples were identified where the external provider assessments of young people coming into the service did not appear to be complete or have sufficient detail recorded. There is also a lack of assurance over the quality and completeness of assessments carried out by these providers. There is a reported issue of young people coming into the service with higher support needs than their service package is designed for which may impact on how the young person's support needs are delivered as well as impacting on the level of support provided to other young people in that placement. There is an ongoing review of how providers accurately report on young people being ready to move on.

Shared Lives 22/23

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance	**A**	**0**	**2**
Financial Planning & Monitoring	**A**	**0**	**3**
Procurement	**G**	**0**	**0**
Income	**A**	**0**	**2**
Assets	**G**	**0**	**0**
Staffing/Payroll	**A**	**0**	**1**
		0	**8**

Opinion: Amber	
Total: 8	Priority 1 = 0 Priority 2 = 8
Current Status:	
Implemented	6
Due not yet actioned	1
Partially complete	0
Not yet Due	1

Shared Lives offers adults in Oxfordshire with varying support needs the opportunity to live or stay temporarily in a Shared Lives carer's home, or sometimes to be supported in their own home and community, enabling them to live as independently as possible.

The audit of the Shared Lives service was completed at the end of the 2022/23 financial year. It is acknowledged that this has been an unusual year for the team due to the diverting of team resources to support the Council's Homes for Ukraine work for much of the year. This has impacted on the level of resource available within the team to carry out routine shared lives processes. As a result of this, there has been some impact on the timeliness of completion of tasks across carer assessment, review and monitoring processes and the processes in place for the monitoring of individual placements. The team are now making progress in catching up with overdue reviews and visits and this is being monitored by the Team Manager.

Policies & Procedures – It was found that there is comprehensive guidance and information for shared lives carers. Review of available guidance in relation to Shared Lives scheme workers noted that whilst there is guidance, checklists and template documents in place across the majority of key shared lives tasks, there were some areas noted where guidance could be enhanced (for example in relation to the process for the follow up and escalation of vetting check returns and processes following on from panel approval). There is also a need for staff guidance to cover the financial processes undertaken within the team for the set up and close down of long- and short-term arrangements and the processing of expense claims.

Some inconsistencies were also noted in relation to document retention and the saving of key documents to SharePoint. Across a number of different processes, testing identified examples where documentation had not been saved as expected. It is acknowledged that carer casework recording is not yet on LAS which means that there are some inherent weaknesses in terms of being able to track and report on document recording and retention. There is a project to move carer casework recording on to LAS although timescales for this are not currently confirmed.

Vetting & Assessments – Sample testing identified examples where evidence of carer vetting checks appeared to be incomplete. Following review by the Shared Lives Team Manager of these exceptions, it has been reported that this was a document retention issue. There were also examples where it was not possible to evidence that carer agreements and confidentiality agreements had been provided and returned. Discussions with staff over the expected process in this area suggest that some additional guidance around requirements would be beneficial. Following on from the outcomes from audit testing in this area, the Shared Lives Team Manager is implementing revised processes to ensure that there are clearly defined triggers for these tasks as well as tracking to ensure satisfactory completion.

For the sample of new carers reviewed, it was noted that there is evidence of ongoing support and communication between scheme workers and carers throughout the vetting and assessment process. New carers sampled had all been reviewed, discussed and approved by the Panel.

Training & Ongoing Support - Internal Audit assessed the processes for training, reviewing, and re-approving Shared Lives carers to be appropriate and sufficient. As previously noted, it is acknowledged that there have been some delays in relation to these processes due to the impact of the diversion of team resource to the Homes for Ukraine work, however audit testing was able to evidence that there was ongoing support and training provided to the carers sampled.

Shared Lives Placements – The audit noted that there are clear processes and expectations for the support to be provided to service users in shared lives placement. The expected process is documented using compliance tables which are completed by shared lives scheme workers. Sample testing noted gaps in relation to the provision of service user information folders to some of the service users sampled, it was also noted that there were some inconsistencies in the compliance table templates being used. It was reported that issues with the provision of service user information had been identified by the Team Manager earlier in the year and has been discussed at recent team meetings.

Payments & Finance – There are clear processes in place for payment of long- and short-term shared lives placements and for the payment of expenses. Sample testing noted that carers were paid accurately, on a timely basis and that where relevant, payments ended in accordance with the relevant care end date. There are appropriate routine budget monitoring processes in place.

Management Information – It is noted that Directorate level reporting on the Shared Lives service is currently being provided as part of the At A Glance (AAG) reporting which is collated and circulated on a monthly basis. It is reported that the directorate are in the process of developing performance dashboard reporting using PowerBi which will replace AAG reporting.

At a service level, the Shared Lives Team Manager is keen to develop management information and reporting which provides oversight of team performance. Information and reporting requirements are in the process of being considered and confirmed. This will be important in terms of being able to define requirements as part of the development of PowerBi reporting and with the implementation of LAS for carer casework recording.

Providers Quality Assurance 22/23

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance & Oversight	**A**	**0**	**3**
B: Contract Management & Quality Assurance Processes	**A**	**0**	**6**

C: Management Information	**A**	**0**	**4**
		0	**13**

Opinion: Amber	
Total: 13	Priority 1 = 0 Priority 2 = 13
Current Status:	
Implemented	2
Due not yet actioned	3
Partially complete	0
Not yet Due	8

The Quality Improvement Team is responsible for working with care providers across all age groups and types of service provision to ensure they are providing good quality services to the residents of Oxfordshire. For Age Well, the focus of this audit, this includes monitoring visits to providers, as well as working with other teams and organisations to improve the quality of care. This audit therefore reviewed the robustness and effectiveness of the quality assurance processes over the providers in this area.

The audit found good evidence of cross-team working with various established meetings between different services, such as Operational Teams, Safeguarding, and the Provision Hub, to ensure information is shared appropriately. Some areas of weakness noted, including guidance and the methodology for routine provider visits, had already been identified by the service, with action taken to improve such processes. Other weaknesses identified include the documenting of evidence and outcomes relating to monitoring activity, and the consistency of management information being reported on.

Governance & Oversight

A review of guidance available to staff noted several areas that are not covered by current guidance, and further areas where existing guidance requires updating. It is positive to note this has already been recognised by the service, with the Care Governance Framework (which provides an overview of the monitoring processes carried out by the Council) recently refreshed and re-issued as the Quality Improvement Protocol. Work is now underway to document key processes sitting below this, and consideration is being given as to how to make the Protocol available to providers. It was noted that roles and responsibilities between the Quality Improvement Team and the Procurement Hub in regard to contract management are not clearly assigned or documented. Work is ongoing in this area, with workshops held with the Hub and HESC (Health, Education & Social Care Commissioning) to understand roles and responsibilities, and further sessions planned on contract segregation and contract management.

Contract Management and Quality Assurance Processes

Review of routine monitoring activity carried out by the Quality Improvement Team of providers over the past year noted an inconsistent approach to how providers were sampled for review, and how work carried out was documented and evidenced. In discussion with the service, it was positive to note this has been identified, and a new approach implemented. All providers have recently been classified depending on the number of service users supported, with the level of monitoring activity required defined for each category.

In terms of reactive work (for example responding to safeguarding referrals or complaints), weaknesses were also noted in the recording of information and outcomes. From review of five referrals shared by the Safeguarding Team regarding a provider, it was difficult to evidence from the information available how they had been managed and whether the follow up was appropriate, with responsibilities for recording such information unclear. Similarly, from review of five complaints received regarding providers, it was not possible to determine from the Quality Improvement Team's records how the complaint had been managed in three of the cases, with no record of the complaint within the provider's file in one case.

For the traffic light / Serious Concerns and Standards of Care process, while it was positive to see the refreshed Quality Improvement Protocol aligned the traffic light statuses more closely to the Serious Concerns and Standards of Care processes, exceptions were noted during sample testing including a three month delay in moving a provider to a Red traffic light following a 'Requires Improvement' CQC report and warning notice, two cases where it was not possible to evidence the provider had been notified they were now subject to the process, and a case where the provider's action plan could not be provided.

The audit testing carried out confirmed new providers (either applying to join frameworks or being commissioned as a spot contract), had undergone appropriate background checks prior to care placements being made.

Management Information

While a review of internal performance monitoring found management information has been ad-hoc or upon request, it was reported work is underway to develop a series of automated dashboards. This will allow oversight in certain areas across Quality Improvement, with Age Well-specific dashboards overseeing monitoring activity carried out (in line with the new categorisation of providers and resulting review requirements), and of traffic light statuses.

Current performance reporting requirements were found to vary across contracts and care types. For the four strategic partners of the Live Well at Home contract, quarterly KPI meetings could be evidenced as stipulated in the contract, with minutes showing appropriate review and challenge of the information, with agreement of actions documented.

It is recognised that under this contract, ETMS is no longer used to record exact visit times by carers. Instead, providers use their own systems to record visit data, and are required to upload this data to the Council's provider portal every four weeks. It is then the responsibility of the Payments and Systems Data Team to investigate recorded visits that do not match planned care, and

subsequently allow or reject the payment. This specific process was not tested as part of this audit and will instead be reviewed under the 2023/24 Payments to Providers Audit.

From a quality assurance perspective, the Quality Improvement Team will investigate consistent over or under delivery upon notification of concerns in this area (for example, following a complaint), but also monitor a provider's performance through the contract KPIs, which includes "people receiving the service are receiving the correct amount of care required". This metric is measured as the percentage difference between the total care hours commissioned by the Council, and the 'actual' care hours delivered by the provider. Providers are required to report on this figure on a quarterly basis, however it was noted that for two of the four strategic providers (and therefore the only ones currently subject to this level of monitoring), 100% had consistently been reported across the year, which is not in line with how the metric should be measured and had not been picked up during the quarterly review meetings.

For other contracts / care, further consideration is required as to what performance metrics would be meaningful and add value. The Live Well at Home contract allows for 'zonal partners', who would be subject to similar KPI requirements as strategic partners, however no providers on the framework have yet met the requirements detailed in the contract to become a zonal partner. Similarly, for care homes, with the exception of the block bed contract, no reporting metrics are required from homes other than those required by CQC (which would then be reviewed by the Quality Improvement Team as necessary).

2023/24 – completed audits

Business Continuity Planning Review 23/24

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Corporate Policy	**G**	**0**	**1**
Management Framework	**A**	**0**	**4**
Business Impact Analysis	**A**	**0**	**3**
Business Continuity Plans	**A**	**1**	**3**
Incident Response	**A**	**0**	**2**

Testing	**R**	**1**	**1**
Pandemic Preparedness	**A**	**0**	**3**
		2	**17**

Opinion: Amber	
Total: 19	Priority 1 = 2 Priority 2 = 17
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	2
Not yet Due	17

An audit on business continuity planning was previously undertaken pre-covid in 2018/19. It identified a number of high risks, and the overall conclusion was red. This current review has found there is a stronger control framework in place and business continuity planning has improved, although risks remain which should be addressed, and therefore new management actions have been agreed. The weakest area remains the testing of business continuity plans as there is no strategy in place and regular testing of plans is not performed.

Business continuity plans were invoked during the covid-19 pandemic. The plans included moving to agile working but scaling this up quickly for the whole organisation was an issue due to the supply of laptop computers and other equipment. Existing agile workers were able to continue working with minimal disruption compared to those who were traditionally office based. Essential teams, such as those involved in community response and resilience, were up and running quickly.

Corporate Policy:

There is a documented Business Continuity Policy which is available on the corporate Intranet and is owned by the Chief Fire Officer, the council's lead for business continuity. A review of the policy found that whilst it covers all relevant areas, it is dated 2019-2022 and refers to supporting the Corporate Plan 2018-2021. It is therefore out-of-date and may not reflect the council's current priorities and objectives.

Management Framework:

Roles and responsibilities for business continuity are defined at a corporate and operational level and members of the Emergency Planning team hold formal business continuity qualifications. There is a Business Continuity Steering Group (BCSG), who are responsible for embedding business continuity across the council. A review of the BCSG identified the following:

- Each directorate/service area is represented apart from Law & Governance and Strategy, Insight & Comms, who because of staff changes are represented by the Emergency Planning Officer. Service

area leads should be identified as soon as possible for these two areas to ensure there is local ownership and engagement.
- Meetings are not recorded and hence attendance cannot be confirmed or that any issues/actions raised are subsequently followed up.
- Some BCSG members have not received any formal training in their role and hence may not have the skills to lead on business continuity for their respective areas.

There is also no formal reporting on business continuity at a directorate level and hence leadership teams may be unaware of any gaps in planning within their areas which need to be addressed.

Business Impact Analysis:

A Business Impact Analysis (BIA) is used to identify all critical services and activities and underpins the business continuity planning process. There are 13 BIA's for directorates/service teams, which are based on a template supplied by the Emergency Planning team. A review of the BIA template found that it includes key information required for business continuity, such as the identification of critical services/activities, the impact of their loss over an increasing timeline, Maximum Acceptable Outage (MAO) and the Recovery Time Objective (RTO). All BIA's are required to be signed-off at Director/Head of Service level and this was tested and confirmed.

A review of BIA's found that one has not been completed for Registrations & Coroners and Museums, and others have not been reviewed annually to ensure they are current and valid. The reporting and logging of business continuity risks also needs to be re-affirmed with BCSG as we found that not all members are aware of the agreed procedure i.e. they should be logged on local risk registers.

Business Continuity Plans:

The BIA's identify the number of Business Continuity Plans (BCP's) in each directorate/service area. In total, there are over a 100 BCP's across the council. We sample tested 10 plans and confirmed each has a nominated owner and has been reviewed in the past 12 months. All BCP's should be formally signed-off and approved by the plan owner but our testing identified three out of 10 plans had not been approved and one which has been updated since approval and not submitted to the Emergency Planning team. All plans should be approved to ensure they are formally agreed. There are at least 11 service areas/teams, mainly in Libraries and Museums but including one each in CEF and Adults, that do not have a BCP and hence may not be able to maintain their critical services.

The testing of BCP's found that some are not based on the corporate template and thus do not capture all relevant details. We also found gaps in the template itself, such as a lack of action cards, staff/supplier contact details or where they can be found and responsibilities for internal/external communications. The recovery actions identified in some plans for loss of ICT and loss of telephony are also based on assumptions which may not be realistic.

Critical suppliers and partners are identified in BIA's but beyond a contractual requirement to have business continuity in place, no assurance is sought that they maintain and test their plans. Secondary supply sources are also not

identified for key services/products and this presents a risk of a supply chain failure impacting key council services/activities.

Incident Response:

An Incident Management Framework (IMF) is documented and provides details of how to respond and recover from major incidents. A review of the IMF found that it covers many of the areas we would expect to find, although there are some gaps and areas which should be further defined, such as the use of action cards for command structures and media communications. Formal debriefs are not held at the end of all major incidents and when they have been performed they are not completed on a timely basis to ensure any lessons learned are captured and incorporated within the IMF.

Testing:

The testing of business continuity plans remains an area of risk. There is no formal testing strategy or plan giving guidance on the frequency, scope and type of testing that should be performed. We found that where service areas have tested their plans in the past 12 months, there has been no formal output to show what was tested, who was involved, which scenario was used and more importantly any lessons learned.

Pandemic Preparedness:

Responsibilities for pandemic preparation and response planning are defined within Public Health and there is a health protection risk on the local risk register. The Director of Public Health chairs a Health Protection Forum, which includes partner organisations, and has a remit to ensure sufficient plans are in place to prevent and manage outbreaks of infectious diseases.

There is a documented Human Infectious Diseases Response Framework (HIDRF) which was approved in May 2022 and covers key responsibilities, activation, outbreak management, recovery and identifies key partner organisations. We have identified aspects of the HIDRF which need to be reviewed and updated, including responsibilities assigned to the BCSG, to ensure it aligns with the IMF and BCP's.

A lesson learned review of the response to covid-19 was performed in 2021. A formal report was produced that identifies a number of key learnings, but they were not recorded in an action plan and followed up. There was also a requirement for BCP's to be updated to include mitigations against another outbreak of an infectious disease. However, we found a number of plans do not currently have this information and the BCP template itself has not been updated to reflect the requirement. This should be addressed to ensure the council is better prepared to respond to any future pandemic or similar threat.

Parking Contract Management 23/24

Overall conclusion on the system of internal control being maintained	G

Opinion: Green	
Total: 0	Priority 1 = 0 Priority 2 = 0
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	0

The audit reviewed the robustness of contract management arrangements in place for the contracts relating to parking enforcement and management. The overall conclusion of the audit is **Green**, noting a strong system of contract governance in place. Performance is monitored through reports and regular meetings with the contractor. Income and expenditure are accurately recorded on a budget tracker that enables appropriate budget monitoring and oversight. The audit found that payments to the contractor are accurate and timely, and the overall annual income remains higher than forecasted.

Pensions Administration – IT Applications Review 2023/24

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Logical Security	**A**	**0**	**2**
Access Rights	**G**	**0**	**1**
System Administration	**A**	**0**	**1**
Audit Trails	**G**	**0**	**0**
Backups	**A**	**0**	**1**
System Support	**G**	**0**	**0**
Security Assurance	**G**	**0**	**1**
		0	**6**

Opinion: Amber	
Total: 6	Priority 1 = 0 Priority 2 = 6
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	6

Several of the areas we reviewed are well managed and controlled. The main risks identified is a lack of multi-factor authentication on systems that are accessible over the Internet and a lack of assurance over data backups taken by the supplier.

Logical Security:

There is a two-stage login process to the system. The main access is based on username and password authentication and is restricted to the OCC corporate network. There is a secondary way of accessing the system, which was established as a backup, and is accessible outside the corporate network. This method is also based on username and password alone and does not have multi-factor authentication (MFA) in place. MFA is a key security control for authenticating remote users on the Internet and preventing unauthorised access and cyber-attacks. The current system password policies are also not compliant with the corporate password policy and recommended good practice.

Access Rights:

Access rights within the system are defined using “roles”. We reviewed a sample of users and their roles and no exceptions were identified. The roles can be setup at a granular level but there is no documentation showing what rights they provide, which could lead to new users being allocated incorrect roles and thus excessive access. The review of user access performed by the Technical Manager is also not evidenced.

System Administration:

System administration access is limited to two members of the Pensions team. The two administrators have full access to the system, including payroll, and controls are in place to identify any unauthorised changes to the payroll by these officers. We found these controls are not working effectively and should be reviewed and re-designed.

Audit Trails:

The system maintains an audit trail of all user access and changes to data, which goes back to when the system was originally implemented. Audit reports can be run using search facilities but reporting is slow and not user friendly. The supplier is addressing this by developing a new reporting tool that is available on their portal.

Backups and Disaster Recovery

The system is cloud hosted and hence the supplier is responsible for taking data backups and for IT disaster recovery. The contract for the system says the supplier will take secure backups of data but no details are provided beyond

this on retention, testing, storage or recovery. Similarly, the contract says the supplier has a disaster recovery plan but no details are given. These areas should be confirmed with the supplier to ensure the risk of data loss and/or system failure are being managed.

System Support:

There is a support and maintenance contract for the system which is valid until August 2024 and includes an option for an extension beyond this. The Pensions service are running the latest version of the system and we confirmed there are sufficient licenses for the current number of users. All incidents and service requests are logged on the supplier's support portal and there were six open tickets at the time of the audit. One related to a problem which will be fixed in the next version of the system and all others are being progressed by the supplier.

Security Assurance:

All key third-party suppliers claim to hold various information/cyber security certifications but evidence is not always sought to confirm they are current and valid. On a positive note, the main system supplier commission an annual technical review of their cyber security and share a summary of the report with the Pensions service. No critical or high rated issues were identified in the last test in February 2023.

APPENDIX 3 – As at **08/08/2023** - all audits with outstanding open actions (excludes audits where full implementation reported):

	ACTIONS								
	P1 & P2 Actions			IMPLEMENTED					
Report Title	1	2	**Total**	1	2	**Total**	Not Due for Implementation	Not Implemented	Partially Implemented
OCC Adults CM & QA 22/23	0	13	**13**	-	2	**2**	8	3	-
OCC Business Cont 23/24	2	17	**19**	-	-	**-**	19	-	-
OCC Capital Majors 22/23	0	2	**2**	-	-	**-**	1	1	-
OCC Carterton Comm College 20/21	4	16	**20**	4	15	**19**	-	-	1
OCC Childrens Finances 22/23	0	12	**12**	-	1	**1**	6	3	2
OCC Client Charging and Prov Payments 2019/20	0	21	**21**	-	20	**20**	1	-	-
OCC Climate Audit 22/23	5	12	**17**	1	3	**4**	9	3	1
OCC Controcc Payments 19/20	4	18	**22**	4	17	**21**	-	-	1
OCC Controcc Payments 2122	0	9	**9**	-	5	**5**	-	2	2
OCC Covid Payments Audit 2020/21 – 85% Transport Payments	0	5	**5**	-	1	**1**	4	-	-
OCC Cyber Security (Ransomware) 22/23	1	6	**7**	1	5	**6**	-	1	-
OCC Cyber Security 21/22	2	11	**13**	2	10	**12**	1	-	-
OCC Direct Payments 22/23	0	11	**11**	-	2	**2**	7	-	2
OCC Educ IT System – processes 22/23	0	5	**5**	-	3	**3**	-	-	2
OCC Five Acres School 21/22	2	9	**11**	2	8	**10**	-	-	1
OCC Fleet Mgmt Compliance 21/22	0	5	**5**	-	4	**4**	1	-	-
OCC FM Follow up 22/23	0	13	**13**	-	7	**7**	6	-	-
OCC Gartan Payroll 21/22	1	34	**35**	1	25	**26**	4	-	5
OCC GDPR 21/22	1	11	**12**	1	7	**8**	-	2	2
OCC GIS IT Application 22/23	0	11	**11**	-	10	**10**	-	1	-
OCC HR Contract Management 22/23	0	1	**1**	-	-	**-**	-	1	-
OCC HR Employee Relations 22/23	0	2	**2**	-	1	**1**	1	-	-
OCC IT Asset Management 20/21	0	1	**1**	-	-	**-**	1	-	-

OCC LAS IT Application 22/23	0	9	**9**	-	7	**7**	2	-	-
OCC Leases 22/23	0	10	**10**	-	6	**6**	3	-	1
OCC Longfields School 22/23	2	31	**33**	2	16	**18**	11	3	1
OCC M365 Cloud 22/23	0	11	**11**	-	8	**8**	1	2	-
OCC Music Service Follow Up 22/23	0	17	**17**	-	15	**15**	1	1	-
OCC OSJ Contract Mgmt 2020/21	3	18	**21**	1	18	**19**	-	-	2
OCC Payments to Providers 21/22	0	6	**6**	-	5	**5**	-	-	1
OCC Pensions Admin 21/22	0	5	**5**	-	4	**4**	1	-	-
OCC Pensions Admin 22/23	0	3	**3**	-	-	**-**	2	1	-
OCC Provision Cycle 2021/22	0	19	**19**	-	17	**17**	2	-	-
OCC Risk Management 20/21	0	14	**14**	-	10	**10**	2	-	2
OCC S106 21/22	0	6	**6**	-	1	**1**	4	-	1
OCC SEND 2020/21	14	27	**41**	14	26	**40**	-	-	1
OCC SEND follow up 22/23	1	5	**6**	-	1	**1**	5	-	-
OCC Shared Lives 22/23	0	8	**8**	-	6	**6**	1	1	-
OCC Street Lighting Contract 22/23	0	4	**4**	-	-	**-**	3	-	1
OCC Thomas Reade School 22/23	4	34	**38**	4	30	**34**	3	-	1
OCC Treasury Mgmt 21/22	0	2	**2**	-	1	**1**	1	-	-
OCC Web Portals 20/21	0	9	**9**	-	8	**8**	1	-	-
OCC Wellbeing and Sickness Mgmt 21/22	0	6	**6**	-	4	**4**	1	-	1
OCC YPSA 22/23	1	18	**19**	1	4	**5**	12	2	-
Purchasing (inc Acc Payable) 2017/18	0	2	**2**	-	1	**1**	1	-	-
Samuelson House 2018/19	0	5	**5**	-	4	**4**	-	-	1
TOTAL	**47**	**514**	**561**	**38**	**356**	**394**	**126**	**27**	**32**