AUDIT AND GOVERNANCE COMMITTEE

8 MAY 2024

ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR

Report by Chief Internal Auditor

RECOMMENDATION

1. **The Audit and Governance Committee is RECOMMENDED to**

   - consider and endorse this annual report.

Executive Summary

2. This is the annual report of the Chief Internal Auditor, summarising the outcome of the Internal Audit work in 2023/24, and providing an opinion on the Council's System of Internal Control. The opinion is one of the sources of assurance for the Annual Governance Statement.

3. The basis for the opinion is set out in paragraphs 22 – 35, followed by the overall opinion for 2023/24 which is that there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

Background

4. The Accounts and Audit Regulations 2015 require the Council to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The Public Sector Internal Audit Standards 2017 (PSIAS), which sets out proper practice for Internal Audit, requires the Chief Internal Auditor (CIA) to provide an annual report to those charged with governance, which should include an opinion on the overall adequacies and effectiveness of the internal control environment, comprising risk management, control and governance.

5. Oxfordshire County Council's Internal Audit service fully conforms to the PSIAS 2017.

6. The Accounts and Audit Regulations 2015 require the Annual Governance Statement (AGS) to be published at the same time as the Statement of Accounts is submitted for audit and public inspection. In order for the Annual Governance Statement to be informed by the CIA's annual report on the system of internal control, this CIA annual report has been produced for the May Audit and Governance Committee meeting. This is the full and final CIA annual report.

Responsibilities

7. It is a management responsibility to develop and maintain the internal control framework and to ensure compliance. It is the responsibility of Internal Audit to form an independent opinion on the adequacy of the system of internal control.

8. The role of Internal Audit is to provide management with an objective assessment of whether systems and controls are working properly (financial and non-financial). It is a key part of the Authority's internal control system because it measures and evaluates the adequacy and effectiveness of other controls so that:

    - The Council can establish the extent to which they can rely on the whole system; and,
    - Individual managers can establish how reliable the systems and controls for which they are responsible are.

Internal Control Environment

9. The PSIAS require that the internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement.

10. The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organisation's governance, operations and information systems regarding the:

    - Achievement of the organisation's strategic objectives;
    - Reliability and integrity of financial and operational information;
    - Effectiveness and efficiency of operations and programmes;
    - Safeguarding of assets; and
    - Compliance with laws, regulations, policies, procedures and contracts.

11. In order to form an opinion on the overall adequacy and effectiveness of the control environment, the internal audit activity is planned to provide coverage of financial controls through review of the key financial systems, and internal controls through a range of operational activity both within Directorates and cross cutting, including a review of risk management and governance arrangements. The Chief Internal Auditor's annual statement on the System of Internal Control is considered by the Corporate Governance Assurance Group when preparing the Council's Annual Governance Statement.

The Audit Methodology

12. The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAS). The annual self-assessment against the standards is completed by the Chief Internal Auditor. It is a requirement of the PSIAS for an external assessment of internal audit to be completed at least

every five years. The external assessment was undertaken by CIPFA (Chartered Institute of Public Finance & Accountancy) in November 2023, the results were reported to the January 2024 Audit & Governance Committee meeting. The results of the assessment were very positive, with an overall conclusion that Oxfordshire County Council's Internal Audit Service FULLY CONFORMS to the requirements of the standards. There were no areas of either partial or non-conformance with the standards identified and no recommendations arising.

13. The Monitoring Officer conducted a survey of Senior Management on the effectiveness of Internal Audit in September 2023. The results from this survey were presented to the November 2023 Audit & Governance Committee meeting. The conclusion from the survey was that there was a strong level of satisfaction with the nature and effectiveness of the internal audit service.

14. The Internal Audit Strategy and Annual Plan for 2023/24 was presented to the May 2023 Audit and Governance Committee. The Committee then received quarterly progress reports from the Chief Internal Auditor, including summaries of the audit findings and conclusions.

15. The Internal Audit Plan, which is subject to continuous review, identified the individual audit assignments. The activity was undertaken using a systematic risk-based approach. Terms of reference were prepared that outlined the objectives and scope for each audit. The work was planned and performed so as to obtain all the information and explanations considered necessary to provide sufficient evidence in forming an overall opinion on the adequacy and effectiveness of the internal control framework.

16. Internal Audit reports provide an overall conclusion on the system of internal control using one of the following ratings:

GREEN	There is a strong system of internal control in place and risks are being effectively managed.
AMBER	There is generally a good system of internal control in place and the majority of risks are being effectively managed. However, some action is required to improve controls.
RED	The system of internal control is weak and risks are not being effectively managed. The system is open to the risk of significant error or abuse. Significant action is required to improve controls.

17. In Appendix 1 to this report there is a list of all completed audits for the year showing the overall conclusion at the time audit report was issued, and the current status of management actions against each audit, (based on information provided by the responsible officers).

18. To provide quality assurance over the audit output, audit assignments are allocated to staff according to their skills and experience. Each auditor has designated either the Audit Manager or Chief Internal Auditor to perform quality reviews at four stages of the audit assignment: the terms of reference, file review, draft report and final report stages.

The Audit Team

19. During 2023/24 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit. From April 2020 under a joint working arrangement the team also provided the Internal Audit Service to Cherwell District Council, this has continued since the partnership de-coupling and the service is provided to Cherwell District Council under a service level agreement. This arrangement will cease from April 2024, due to the current resourcing difficulties experienced by the internal audit team.

20. Throughout the year the Audit and Governance Committee and the Audit Working Group were kept informed of staffing issues, challenges with recruitment of senior internal auditors and the impact on the delivery of the Plan.

21. It is a requirement to notify the Audit and Governance Committee of any conflicts of interest that may exist in discharging the internal audit activity. There are none to report for 2023/24.

Opinion on System of Internal Control
Basis of the Audit Opinion

22. The 2023/24 revised plan has been completed.

23. The plan is intended to be dynamic and flexible to change. 26 audits were undertaken in the year (30 in 2022/23, 26 in 2021/22). Since the last report of amendments to the plan at the January 2024 Audit and Governance Committee meeting, there has been no further amendments.

24. The completed internal audit activity and the monitoring of audit actions through the action tracker system enable the Chief Internal Auditor to provide an objective assessment of whether systems and controls are working properly. In addition to the completed internal audit work, the Chief Internal Auditor also uses evidence from other audit activity, including counter-fraud activity, and attendance on working groups e.g., Corporate Governance Assurance Group.

25. In giving an audit opinion, it should be noted that assurance can never be absolute; however, the scope of the audit activity undertaken by the Internal Audit Service is sufficient for reasonable assurance to be placed on our work.

26. A summary of the work undertaken during the year, forming the basis of the audit opinion on the control environment, is shown in Appendix 1.

27. Of the 26 audits undertaken for 2023/24, three were graded as RED. In 2022/23 one audit was graded red, in 2021/22 one audit was graded red, 2020/21 one audit was graded red, in 2019/20, two audits were graded as red. (See also paragraph 36 for trend analysis on individual audit overall conclusions)

28. The overall opinion for each audit, highlighted in Appendix 1, is the opinion at the time the report was issued. The internal audit reports contain management action plans where areas for improvement have been identified, which the Internal Audit Team monitors the implementation of by obtaining positive

assurance on the status of the actions from the officers responsible. The current status of those actions is also highlighted, in Appendix 1, for each audit. Reports on outstanding actions have been routinely reported to Directorate Leadership Teams, Council Management Team and the Audit Working Group. The Chief Internal Auditor's opinion set out below considers the implementation of management actions.

29. As part of governance arrangements developed when Oxfordshire County Council joined the Hampshire Partnership in July 2015, it was agreed that the Southern Internal Audit Partnership (SIAP) would provide annual assurance to Oxfordshire County Council on the adequacy and effectiveness of the framework of governance, risk management and control from the work carried out by the partnership, via the Integrated Business Centre (IBC). Due to the onboarding of three additional partners, since 2019/20 the assurance arrangements were amended. The Hampshire Partnership/IBC commissioned Ernest and Young (EY) to undertake a Service Organisation Controls review under International Standard on Assurance Engagements (ISAE 3402). This provides a framework for reporting on the design and compliance with control objectives related to financial reporting. In addition to this Partners can separately take a view on any additional risk-based pieces of assurance work that could be commissioned from SIAP covering any core elements of the control environment.

30. The ISAE 3402 report covering both the design and operating effectiveness of the internal control environment for 2023/24 has not yet been made available to the Executive Director of Resources and the Chief Internal Auditor. The Hampshire Partnership are waiting for EY to complete and report on their work. This report will provide assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. It has been confirmed, at draft stage, that there are no substantial risks in relation to the control objectives within these areas. Once the report is received the Audit & Governance Committee will be updated.

31. The anti-fraud and corruption strategy remains current and relevant. In 2023/24 the Audit and Governance Committee and Audit Working Group have been updated on reported instances of potential fraud. Most of these are minor in nature. Work has been undertaken to address the control weaknesses identified in each area identified to reduce the possibility or reoccurrence.

32. Internal Audit continue to manage the National Fraud Initiative data matching exercise which is completed once every two years. Key matches are investigated, and results are reported to the Audit & Governance Committee in the quarterly updates.

33. It should be noted that it is the responsibility of management to operate the system of internal control, not Internal Audit's responsibility. Furthermore, it is management's responsibility to determine whether to accept and implement recommendations made by Internal Audit or, alternatively, to recognise and accept risks resulting from not taking action. If the latter option is taken by management, the Chief Internal Auditor would bring this to the attention of the Audit and Governance Committee.

34. 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.

35. In arriving at our opinion, we have taken into account:

- The results of all audits undertaken as part of the 2023/24 audit plan;
- The results of follow up action taken in respect of previous audits;
- Whether or not any priority 1 actions have not been accepted by management - of which there have been none;

  (Priority 1 = Major issue or exposure to a significant risk that requires immediate action or the attention of Senior Management. Priority 2 = Significant issue that requires prompt action and improvement by the local manager)

- The effects of any material changes in the Council's objectives or activities.
- Whether or not any limitations have been placed on the scope of Internal Audit – of which there have been none.
- Assurance provided by ISAE 3402 report, covering both the design and operating effectiveness of the Hampshire Partnership/IBC internal control environment.
- Corporate Lead Assurance Statements on the key control processes, that are co-ordinated by the Corporate Governance Assurance Group (of which the Chief Internal Auditor is a member of the group), in preparation of the Annual Governance Statement.

Chief Internal Auditors Annual Opinion

In my opinion, for the 12 months ended 31 March 2024, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

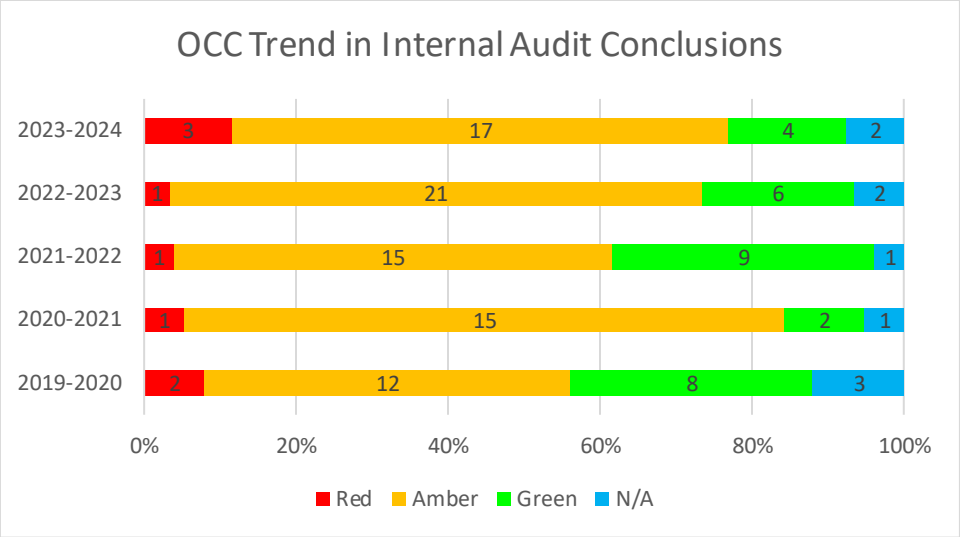
Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective action and timescale for improvement.

This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

Oxfordshire County Council's Internal Audit service conforms to the Public Sector Internal Audit Standards (2017)

See appendix 2 for definitions of overall assurance opinion.

36. The following table shows the percentage trend in individual audit conclusions.



Audits completed since last report to Audit and Governance Committee

37. The outcomes of the audits, including a summary of the key findings are reported quarterly to the Audit and Governance Committee. The summaries of the audits completed since the last report (January 2024) are attached as Appendix 3.

- S106 IT System 23/24
- IT Incident Management 23/24
- Adults Payments to Providers 23/24
- Property Health and Safety 23/24
- Pensions Administration 23/24
- Proactive Review of Purchasing Cards 23/24
- Local Transport and Connectivity Plan 23/24
- Feeder System Controls 23/24
- Innovation Hub Governance and Project Management Review 23/24
- Adults Income and Debt Recovery 23/24
- Legal Case Management 23/24
- Childrens Change Programme 23/24
- Primary School Audit 1 23/24
- Risk Management - Directorate/Service Level 23/24
- Health Funded Payments 23/24
- Proactive Review of Expenses 23/24
- Adults Safeguarding 23/24
- Supported Transport 23/24

38. Since the last report to the January 2024 Audit & Governance Committee the following grant certifications have been completed:

- 5G Innovation Regions Programme.

Internal Audit Performance

39. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2023/24 performance.

40. Despite the staffing issues, including managing two vacancies throughout 2023/24 and the Principal Auditor being on maternity leave during quarter 4, performance has not declined in achieving the target date for the exit meeting for each audit assignment. This continues to be an area of focus for improvement. Performance for the issue of draft and final reports is good.

41. We are pleased to report the continued improvement with the implementation of management actions by the organisation, with the majority implemented or not yet due (86%)

42. Our customer satisfaction questionnaires continue to provide positive feedback.

Measure	Target	Actual Performance 2023/24 – as at 11/04/2023
Elapsed time between start of the audit (opening meeting) and the Exit Meeting	Target date agreed for each assignment by the Audit Manager, no more than three times the total audit assignment days	67% of the audits met this target. 2022/23 67% 2021/22 59% 2020/21 50%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	96% of the audits met this target. 2022/23 93% 2021/22 86% 2020/21 85%
Elapsed time between receipt of management response to the draft report and the issue of the final report	15 Days	100% of the audits met this target. (Previously measured issue of draft report to the issue of the final report) 2022/23 100% 2021/22 66% 2020/21 80%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2023.	100% of the plan was completed by the end of April 2023 (including grant certification work). 2022/23 83% 2021/22 87% 2020/21 74%
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at April 2024: 518 actions being monitored on the system. • 68.7% implemented • 18% not yet due • 7.5% partially implemented • 5.8% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2 1 - Good 2 – Satisfactory 3 – Unsatisfactory in some areas 4 – Poor	Average score was 1 2022/23 1.2 2021/22 1.1 2020/21 1.06
Directors satisfaction with internal audit work	Satisfactory or above	Review of effectiveness of internal audit completed by Monitoring Officer in September 2023 and reported to the Audit & Governance Committee in November 2023 – Satisfactory

Financial Implications

43. There are no direct financial implications arising from this report.
Comments checked by: Lorna Baxter, Executive Director of Resources
lorna.baxter@oxfordshire.gov.uk

Legal Implications

44. There are no direct legal implications arising from this report.
Comments checked by: Paul Grant, Head of Legal
paul.grant@oxfordshire.gov.uk

Staff Implications

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

Equality & Inclusion Implications

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

Sustainability Implications

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

Risk Management

48. There are no direct risk management implications arising from this report.

Sarah Cox, Chief Internal Auditor, May 2024.

Annex:	Annex 1: Overall conclusion and management action implementation status of 2023/24 audits Annex 2: Annual assurance opinion definitions Annex 3: Executive Summaries of Audits finalised since last report to Audit and Governance Committee.
Background papers:	None.
Contact Officer:	Sarah Cox, Chief Internal Auditor Sarah.cox@oxfordshire.gov.uk

APPENDIX 1 - Overall conclusion and management action implementation status of 2023/24 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 15/04/2024
Cross Cutting				
Transformation - Programmes & major projects.	Deferred to 24/25 plan	-	-	-
Business Continuity	Final Report	Amber	19	9 implemented, 2 being implemented, 8 overdue.
Strategic Contract Management	Deferred to 24/25 plan	-	-	-
Risk Management – directorate / service level	Final Report	Amber	9	1 implemented, 8 not due for implementation.
Joint Internal Audit & Counter Fraud proactive review – Procurement Cards	Final Report	Amber	21	1 implemented, 20 not due for implementation.
Joint Internal Audit & Counter Fraud proactive review - Expenses	Final Report	Amber	14	14 not due for implementation
Childrens				
Placements – Contract Management / Quality Assurance	Final Report	Amber	17	10 implemented, 4 superseded, 3 not due for implementation.
Transformation Programme – including Financial Management	Final Management Letter – position statement	n/a	-	-
Supported Families	Continuous programme of claim verification throughout year – 4 completed	n/a	-	-
Independent Reviewing Officers	Deferred to 24/25 plan	-	-	-
Primary school 1 – Audit	Final Report	Amber	24	3 implemented, 21 not due for implementation.

Adults				
Payments to Providers	Final Report	Amber	9	4 implemented, 3 not due for implementation, 1 being implemented, 1 overdue.
Health Funded Payments	Final Report	Amber	8	8 not due for implementation
Safeguarding	Final Report	Amber	5	5 not due for implementation.
Income and Debt Recovery	Final Report	Amber	7	1 implemented, 6 not due for implementation
Customer Services				
Corporate & Statutory Complaints	Final Report	Amber	13	6 implemented, 1 superseded, 6 not due for implementation
Property				
Property Health & Safety	Final Report	Amber	30	12 implemented, 11 not due for implementation, 3 implemented, 4 overdue.
Property Strategy Implementation	Deferred to 24/25 plan	-	-	-
Physical Security Systems	Final Report	Red	14	12 implemented, 1 not due for implementation, 1 overdue
Finance				
Pensions Administration	Final Report	Green	3	3 not due for implementation
Pensions Administration – IT Application Audit	Final Report	Amber	6	4 implemented, 1 superseded, 1 being implemented.
Feeder System Controls	Final Report	Green	4	4 not due for implementation

IT				
IT Incident Management	Final Report	Amber	7	5 implemented, 2 overdue
Cyber – Incident Preparedness and Response	Final Report	Green	2	1 not due for implementation, 1 being implemented.
I-Hub Governance and Project Management	Final Report	Amber	9	8 not due for implementation, 1 being implemented.
Legal				
Case Management	Final Report	Red	11	11 not due for implementation.
Public Health				
Pandemic Preparedness	Covered under audit of Business Continuity	-	-	-
Environment & Place				
Supported Transport	Final Report	Red	15	1 implemented, 14 not due for implementation.
Parking Contract – Contract Management	Final Report	Green	0	-
Local Transport Connectivity Plan	Final Report	Amber	9	8 not due for implementation, 1 being implemented.
S106 – New IT System	Final Report	Amber	6	1 implemented, 5 not due for implementation

Grant Certification work completed during 2023/24:

- Business in Rural Oxfordshire Airband
- Business in Rural Oxfordshire BT
- Better Broadband for Oxfordshire
- Top-up Vouchers
- Gigahubs
- Local Authority Bus Subsidy (Revenue) Grant
- Disabled Facilities Grant
- Local Transport Capital Block Funding (Integrated Transport and Highway Maintenance Blocks)
- Local Transport Capital Block Funding (Pothole Fund)
- Homes Upgrade Grant, Phase 1
- 5G Innovation Regions Programme

APPENDIX 2

Overall annual opinion – definitions based upon framework recommended by Institute of Internal Auditors.

Substantial

There is a sound framework of control operating effectively to mitigate key risks, which is contributing to the achievement of business objectives.

- no individual audit engagement graded as "red" or significant "amber".
- occasional medium risk rated weaknesses identified in individual audit engagements although mainly only low/efficiency weaknesses.
- internal audit has confidence in managements attitude to resolving identified issues.

Satisfactory

The control framework is adequate and controls to mitigate key risks are generally operating effectively, although a number of controls need to improve to ensure business objectives are met.

- medium risk rated weaknesses identified in individual audit engagements.
- isolated high risk rated weaknesses identified for isolated issues.
- no critical risk rated weaknesses were identified.
- internal audit is broadly satisfied with management's approach to resolving identified issues.

Limited

The control framework is not operating effectively to mitigate key risks. A number of key controls are absent or are not being applied to meet business objectives.

- significant number of medium and/or critical risk rated weaknesses identified in individual audit engagements.
- isolated critical and/or high risk rated weaknesses identified that are not systemic.
- internal audit has concerns about managements approach to resolving identified issues.

No Assurance

A control framework is not in place to mitigate key risks. The organisation is exposed to abuse, significant error or loss and/or misappropriation. Objectives are unlikely to be met.

- serious systemic control weaknesses identified through aggregation of individual audit engagements.
- significant number of critical and/or high risk rated weaknesses identified for isolated issues.
- internal audit has serious concerns about managements approach to resolving identified issues.

APPENDIX 3

Summary of Completed 2023/24 Audits since last reported to the Audit and Governance Committee - January 2024.

S106 IT System 23/24

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

Opinion: Amber	
Total: 6	Priority 1 = 0 Priority 2 = 6
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	5

Following the implementation of the new IT system, DEF, to record information across planning operations, this audit was included in the 2023/24 Internal Audit plan to provide assurance over the effectiveness of the system, specifically in the management, oversight, and reporting of S106 contributions.

During the course of this audit, a large piece of work has been underway by the service reviewing all S106 contributions secured, held, and allocated, in order to identify opportunities to release monies to address in-year pressures where it is appropriate and legitimate to do so. More detailed work on governance and spend plans for service areas is scheduled for late 2023/24, including an end-to-end process review. This will cover current S106 workflows, operability of processes, visibility of data and mechanisms for sharing information, which will address a number of previously identified weaknesses, and further weaknesses noted within the report.

While it is acknowledged the new system has led to improved oversight and reporting capabilities, and a review of S106 is currently being carried out within the service, it is noted a number of actions from the previous audit remain outstanding and overdue, with progress tied into the ongoing review work. The 2020/21 Internal Audit of S106 Spend contained six management actions, five of which are yet to be implemented. These cover project closedowns and how the Planning Obligations Team are promptly informed where funds have been spent (thereby enabling accurate reporting of funding held and available for allocation to projects); how funds held by District Councils on behalf of the County Council are secured and transferred in a consistent and timely manner; how longstop dates are recorded and monitored to ensure held monies are appropriately prioritised to maximise utilisation of S106 funding and how and what performance monitoring should be undertaken in relation to S106 expenditure.

In terms of the accuracy and integrity of data held within the system, sample testing identified delays in the recording of received payments, a process that is still manual as there is currently no interface between DEF and SAP. Examples were also noted

in which information was omitted when new agreements were added to the system, as well as an inconsistent approach in how longstop dates are recorded.

In terms of reporting from the system, the audit noted the development of a series of dashboards, run through PowerBI (using data from DEF). It was reported these are mainly used for locality reporting, and as such, are focused on the project side, showing each created project and agreements / funding related to that project.

Reporting in other areas is still under development, including the monitoring of longstops. While projects and associated longstops are now included within the PowerBI reports, further work is ongoing to enable alerts within the system. The end-to-end review of S106 processes will then consider how to ensure prioritisation of spend in relation to longstop dates. Another area of reporting in progress is around unallocated funding. For all agreements entered into, corresponding projects should be created / linked within DEF to record what the secured funding will be spent on, improving oversight of allocations. The creation of this report will allow identification of any secured funding that has not been allocated to a project.

Further areas for development in terms of reporting noted as part of the audit include how supplemental or conditional contributions are recorded on the system. Some agreements reviewed contained requirements for additional contributions dependent on a particular event happening and were therefore found to not fall into regular reporting on secured contributions. The management and spending of late payment interest also needs to be determined. This is an area that has been subject to recent discussion across the Council, with approximately £800k held but no clear governance process as to how this should be monitored or spent.

IT Incident Management 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
Service Desk Function	A	0	1
Incident Logging & Tracking	A	0	1
Incident Management & Escalation	A	0	3
Management Reporting	A	0	1
Access Rights	A	0	1
		0	7

Opinion: Amber	
Total: 7	Priority 1 = 0 Priority 2 = 7
Current Status:	
Implemented	5
Due not yet actioned	2
Partially complete	0
Not yet Due	0

All day-to-day IT incidents are reported to IT, Innovation and Digital (ITID) where they are logged and triaged by the customer support team. Incidents that cannot be resolved by the team are escalated to other support teams within the service for resolution. A review of the systems of control for logging and managing incidents has identified a number of improvement opportunities. The two key ones are ensuring all incidents are prioritised in accordance with defined standards and, secondly, introducing more formal monitoring of all open tickets to ensure they are resolved within agreed service levels.

Service Desk Function:

There is a formal and structured service desk function within ITID and details of how it can be contacted are available on the Intranet. Following some staffing changes, there are plans to review the resources required by the service desk team in the new year. IT incident management processes are documented but we found they have not been subject to any recent review and are thus out-of-date.

Incident Logging & Tracking:

All IT incidents are logged on a dedicated service desk system. A review of the incident logging process confirmed that all relevant details are captured, including customer contact details, a brief description and category of incident. As customers enter details of their incident, relevant self-help articles are made available. Incidents should be prioritised as urgent, high, medium or low but we found that this is not done and all incidents are left at the default low priority. This can lead to priority incidents not being clearly identified and resourced over other incidents. Service levels are defined against the different priority levels but are not meaningful as the incidents are not correctly prioritised.

Incident Management & Escalation:

Incidents that cannot be fixed at first contact by the service desk are escalated to one of the support teams for review and resolution. Each support team has their own queue on the service desk system and are responsible for managing tickets that are escalated to them. Each support queue should have a nominated owner but details of these and their responsibilities are not formally documented. There are a significant number of old incidents on the service desk that are still open and have not been recently updated. The management and monitoring of these incidents should be improved to ensure they are closed on a timely basis.

All incidents with a common underlying root cause are logged against a single master ticket for problem management and are reviewed at a weekly problem management meeting. There is a knowledge base on the service desk system and all resolved incidents are confirmed with customers before they are closed.

Management Reporting:

A weekly highlight report is produced showing the number of tickets opened and closed in the past week and includes details on open tickets. This is shared with the Director of Digital and IT and the Head of IT. A similar report but with a trend analysis over a four month period has recently been developed for the Director of Digital and IT. Whilst these reports are useful for seeing activity levels, other indicators would prove more insightful for reviewing the performance of the service desk.

Customers have an opportunity to complete a survey when their tickets are resolved and any with negative feedback are followed up.

Access Rights:

Access within the service desk system is provided through roles. We have identified exceptions with two roles; one is the admin role that is granted to a user who does not require this level of access and the other is a supervisor role which is granted to users outside the customer support team and gives them the ability to delete tickets. Access to both roles should be reviewed.

Adults Payments to Providers 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
Governance	**A**	**0**	**1**
Payment Accuracy and Timeliness	**A**	**2**	**6**
Budget Monitoring	**G**	**0**	**0**
		2	**7**

Opinion: Amber	
Total: 9	Priority 1 = 2 Priority 2 = 7
Current Status:	
Implemented	4
Due not yet actioned	1
Partially complete	1
Not yet Due	3

Payments to providers of Adult Social Care totalled £333M during 2022/23, and for 2023-24 approximately £305.4M has been paid up to and including January 2024. This is an average of £30.5M per month, of which approximately £23M is residential and approximately £3M is home support.

The approach to the delivery of home support, reablement and extra care changed in October 2021 with the introduction of the Live Well At Home model. This model includes the development of supply of both home support and reablement with key delivery partners through the agreement of Guaranteed Minimum Volumes (GMVs) which effectively work as a block contract arrangement where these key partners are paid to provide care but are also supported, through the GMVs to build the market to ensure that going forward they are able to meet the demand for this type of care from the Council. As part of the new arrangements, recording and monitoring of home support provision has moved away from using the ETMS (Electronic Time Management System), with providers either being paid through GMV payments or on the basis of data uploaded via a Provider Portal.

The audit noted that a review was completed of implementation of the model for the first year's activity which resulted in reductions in the agreed GMV's for both reablement and home support.

Internal Audit analysis of accuracy and timeliness of payments found payment processes to be working well with a significant volume of transactions being processed in relation to both residential and non-residential care. However, areas of weakness were identified in relation to the accuracy of provider portal uploads made by providers and in relation to the oversight of Guaranteed Minimum Volumes for reablement as detailed below.

Governance

Roles and responsibilities within the Payments Systems Data team are reflected in job descriptions which include assurance and control processes and segregation of duties. Documented policies and procedures for the Payments Systems Data team are comprehensive and appear to be up to date. There is also detailed guidance available to providers on using the provider portal.

Management information regarding the timeliness, accuracy and completeness of payments is captured, monitored and reported on regularly, this includes reporting on overpayments, closing CPLI's (Care Package Line Item) and issues with the provider portal. Review of meeting notes at various levels showed that there is meaningful discussion of performance information, and that the information is used to drive improvements in performance and in quality of data.

Arrangements for the Quality Improvement Team to monitor Home Support provider performance to identify consistent under or over delivery are not yet in place. A process has been designed but has not yet been implemented. There was a management action to address this in the previous audit report which has not been fully implemented.

Payments

It is positive to note that testing on potentially incompatible CPLI's carried out by Internal Audit reviewing 11,000 CPLI's from the first 6 months of the 2023/24 financial year (covering both residential and non-residential payments), identified a very small proportion of incompatible CPLIs (0.2%) and only two of these have resulted in the identification of an overpayment (one of approximately £10,000 and the other approximately £500).

There is no periodic checking to identify instances where there is multiple but incompatible CPLI's in relation to individual clients, which has been highlighted during previous audits. There would be value in repeating the analysis undertaken by Internal Audit on a periodic basis to provide ongoing assurance regarding the appropriateness and accuracy of payments.

Residential Care Payments

Sample testing on the set up and approval of care packages for residential care identified two packages which had not been approved in accordance with the Scheme of Financial Delegation specified on LAS (one had been approved by a Team Manager when it should have been approved by a Service Manager and the other had been approved by a Service Manager when it should have been approved by a Deputy Director). Controls in place to challenge non-compliance with delegated approval levels could not be evidenced to have been operating effectively.

A small sample of scheduled payments were tested and were found to be being paid accurately and on time. The process for recovering overpayments made on residential care packages was reviewed and found to be operating satisfactorily.

Non-Residential Care Payments (Home Support)

Sample testing on the set up and approval of care packages for non-residential care was satisfactory.

Some home support payments are paid via invoice, walkthrough testing confirmed that there are satisfactory controls in place to prevent duplicate invoices being processed and that there is a process for checking validity of invoices within defined tolerances. It was also noted that the payments team regularly meet the target of paying 95% of invoices within 30 days.

Audit testing found that whilst there was a significant volume of unmatched visits (for example 463 for August 2023) being identified and resolved each month by the Payments Systems Data Team, the process for review and resolution of these was found to be robust. There are continuing efforts by the team to liaise with providers to address any ongoing accuracy issues identified. They have also reported that refresher training is provided where appropriate and where there are ongoing problems, there is a process in place to involve the QI (Quality Improvement) team and work collectively to ensure performance improves.

It was noted that, until October 2023, there was no checking or validation of the duration of home support visits paid on the basis of visit times uploaded by Providers via the Provider Portal. The Payments Systems Data Team reviewed portal data in October 2023 and confirmed to Internal Audit that they had identified a number of significant errors. Internal Audit completed analysis on portal data prior to October 2023 focussing on data submitted between April and September 2023 for 12 providers (out of 146). Our analysis identified 1 significant overpayment made as a result of visit start and end times being transposed incorrectly (resulting in 23.5 hour visits being submitted for payment which should have been 0.5 hour visits) and 5 of 12 providers entering visit data for visits after the care package had ended which included one provider who had submitted 29 visits after the client had gone into residential care. Other issues which question the credibility of the data submitted via the portal were

also noted, including submission of identical planned and delivered times for care and providers reporting no cancelled or undeliverable visits (typically providers report numerous changes in planned activities due to cancelled or undeliverable visits). The exceptions identified by Internal Audit are being investigated and corrected by the Payment Systems Data team, however at present there is no clear and systematic process for ongoing validation of data received via the Provider Portal or over how this process can be resourced.

Reablement Payments

Reablement is short-term specialist support to help a patient at home regain independence. The majority of reablements are paid on the basis of Guaranteed Minimum Volumes (GMVs) whereby we commit to paying a group of nine specialist providers for a minimum number of episodes in a fixed period. The GMVs are in place to try help key providers develop their provision so that they are able to maintain enough capacity to meet demand. If these providers deliver more episodes than the GMV, they get paid accordingly for each additional episode.

There are no robust controls in place to monitor the volume of reablement episodes being delivered under the "Guaranteed Minimum Volume" (GMV) agreed with the 9 strategic partners. The processes and responsibilities for commissioning, deploying, and paying for the reablements are carried out in isolation from each other and none of those processes currently includes a robust reconciliation or review of reablement activity versus payments.

Internal Audit testing looked at activity over a six-month period for 6 of the 9 strategic partners, we identified that 3/6 providers are delivering significantly fewer reablement episodes than they are being paid for. This has been discussed with senior management within Commissioning for further investigation. Whilst it is acknowledged that GMV payments are not intended to be matched to a specific number of reablement episodes provided, as the expectation is that the GMV allows the provider to build the market to be able to meet future demand, it is still important that there is some assurance over the appropriateness of GMV levels and the value for money the arrangement provides for the Council.

Budget Monitoring

The audit reviewed budget forecasting and monitoring arrangements and noted that these were working effectively. It is noted that the activity is demand led and statutory. The forecasting process comprises commitments from current placements and extrapolating them to the end of the financial year, this data is refined by both management accountants and commissioning working together to ensure that forecasts are as accurate as possible.

Property Health and Safety 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
Governance, Roles & Responsibilities	**A**	**1**	**6**
Property Health and Safety Compliance	**R**	**0**	**19**
Management Information	**A**	**1**	**3**
		2	**28**

Opinion: Amber	
Total: 30	Priority 1 = 2 Priority 2 = 28
Current Status:	
Implemented	12
Due not yet actioned	3
Partially complete	4
Not yet Due	11

The safety of Council owned buildings and those used by Council staff to deliver services to the public is the responsibility of a number of different Council teams. Health & Safety assurance on statutory compliance is overseen by the Corporate Health & Safety Team, the Health, Safey & Compliance Team within Property and Facilities Management (FM), the Schools Health & Safety Team and the Fire & Rescue Health & Safety Team. There are also various other teams including Hard FM, Estates and the FM Helpdesk who play a key role in the management of the Council's estate.

Over the last 18 months, there have been a number of changes to staffing, team structures and processes across areas of Property and FM which impact on the way in which building safety is managed, including within the Health, Safety & Compliance Team responsible for providing assurance, and Hard FM and the Helpdesk responsible for coordination and management of statutory compliance checking processes and associated works. In addition to staffing changes, processes across these teams have been reviewed and updated and a new IT system (Concerto) for the tracking and management of checks and works was also introduced in February 2023.

These changes are enabling improvements to processes; however the audit has identified a number of examples where property assurance is not joined up and where there is the potential for duplication and gaps in coverage. The examples identified are expanded on below.

Governance, Roles & Responsibilities

It is positive to note that dedicated resource has been brought in to focus on being able to provide assurance across the Council in relation to statutory compliance and building safety. However, there are examples where the different health & safety assurance functions and the teams involved in ensuring the safety of Council buildings are not working in a coordinated and joined up way. Examples of this include the duplication of activity between the Corporate Health & Safety team and the Health, Safety & Compliance Team and a number of examples where information isn't being effectively and systematically shared (between the different health & safety assurance functions, between Estates and Hard FM and within Hard FM), increasing the likelihood of inefficiencies and silo working, duplication of effort and / or gaps in either assurance or service delivery.

The need to work more collaboratively between the health and safety assurance functions, specifically the Corporate Health & Safety function and the Health, Safety & Compliance function within Property is acknowledged by both teams. Away days have taken place to progress this, however the outputs from these away days have yet to achieve any significant progress. Both teams still complete site visits which duplicate coverage in some areas, information is not being shared effectively and systematically and assurance reporting is very separate.

It is noted that there is a lack of clarity / understanding of the role of the Health, Safety & Compliance Team in providing assurance on building safety and statutory compliance and where this fits with the corporate health & safety function. This distinction is not currently covered within the Health and Safety Part 2 policy. Differences of opinion were also noted in relation to the role that the Health, Safety & Compliance Team should have in providing assurance over properties that the Council use under a contractual arrangement or lease.

There is also a lack of documented team guidance for Health, Safety & Compliance Team specific activities, for example carrying out audit visits and inspections, follow up and escalation processes and performance reporting.

Property Health & Safety Compliance

Over the last year, the responsibilities of Responsible Premises Managers (RPMs) and the way in which they complete and document their checks in relation to building safety have been reviewed and improved. An RPM SharePoint site and virtual logbook have been developed and implemented which will enable real time information and assurance to be available for this activity. Work is ongoing to ensure that all RPMs are aware of what they are required to do and how to use the online system and in being able to ensure any gaps in reporting can be promptly identified and addressed.

For leased properties, work has been undertaken between Hard FM and the Estates team to identify and document the statutory compliance responsibilities and required activities on the new IT system (Concerto). Whilst this is a positive development, audit testing noted that improvements could be made to the way in which information on the statutory compliance requirements and responsibilities is shared. Improved recording on the IT system (Concerto) which would ensure that Hard FM are able to access the required information from the system without having to liaise with a member of the

Estates team would be more efficient and make better use of resources across both teams.
It was also noted that for properties including leased properties that the Council has use of but doesn't own, there is a lack of a clear and systematic process for ensuring that we get positive assurance from landlords where we are not the party responsible for statutory compliance checks, that buildings used by our staff and customers are safe. There is evidence of both the corporate health & safety function and the Health, Safety and Compliance team undertaking reactive reviews and following up where concerns are raised, however this is not always clearly communicated between the teams and there is a lack of clarity over where responsibility for this type of activity should sit. It is understood that there have been some preliminary discussions around this recently with the Director of Property Services who is keen to ensure that there is appropriate and clear oversight.

Assurance activity over statutory compliance and building safety for properties the Council has responsibility for is now concentrated within the Heath, Safety & Compliance Team, however it was noted that there is some overlap and duplication between site visits completed by this team and those completed by the Corporate Health & Safety team. Both teams use the same system (Safety Culture) for recording the outcomes from their visits, however it is not used in the same way. Although there have been discussions about the need to work more collaboratively there is a lack of agreement in how this can be achieved. There is therefore currently a risk of duplication of effort, gaps in coverage and inefficient use of available staff resources.

The majority of the assurance activity undertaken by the Health, Safety and Compliance team during the current financial year has been focussed on the review and completion of Fire Risk Assessments (FRA). It is noted that a decision was taken to remove existing information from the system (Concerto) used to monitor required checks and completed works, which means that only the Health, Safety & Compliance team have access to historic fire risk assessment information and that currently, this part of statutory compliance information is not available with the rest of the site information or to other teams involved in coordination and management of checks and works. Regular meetings are held between Heath, Safety & Compliance and a member of the Helpdesk where any works required in relation to FRA are arranged on the system (Concerto). However, there is no link between the two teams records to be able to provide oversight and assurance that works required have been completed.

Whilst Hard FM have their own processes for the monitoring and follow up on delayed / overdue works, the Health, Safety & Compliance team do not have any involvement in or visibility of this. Whilst no evidence has been identified to suggest that works required are not being arranged and carried out, there is a lack of joined up assurance in relation to this due to the way in which information on FRA is currently being maintained. It is understood that it is now planned that FRA information will be added back on to the main system (Concerto).

Also in relation to fire risk, there is an ongoing project to complete Fire Line Compartmentation Surveys across approximately 90 council properties. These detailed surveys, carried out by an external contractor commissioned by the Head of FM, and completion of any required associated works, should result in a comprehensive and up to date FRA for each site reviewed. However, it is noted that

there have been delays in obtaining information from the contractor in relation to works completed and an example was noted by Internal Audit where a survey appears to have been completed on a site where we do not have responsibility for the FRA. This project was being managed by an external resource, but this has recently been passed over to the Operations Manager Health, Safety & Compliance. Work is ongoing to review progress across the project to date, to obtain and assess the information and reporting on all the works completed so far and manage the completion of the remaining aspects of this work to enable the survey process to be concluded and updated FRA to be put in place. It was also agreed that the review of progress and activity on the project should include review of the properties being surveyed to ensure that there are no further examples where the Council is funding surveys where we do not have statutory responsibility for the FRA.

Whilst sample testing on statutory compliance checks managed and overseen by Hard FM noted that the majority of checks expected for the sample of properties reviewed had been completed, there were examples where checks are overdue or were delayed as well as where required checks and information on checks were missing from the system. This included examples in relation to remedial works linked to statutory compliance checks. Despite this, it is apparent that there is close monitoring and management of open works including statutory compliance checks and remedials by the Operational Manager Hard FM, his team and the Helpdesk with weekly meetings being held to review and follow up on late and delayed checks and works and to discuss, identify and progress areas where issues are identified with contractor performance. However, the Health, Safety & Compliance Team do not review information on open / outstanding jobs and are not involved in any monitoring activity or oversight in this area. It is acknowledged that the team has limited resources, but without oversight over where works are not completed or are delayed, part of the picture over the assurance the team is able to give in relation to statutory building compliance is missing.

A further project which has been completed this year is the commissioning of a programme of condition surveys across the Council's maintained schools. It is understood that the final reports were due to be received from the contractor by the Head of FM during the summer and that a feedback session was to be delivered to schools on the results of the surveys and how these should be interpreted. There are also plans to offer a repairs and maintenance package which these schools could buy into in order to action remedial works identified as required. This work is still in progress. Neither the Hard FM team or Health, Safety & Compliance were aware of the outcomes from these surveys. It is also unclear how this work is currently able to feed into the Schools Health & Safety Teams monitoring visits as the results of the surveys have not yet been shared.

Management Information

It is recognised that there is work underway to review and improve the management information and performance reporting produced and circulated in relation to statutory compliance and building safety from team level upwards.

Audit testing noted that reporting produced by the Health, Safety & Compliance team to date has been overly complex and detailed with it being difficult to interpret in terms of the safety of Council buildings and whether statutory compliance requirements are

being met. Reporting titled as statutory compliance has focussed on the timeliness of completion of closed jobs across Hard FM rather than being focussed specifically on statutory compliance works. There has not been any reporting on delays in completion of late works (open work orders) or on completion of open remedials relating to statutory compliance checks which are relevant indicators of whether statutory compliance requirements are being met. As noted above, although open work orders are being monitored and managed across Hard FM by the Hard FM team, this is not currently subject to review or monitoring by Health, Safety & Compliance.

It is also noted that the reporting produced for audiences outside of Property and FM in relation to statutory compliance across Council properties (for example reporting to CMT and the Health, Safety & Assurance Board) is produced and reported on in isolation. It is not joined up with corporate health & safety reporting in the same way as other parts of the Council with responsibilities for provision of assurance on health and safety issues is. This is a further area where more joined up and collaborative working could be of benefit.

By using the current review and updating of reporting arrangements to confirm requirements of different stakeholders, the considerable effort going into the production of current reporting can be channelled to ensure that reporting on property compliance is relevant, useful, complete and timely.

Pensions Administration 23/24

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
Regulatory Framework	**A**	**0**	**3**
Scheme Employer & Member Lifecycle	**G**	**0**	**0**
Debtor Management	**G**	**0**	**0**
		0	**3**

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

Regulatory Framework Overall, audit testing found that controls and processes in relation to Pensions Administration are strong and working well. There is comprehensive staff guidance is in place for all key team pensions administration processes, with evidence that guidance is being reviewed and updated promptly when processes change.

There is a project ongoing to progress action needed following on from the McCloud judgement (this is a court ruling which provides a remedy following Government reforms to public service pension schemes in 2014 and 2015 which have been found to potentially disadvantage some scheme members), which must be concluded, and any changes required to pension records by the statutory deadline of August 2025. The team is working with Scheme Employers to identify where updates need to be made. Updates on project progress are being reported on to the Pension Fund Committee.

The team continue to monitor and report on performance against SLA targets, with routine reporting to the Pension Fund Committee.

Significant changes to staffing arrangements within the Service are taking place during 2024. The Pension Services Manger retired in the middle of February and the Service Manager Pensions is due to retire during the summer. At the time of writing, the recruitment for replacements for these two key roles had not yet commenced and the interim arrangements for cover of the Pension Services Manager role were in the process of being determined. Although it is planned that the recruitment of both roles is being timed to enable sufficient handover from the Service Manager Pensions, it is acknowledged by management that timescales are tight. Should there be delays in recruiting to either post, there is a risk that the opportunity to ensure that the considerable knowledge and experience of these key officers, who have been in post for a significant amount of time, will be lost. There was no opportunity for a managed handover prior to the Pension Services Manager leaving, although it is understood that handover notes were produced where possible and appropriate.

There are also several other members of staff leaving over the next few months and existing vacancies which are contributing to resourcing pressures within the team.
It is noted that the Administration Strategy has been reviewed, consulted on and was relaunched from the start of January 2024. This strategy sets out the role of scheme employers, information to be provided by the Fund, and sets out where the Fund is able to recover costs following unsatisfactory scheme employer performance as well as where the Fund is able to make additional charges for work carried out beyond what is included as part of the scheme employer's general contribution rate.

Scheme Employer & Member Lifecycle The remaining element (Deaths) of the Administration to Pay system implementation is being tested and is due to go live following the February payroll run. It is reported that a decision has been taken to pause implementation of the Fire element of the system due to the low number of transactions and ongoing work on this part of the system by the developer. Ongoing progress with the implementation is being reported to the Pension Fund Committee.

Debtor Management Pension fund debts are now being managed by the Income and Banking team and there is an agreed Standard Operating Procedure (SOP) in place. Debts are being reviewed on a monthly basis with the updated status being communicated to and / or any queries being discussed with the Pensions Administration team. Historic debts are being worked through with a number having been referred to Legal for recovery action and others have been written off or are in the process of being approved for write off. The debtor position is being reported on to the Pension Fund Committee as part of the Administration report on a quarterly basis.

Follow Up – there was 1 management action outstanding from the 2021/22 Pensions Administration audit. This relates to completion of the implementation of the remaining parts of the Administration to Pay system and it is expected that this will be closed following the February payroll run. There were also 3 management actions agreed as part of the 2022/23 Pensions Administration audit. All 3 have been reported as fully implemented.

Proactive Review of Purchasing Cards 23/24

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

Opinion: Amber	
Total: 21	Priority 1 = 1 Priority 2 = 20
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	20

Oxfordshire County Council operates a purchasing card system that enables authorised employees to purchase goods and services on behalf of the Council. The use of purchasing cards offers benefits including cost savings, enhanced control and visibility, and a streamlining of the purchasing process for low-cost items to the Council over other methods of payment. The total value of purchasing card expenditure over the period covered by the analysis completed as part of this review, from April 2022 to the end of July 2023, was £6.7 million. Children, Education and Families accounted for approximately 65% of the total spend, with 38% attributed specifically to schools.

Purchasing card administration and management has recently become the responsibility of the Financial Systems & Support Team, with some compliance checking also completed by the IBC (Integrated Business Centre). A Purchase to Pay Lead is currently being recruited. This post will have responsibility for purchasing card strategy, policy, and compliance.

This review has identified that a significant amount of VAT is potentially not being coded correctly by cardholders. The audit testing has identified the Council could be

losing more than £200K a year in unclaimed VAT. It is understood that this cannot be retrospectively claimed for past financial years.

Other key areas for improvement have been identified as part of this audit including the need to increase the level of transactions being reviewed by cardholders and then approved by managers and the implementation of the upload of supporting receipts to the system.

Full Population Testing and Sample Testing Methodology
This audit has used data analytics to undertake full population testing and target a sample of transactions. The full population testing covered over 92,000 transactions across 16 months from 1 April 2022 to 31 July 2023.

Data matching with data supplied by IBC, the Financial Systems & Support Team, and HR, enabled comprehensive compliance checking across internal control areas. A sample of 50 transactions were chosen for further review that covered all directorates.

Key Findings

Guidance & Training - Purchasing card holders must complete mandatory e-learning prior to be able to apply for a card, however sample testing identified a lack of awareness of areas of required compliance or process, for example card sharing with other employees being prohibited, and the requirement to cancel cards where appropriate. There is guidance in place from both the Council and IBC, however this requires review and updating to ensure guidance is consistent.

There is a lack of clear guidance and training for purchasing card approvers. It was also noted that there is limited guidance for users of embedded / virtual card accounts.

Receipt Retention - It is positive to note that sample testing confirmed that receipts for purchasing card transactions are being retained locally with receipts provided for 87% of the sample reviewed, however although there is now the functionality (identified and initially discussed with Finance following completion of the Facilities Management Contracts Follow Up audit in March 2023) to be able to upload receipts to the system, this is not currently a requirement. Requiring the upload of receipts would provide a more robust control, mitigating against receipts being lost or losing access when a cardholder leaves the Council, would enable comprehensive remote review by the approver, provide accessible evidence for VAT and accounting purposes and would also act as a fraud deterrent.

VAT - The system allows cardholders to fill in a VAT code during review of their expenditure so that VAT can be reclaimed from HMRC by the Council. This field is currently optional and there is no defined process which reviews or challenges where there is no VAT code entered.

As part of the Facilities Management Contract Follow Up audit, completed in March 2023, transactions were identified which had not been coded correctly in relation to VAT. This was raised with the Chief Accountant, who undertook an analytical review of transactions over the 2022/23 financial year and identified £1.2M spend with no VAT code, and therefore up to £250,000 of VAT which had potentially not been

claimed. Additional analysis completed by Internal Audit as part of this review calculated that transactions worth £552,000 had not been coded in 2023-24 (April to October 2023), with up to £110,000 in potentially unclaimed VAT. Our analysis indicates that the Council could be losing more than £200K per year in unclaimed VAT. It is understood from the Chief Accountant, who has sought advice from the Hampshire VAT Lead, that it has been confirmed that the Council will not be able to go back and reclaim VAT from previous accounting periods.

Whilst the IBC run compliance checks on transactions that have been VAT coded, where individual transactions are followed up with cardholders to confirm that appropriate evidence of VAT has been retained and that VAT coding is accurate, there is no clear process for follow up of non-compliance / failure to provide receipts or for highlighting these instances to colleagues at Oxfordshire County Council. The issues identified by this audit would not have been picked up through the current compliance checking process.

Review and Approval of Transactions – Cardholders are required to review and confirm purchasing card transactions by the 15th of each month. Testing identified 7% of transactions in the testing period had not been reviewed within the spend cycle and remained unreviewed at the time of analysis. Audit testing confirmed that the process of suspending cardholders with three consecutive unreviewed monthly spend cycles was operational. However, it was also noted that it is not uncommon for cardholders to be suspended more than once, suggesting that suspensions are not always producing the desired change in cardholder behaviour.

It is also required that purchasing card spend is approved by managers on a monthly basis (although as noted above, there is currently an absence clear guidance and training for approvers on required processes). Testing identified that 42% of transactions over the time period analysed had not been approved. There is no clear process in place for the follow up or escalation of non-compliance with approval requirements. A management action to review and improve the monitoring of purchasing card approval processes was agreed as part of a school fraud investigation and was due to have been implemented in December 2022. An updated action is agreed within this report.

Monthly Reporting - The Financial Systems & Support Team run a monthly purchasing card spend report that is reviewed for high-cost or unreasonable transactions. The percentage of transactions reviewed and approved are also tracked and reported to the Director of Finance Services. The findings are not currently reported to directorates. However, this is an area where it is recognised that further development and monitoring is required to proactively manage, address, and improve areas of concern. Reporting arrangements that involve the inclusion of Strategic Finance Business Partners and Senior Managers from each Directorate are being planned.

Leavers & Absences – From analysis of leaver data (April 22 to July 23) and absence data (April 23 to July 23) against purchasing card transactions, it was observed that 34 cardholders had purchasing card transactions dated after they had left their role, with 4 school employees having transactions dated after leaving employment at the Council entirely. Follow up of these instances with the Headteachers of the schools concerned, identified that cards had been used by other employees at the school after

the cardholder had left. Guidance in relation to leavers who have purchasing cards was noted to be brief and requires review and updating.

Embedded Cards – There are currently four embedded or virtual card accounts held by the Council, with two in use at the time of testing. Whilst the ability to purchase using these accounts is limited to specific staff, it was noted that transactions are not subject to review or manager approval in the same way as individual purchasing card transactions are. Guidance on card use and process is also limited. Responsibility for the management of embedded card accounts has recently been passed from Procurement to Financial Systems & Support. The Head of Financial Systems & Support has already identified that the governance, processes and controls in this area need to be determined.

Local Transport and Connectivity Plan 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
A: Governance and Reporting	**R**	**1**	**1**
B: Risk and Issue Management	**A**	**0**	**4**
C: Stakeholder Management	**A**	**0**	**1**
D: Performance Monitoring	**A**	**0**	**2**
		1	**8**

Opinion: Amber	
Total: 9	Priority 1 = 1 Priority 2 = 8
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	1
Not yet Due	8

The LTCP was adopted in July 2022 and outlines a clear vision to deliver a net-zero Oxfordshire transport and travel system that enables the county to thrive whilst protecting the environment and making Oxfordshire a better place to live for all residents. The aim is to reduce the need to travel, discouraging individual private vehicle journeys and helping to prioritise walking, cycling, public and shared transport. The policy focus areas included in the LTCP (e.g., Walking and Cycling, Road Safety, Public Transport, Local Connectivity etc) represent the tools necessary to achieve this.

The plan focuses on some of the key transport challenges faced by the county including decarbonisation, connectivity, a 36% increase in the use of private vehicles and general travel and transport challenges faced by those living in rural areas. To track delivery of the vision and key themes of the LTCP, a set of headline targets were developed spanning the period from adoption to 2030, 2040 and 2050. The 2030 targets are to:

- Replace or remove 1 out of every 4 current car trips in Oxfordshire,
- Increase the number of cycle trips in Oxfordshire from 600,000 to 1 million cycle trips per week, and
- Reduce road fatalities or serious injuries by 50%.

The LTCP is delivered through several supporting projects, policies and workstreams being delivered across different parts of the department. We selected a sample of two projects, namely Traffic Filters and Zero Emissions Zones (ZEZ), to assess project governance controls. We found that, overall, project level controls are generally adequate and effective with only minor exceptions. However, at an LTCP programme level, whilst good governance arrangements were in place during the development of the LTCP (e.g., defined governance groups and supporting governance documentation such as a risk register and stakeholder plans), these arrangements have not carried on post LTCP adoption as the delivery projects have been passed onto other service areas to put into place.

Governance and Reporting

The LTCP Steering Group and the OCC Task & Finish Group were established to monitor and support the delivery of the LTCP as well as contribute to sharing and shaping the LTCP vision and objectives. One of the key issues we identified during the audit is that these governance groups are not currently carrying out an oversight function post adoption of the LTCP. They have closed down and have not met since June 2023 and the role, remit and purpose of the groups has not been refreshed to ensure they maintain effective oversight over the 39 policies and 42 projects that have been identified as enablers in delivering LTCP outcomes. We also noted a lack of formal documentation setting out roles, responsibilities and accountabilities at an LTCP programme level.

At project level (Traffic Filters and ZEZ), good governance is in place in the form of a defined governance group with regular monitoring and reporting.

Risk and Issue Management

The overarching LTCP risk register only contains risks relating to the development of the LTCP, not the delivery of LTCP outcomes. Once governance arrangements are established, a risk identification and risk assessment process should be carried out to identify risks at an LTCP programme level and ensure they are being adequately managed.

We noted in our testing of two projects (Traffic Filters and ZEZ) that project risk registers are in place. Some gaps in the data fields required in the risk registers were noted across both projects which should be corrected e.g., the next planned review

date was missing from some of the risks in the register. Although these gaps were noted, at a project level, risks are still being regularly discussed and escalated to senior management via the Council's Project Portfolio Management tool.

Stakeholder Management

Stakeholder engagement and communication plans were developed during implementation of the LTCP. These documents have not been reviewed and updated post adoption, and therefore may not be applicable and effective in ensuring all relevant internal and external stakeholders are adequately engaged going forward.

At a project level, we noted stakeholder communication plans were in place to ensure internal and external stakeholders impacted by the project are engaged with regularly.

Performance Monitoring

LTCP targets have been linked to outcomes and outcomes have been linked to set of key performance indicators (KPIs) and their data source (e.g., Outcome 4: Reduce the need to travel by private car by making walking, cycling, public and shared transport the natural first choice has been linked to the KPI: number of bus passenger journeys and its data source: the Department of Transport). Annually, the KPIs are published in a monitoring report to demonstrate progress against the outcomes and targets of the LTCP. The first monitoring report was published in July 2023. As noted in risk area A, there are no longer operational governance arrangements in place at an LTCP level and this includes no performance reporting beyond the annual monitoring report. This frequency does not allow for timely decision making or course correction.

The KPIs have also been mapped at a high level to the policies and projects within the LTCP that play a role in influencing the associated outcome and target. However, further analysis is needed to determine the specific levers that influence a given KPI and which of these are controllable (e.g., via the policies and projects) versus uncontrollable (e.g., the weather). Understanding the Council's scope of influence at a more detailed level would enable more effective monitoring and decision making.

Feeder System Controls 23/24

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 & Oversight	**A**	**0**	**4**
Operational Processes	**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	0
Not yet Due	4

Through the course of the audit it was confirmed that, at an operational level, for the sample of feeder systems reviewed, there are effective controls in place to ensure the accuracy and integrity of data, both within the feeder systems and when it is transferred to the main accounting system, SAP.

Within the Financial Systems Team there are two dedicated posts responsible for the financial configuration of all social care and education systems. It is acknowledged that the bulk of income and expenditure is processed through these feeder systems and therefore this provides corporate oversight and control. The Financial Systems team also manage access to the Business Data Upload and SAP interfaces. There are mechanisms that provide controls over the development of, changes to and operation of feeder systems within the Financial Systems Team. These are currently not formally documented to ensure that roles and responsibilities are clearly understood.

Improvements were noted as being required, but were already in progress, in relation to the governance and oversight across all feeder systems to ensure that assurances are in place and operations are compliant with relevant rules and regulations.

Governance & Oversight

While roles and responsibilities relating to the management of individual feeder systems were found to be assigned and understood for the sample of four feeder systems reviewed, it was noted this is all at service area level. There is currently no Council-wide approach to managing feeder systems, to ensure compliance with corporate financial and procurement procedure rules. This had been recognised by Corporate Finance prior to the audit, with work commencing to develop a more consistent approach in this area. It was reported this will include development of a master list of all feeder systems being used, along with their identified service owner; local finance regulation documentation for each system; an agreed and documented annual assurance approach; and a range of key performance indicators.

The audit also noted further development of guidance is required as to how changes to feeder systems should be authorised and documented; an area stipulated within the Financial Regulations as needing S151 Officer approval, but with no further information around the types of changes requiring this, or how they should be obtained.

Operational Processes

Review of four feeder systems, across different areas of the Council, found there is a good system of internal control to ensure the accuracy and integrity of data being

transferred into the main accounting system, SAP. Of the four systems, guidance and procedure notes within the teams were found to sufficiently document the processes in place, and staff were found to have a clear understanding of their roles and responsibilities in this area. Sample testing reviewing the timeliness and accuracy of the transfer of data identified no issues, with appropriate controls in place to ensure segregation of duties and assurance that data held is both accurate and complete.

Innovation Hub Governance and Project Management 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
Aims and Objectives	**A**	**0**	**1**
Management Structure	**G**	**0**	**0**
External Funding	**A**	**0**	**2**
Financial Management and Monitoring	**A**	**0**	**2**
Project Management	**A**	**0**	**4**
		0	**9**

Opinion: Amber	
Total: 9	Priority 1 = 0 Priority 2 = 9
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	1
Not yet Due	8

The Innovation Hub (iHub) was launched in 2018 and moved from the Environment and Economy directorate into IT Services in December 2020. The iHub lead the Council's innovation initiatives, including securing external funding to deliver innovation programmes and projects, often working alongside a range of external partners and organisations. A strategic plan has recently been developed for the service and there is a formal team structure in place. A key area for control improvement is the need to have formally documented operating procedures to ensure minimum standards are in place for operations. Project management and governance is focussed on meeting the needs of external funding bodies and the challenge for the iHub service is balancing this with the internal assurance required that projects are effectively managed and delivered on time and within budget.

Aims and Objectives:
The iHub service has a documented Strategic Innovation Plan that has been shared with members of the Strategic Leadership Team but has not been formally approved. The Strategic Innovation Plan includes overall ambitions, objectives and priorities for the iHub service but there is no action plan to show how individual priorities will be met. This presents a risk that achievement of objectives cannot be measured or monitored. Key performance indicators should also be developed and agreed for the iHub to allow their performance to be evaluated.

Management Structure:
The iHub has a designated head of service who reports to the Director of Digital and IT. There is a formal team structure in place, which is currently being reviewed, and roles and responsibilities are documented. There are regular meetings between the Head of Innovation and the Director of Digital and IT and also regular team meetings within the service.

External Funding:
There is a documented checklist of the actions and sign-offs required before a grant bid can be submitted. Where OCC are the lead bidder, the checklist requires S151 officer sign-off and where OCC are not the lead bidder, sign-off is in accordance with the scheme of delegation. A review of the checklist found it is not dated and there is no evidence of it being approved and our testing found it is not always followed in practice. All successful bids should have a formal signed grant agreement and this was tested and confirmed for a sample of three bids. Staff within the iHub service are not required to declare any conflicts of interest with third-parties with whom the service may engage, which could result in conflicts not being identified and managed.

Financial Management and Monitoring:
Project managers are responsible for the financial management of projects and for ensuring they are delivered within the agreed budget. Each project has its own cost centre and for a sample of three projects it was confirmed that budgets are being managed and that all relevant backing documentation retained. The two main areas of control improvement are that the iHub service do not have any documented procedures governing the financial management of projects and there is no regular reporting on project finances at a team leader level. These areas should be addressed to ensure there is a consistent and agreed approach to managing project finances.

Project Management:
Projects have a nominated project manager and are managed in accordance with requirements specified by the different funding bodies. Whilst this is understandable, there are no internal project management procedures defining minimum standards and documentation that should be in place, especially when it is not specified by funding bodies. From our sample testing of three projects, we found that the grant agreement is used as a basis for starting a project and there is no Project Initiation Document. We also found one project without a risk and issues log and another where the log is not effectively managed. Project structure and key roles and responsibilities are also not documented. Where the iHub contract with a third-party to deliver an aspect of a project, it was confirmed that Legal and Procurement are engaged to ensure corporate procedures are followed.

Adults Income and Debt Recovery 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
Governance	**G**	**0**	**0**
Income Collection	**G**	**0**	**0**
Debt Recovery	**A**	**1**	**2**
Management Information & Performance Reporting	**A**	**0**	**4**
		1	**6**

Opinion: Amber	
Total: 7	Priority 1 = 1 Priority 2 = 6
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	6

As of the end of January 2024, Adult Social Care Debt was at just under £23M (includes approximately £9.4M of secure debt and £13.5M of debt which is not secure). Whilst the level of outstanding debt is still very high, it is noted that a number of initiatives and projects have been implemented over the last 2 years, with some still in progress, to review process, reporting, roles and responsibilities and ensure that any blockages to improving the debt position are identified and addressed. This work included an end-to-end process review from raising of invoices through to enforcement involving corporate finance and Adult Social Care Income teams. It is understood that work is ongoing as part of a recovery plan being led by Service Manager Provider and Finance, which is focused on income and debt.

There has been targeted review of a group of historic debts as part of the Debt Focus project. This involved collaborative review of a group of 544 historic debts with a value of just under £5M involving staff from the Adult Social Care Income team, Financial Assessments and Social Care. It is reported that this project has reduced outstanding debt by just over £1.8M with debts either recovered or in the process of being recovered (e.g. through instalments), referred to legal for further action or written off. At the time of writing it is reported that there are 115 cases still to be resolved.

Governance – It was found that roles and responsibilities across Adult Social Care Income and Corporate Income teams are clearly defined and understood by staff. It was also found that there is clear, accessible, and up to date guidance on key debt recovery processes available to these staff.

There are mechanisms in place for reporting on and oversight of aged debt from team level upwards. There is also information produced and circulated on key initiatives and projects to improve the debt position and progress recovery work (e.g. progress made as part of the debt focus project). It was noted that there have been regular ongoing meetings over the past year between corporate finance and the service where processes have been reviewed, refined and improved. Some improvements are still in the process of being implemented.

Income Collection – Adult Social Care income forecasts are monitored within corporate finance by the business partnering team. There have been some staffing changes over the course of the financial year which has meant that forecasting has not been completed every month, however it is understood this has now been re-established. There are plans to review the income forecasting process over the next few months to ensure that projections are as accurate as possible.

Debt Recovery – Sample testing identified some historic delays in the debt recovery process, this included allocation of debts, progression of debt recovery and the write off process. It is acknowledged by the Service that there have been staffing / resourcing issues which have resulted in debt recovery processes not being as timely as required. Staffing stabilised towards the end of 2022, and this combined with the establishment of the debt focus project has enabled focus on clearing the backlog of debt.

It is noted that improvements to process including the development of forms within LAS to document write off approvals and the referral for further action on to the corporate Income Team are being implemented which will improve consistency of recording and availability of information in relation to individual debts.

There have also been ongoing delays in progression of debt recovery once debts have been referred on to the Adult Social Care & Litigation Team within Legal. Although it is reported that there have been improvements made to process over the last year, in mid-February 2024 there were 28 cases with a total value of just under £670K outstanding. Changes have recently been made to team management and discussions are ongoing between Legal, Corporate Finance and Adult Social Care as to how remaining issues can be resolved.

Audit testing noted that the process for calculation of debt impairment is based on a clearly defined, documented methodology which includes risks assessment of debts to be included in impairment calculations. The application of the methodology is in the process of being reviewed to confirm that it is appropriately aligned with the rate of collection.

Management Information & Performance Reporting – As noted above, there are clear structures in place for reporting on debt recovery performance from team level upwards. The Aged Debt Report (ADR) is in the process of being reviewed, updated and automated which will improve reliability and consistency of information and remove the need for manual aspects of the current reporting process. A real time dashboard is also in the process of being developed.

It is noted that the Debt Focus Project, which was set up in 2022 to review and progress / resolve 544 historic debts valued at just under £5M, is due to end in March 2024. At the time of writing, there were 115 cases left to resolve. It is reported that these have been allocated to specific officers and are being actively managed, with this process being overseen by the Service Manager. It is planned that lessons learnt from this project will be documented and circulated.

Legal Case Management 23/24

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies, Procedures, and Training	**A**	**1**	**1**
B: Case Logging and Allocation	**R**	**0**	**3**
C: Case Management and Time Recording	**A**	**0**	**2**
D: Case Review and Closure	**R**	**2**	**0**
E: Management Information, Reporting and data	**R**	**2**	**0**
		5	**6**

Opinion: Red	
Total: 11	Priority 1 = 5 Priority 2 = 6
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	11

In January 2023, a Legal Services Improvement Plan was proposed and endorsed by SLT, and proposals for a new staffing structure and other improvement recommendations were put forward. The recommendations were summarised in the form of six key priorities relating to: Embedding Good Practice Standards, Achieving Good Corporate Governance, Growing our Own, Developing a Client Offer, Achieving 'Lexcel Accreditation' and Delivering Financial Management. Whilst the scope of this audit did not directly cover the progress of these priorities and associated recommendations, the audit has identified several control issues within legal case management that would require remediation for the function to meet the requirements of the Improvement Plan and achieve the future vision of the service. Key examples

of actions outlined within the Improvement Plan, relevant to the work performed during this audit, are detailed below:

- **Priority 1 (Embedding Good Practice Standards)** – Improve case management including implementing a standard Operating Manual for IKEN Case Management system and the Practice Management function supporting the delivery of Operational Standards SRA compliance and Case management improvements and monitoring.
- **Priority 3 (Grow Our Own)** – Implement a Core Competency Framework and review skills and development of teams and individuals.
- **Priority 5 (Achieving 'Lexcel' Accreditation)** – Undertake Lexcel assessment and address any gaps and plan for necessary learning and new practice standards and establish a Project Plan and a project team for achieving Lexcel Accreditation in line with the timeline of FY 24/25
- **Priority 6 (Financial Management) –** Provide Directorates with data on case volumes – on a quarterly basis to manage/monitor legal demand and budget provision.

A: Policies, Procedures and Training

Legal Service's 'Office Procedure Manual' and supporting documents detail key processes in relation to legal case management. Although they are easily accessible to staff members, their effectiveness as a reference point is diminished because the documents have not been kept up to date to reflect current ways of working. Training around legal case management and the use of IKEN is ad hoc in nature and further work is needed to identify specific training needs for both permanent and interim (i.e. locum) staff members and produce formally structured training plans. This would not only ensure a baseline level of understanding but would also help to reinforce the importance of using IKEN to appropriately, accurately and consistently log, monitor and closedown cases in a timely manner.

B: Case Logging and Allocation & C: Case Management and Time Recording

The results of our testing over a sample of legal cases confirmed that the IKEN system is not being used appropriately, accurately or consistently. One of the key issues we found were instances where there were significant delays between the date legal case work finished to the date the case was closed in IKEN. Delays in this process of closing cases prevents management from having a complete and ongoing view of fee earner capacity and case allocation, which impacts the effectiveness of monitoring over the function. The largest discrepancy of this we identified was 2540 days (i.e. approximately 7 years). Other examples of sample exceptions noted include case summary forms not being completed, cases allocated to fee earners before being logged in IKEN, and missing case closure form sign offs. Recent staffing changes in the team meant that without adequate case documentation, case knowledge was lost. This not only limited our sample testing but also highlighted that, at present, the Council is unable to effectively monitor the status of legal cases from the case management system to ensure they are being progressed and concluded promptly and appropriately.

D: Case Review and Closure

One of the key detective controls to ensure cases are managed effectively and all interactions, documentation and evidence is maintained appropriately in IKEN is regular file reviews. Currently, the file review control is not formalised and consistent across the four Legal teams. We note that file reviews are a specific requirement of Lexcel and similar to previous years, the expectation will likely be the provision of file reviews across a sample of cases per fee earner. In addition, no assurances are given to the Practice Management team that file reviews are taking place e.g., what files have been selected and what the outcome of the review was. As a result, there is currently a lack of evidence of effective oversight that cases are being managed appropriately, that performance issues and risks are being promptly identified and that staff are effectively discharging their responsibilities.

E: Management Information, Reporting and Data

We noted that a number of weekly and monthly reports are prepared and shared with various stakeholders for monitoring and decision-making purposes. Examples include, locum times vs invoiced hours, income tracker, available hours vs actuals and target vs actuals hours. Internal KPIs to measure the overall performance of the service were scheduled to be reported on and monitored from December 2023 onwards but due to time and resource constraints this did not occur. A revised set of 6 KPIs have been agreed and will be reported on and monitored going forward from April 2024. Whilst these reports and monitoring tools exist as a way to maintain oversight, issues with time recording and how cases are logged diminishes the completeness and accuracy of the data underpinning these reports. This reduces the ability of the Practice Management Team to make well-informed decisions.

As part of the work to implement the Legal Services Improvement Plan, the service has set up two working groups, one to consider how to make systematic Practice Improvements to enable an application for Lexcel accreditation later on in the year, and the other is an IKEN focus group to consider what practical issues there are with the IKEN system and how these can be addressed through targeted and consistent training; and through an upgrade of the IKEN system onto the cloud. The Practice Improvement group has a project plan which is geared towards an application for Lexcel accreditation and is supported by a Project Manager. The IKEN group is supported by the service's IT Business Partner and direct contact with IKEN has been initiated for assistance.

Childrens Change Programme 23/24

Introduction

As part of the 2023/24 Internal Audit plan, it was intended that Internal Audit would review and provide assurance over the implementation of the Children's Change / Transformation Programme, including the improvements made in relation to financial and performance management.

Following scoping discussions, it was agreed with the Executive Director for People that detailed audit testing would not be of benefit at this stage as governance arrangements for oversight of children's change / transformation activity were still in the process of being confirmed. In relation to financial management, within Children's

Social Care, it was noted that there were areas where improvements had been made, but completion of any detailed testing, taking into account the timing of agreement and implementation of the financial strategy, would be more helpful at a later date. In relation to Education, it is acknowledged that improvements are required in relation to financial management, with this still be to actioned.

As part of the 2024/25 Internal Audit Plan, it is intended that a more detailed review will be undertaken in relation to the new governance arrangements in place covering children's transformation / change activity, on the monitoring and reporting on the implementation of the financial strategy, on other improvements to financial management within the directorate and on performance management arrangements.

Conclusion

Following the pausing of the Children's Change Board and Change Team recruitment in the Autumn of 2023, change / transformation governance arrangements have now been confirmed. The Change Board has been removed, with Change / Transformation activity now being reported into Children's Directorate Leadership Team (DLT) as a standing agenda item. There are governance structures in place which will link in with corporate transformation / change oversight. The recruitment of the Children's Transformation Team (previously Change Team) is due to recommence shortly.

Financial improvements made over the last year in relation to Children's Social Care include review and rationalisation of cost centre structures, confirmation of financial roles and responsibilities, the roll out of financial management training and implementation of changes to budget monitoring and forecasting processes with the Finance Business Partnering team providing consolidated oversight, input and guidance. It is acknowledged that financial improvements will be required in relation to Education, however requirements still need to be identified and implemented. It is anticipated that this will be progressed following confirmation of Finance Business Partnering arrangements in this area.

The above summarises the action taken to date, going forward there is a need to understand the impact this has had on the financial management maturity of the managers within the directorate to allow the Finance Business Partnering team to work with the directorate to support making further improvements where required.

Primary School Audit 1 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
Governance	**A**	**0**	**6**
Financial Planning & Monitoring	**A**	**1**	**4**

Procurement	**A**	**1**	**3**
Income	**A**	**0**	**3**
Assets	**R**	**0**	**2**
Staffing / Payroll	**A**	**0**	**4**
Unofficial Funds	**n/a**	**-**	**-**
		2	**22**

Opinion: Amber	
Total: 24	Priority 1 = 2 Priority 2 = 22
Current Status:	
Implemented	3
Due not yet actioned	0
Partially complete	0
Not yet Due	21

This audit was undertaken following concerns raised around financial management and control which became apparent following the appointment of a new Headteacher in September 2023. Our review has covered the financial management practices under the previous Headteacher as well as the arrangements currently in place and being developed. Although the audit has highlighted some areas of concern in relation to financial management processes in place from the time of the previous Head, it is acknowledged that the new Headteacher has made significant progress in improving processes, has been actively engaged with the Local Authority in seeking advice, guidance and support on finance and HR issues and has welcomed the findings of the audit as a means of ensuring that financial processes and controls are appropriate going forward.

It is also noted that the Chair of Governors changed in the autumn of 2023. The audit has noted several areas where it can be observed that the current Headteacher and Chair of Governors are working together to make the required improvements both in relation to financial oversight and ensuring that the governing body are able to perform their role effectively. It is understood that a governance review is in the process of being commissioned by the Chair of Governors.

An action plan has been developed with the Headteacher to improve controls in the areas of Governance, Financial Planning & Monitoring, Procurement, Income, Assets, and Staffing & Payroll.

Risk Management – Directorate/Service Level 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
A: Governance, Roles and Responsibilities	**A**	**0**	**6**
B: Risk Management Process – Risk Identification and Assessment	**A**	**0**	**1**
C: Risk Management Process – Risk Treatment	**A**	**0**	**1**
D: Risk Management Process – Monitoring, Escalation and Reporting	**A**	**0**	**1**
		0	**9**

Opinion: Amber	
Total: 9	Priority 1 = 0 Priority 2 = 9
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	8

A: Governance, Roles and Responsibilities

The Council's Risk Management Strategy 2023 – 2024 document, which was approved by the Audit & Governance Committee in September 2023, is the foundation for the Council's approach to risk and opportunities management. The key aspects and requirements of the Strategy are supported by guidance on risk management on the intranet. We noted that the Strategy is detailed and clearly outlines the end-to-end process that directorates/services should follow, including escalation to the Performance & Insight Team where operational risks become strategic risks impacting the achievement of the Council's priorities and objectives.

The Strategy and intranet guidance represent the main reference points for staff across the Council to understand risk management processes, roles, responsibilities and accountabilities.

Risk management training is available to all members of staff in SuccessFactors. Based on our discussions with the directorates/services across our sample (Adult Social Care, Environment & Place and Contracts & Procurement) we noted that staff either had not carried out the training in several years or they were not aware that risk management training was available. Key members of staff within the Adult Social Care directorate referenced risk workshops/sessions they had attended but noted that this

was not a consistent practice. There is a need to confirm who needs to complete risk management training, and once this has been determined, completion needs to be monitored.
Another enhancement we noted that would improve overarching governance included the Performance & Insight team formalising their attendance across all Directorate Leadership Team (DLT) meetings to enable complete and sufficient oversight of operational risk across the Council and to ensure risks are escalated to the strategic risk register if required, in a timely and effective manner. Currently, these structures and mechanisms have been established for all Directorates/services except for Children's Services where discussions are still ongoing.

We also considered how the Performance & Insight team obtain ongoing assurance that the expectations of the Risk Management Strategy are being adhered to within Directorates. Planned arrangements are to perform a health check by use of a questionnaire that is shared with Directorates/Services that asks a series of questions to gauge awareness and compliance with the strategy and its associated processes. The health check approach will need to be adopted and embedded to provide an ongoing assurance and feedback loop to enable continuous improvement.

B: Risk Management Process – Risk Identification and Assessment
Section 2 of the Strategy outlines the steps to be taken to identify and assess risks, considering factors such as an assessment of the likelihood and impact of the risk using a risk scoring matrix and the identification of key controls currently in place to manage the risk. As part of our sample testing over directorates/services, we noted that within the Adult Social Care directorate, risks were captured in multiple RAID (Risks, Assumptions, Issues and Dependencies) logs, rather than being aggregated into a single directorate level risk register using the guidance and templates provided by the Performance & Insight team. The other directorates/services in our sample had a single risk register summarising all the operational risks facing their areas.

C: Risk Management Process – Risk Treatment
The Strategy also goes into detail in terms of how risks, once identified and assessed, should be treated, controlled and managed. We identified in our review of the Procurement function's risk register that for a small percentage of risks within the risk register, details of mitigating actions and action owners were missing or lacking sufficient detail. The other directorates/services' risk registers we reviewed had adequate and complete details in terms of controls and mitigations and appropriate structures in place to ensure they are regularly reviewed and updated if needed.

D: Risk Management Process – Monitoring, Escalation and Reporting
The gaps we identified in the Procurement function's risk register highlighted a failure in the overall monitoring process, in that review and monitoring of the risk register was not taking place on a regular basis. We did however note a good level of monitoring mechanisms in the other directorates/services in our sample tested.

Follow up of Actions from the 2020/21 Risk Management Audit
We followed up on the implementation of the 14 actions arising from the Risk Management audit performed in 2020/21.
- We evidenced 6 out of 14 actions had been fully implemented.

- We found that one action had been partially implemented. This related to the DLT finding noted in this report. The Performance and Insight Team are now attending most DLT meetings except for the Children's DLT whereby attendance still needs to be agreed.
- A further action was confirmed by management as no longer being applicable. This related to developing a process for joint risks. At the time of the 20/21 audit, there was a risk that was jointly shared by Oxfordshire Council and Cherwell District Council. This is no longer applicable.
- The remaining 6 actions were not found to have been effectively implemented and have been incorporated into new actions in the audit report.

Health Funded Payments 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
Governance	**A**	**0**	**1**
Payment Accuracy & Timeliness	**R**	**1**	**6**
Budget Monitoring	**G**	**0**	**0**
		1	**7**

Opinion: Amber	
Total: 8	Priority 1 = 1 Priority 2 = 7
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	8

The Council processes payments on behalf of the Buckinghamshire, Oxfordshire and West Berkshire Integrated Care Board (BOB ICB), as part of the Integrated Commissioning arrangements set up in accordance with Section 75 of the National Health Services Act 2006.

The payments that are within the scope of this audit are those which are processed through the Payments Systems Data Team with the value of these health funded payments forecast to be in excess of £100M for the 2023-24 financial year.

Changes are being made to the types of health funded payments being processed through the Payments Systems Data Team. Some health funded payments are

processed via provider invoices, and the BOB ICB commenced processing their own invoices from July 2023. The BOB ICB has proposed to take over payment of Funded Nursing Care (FNC) from April 2024, and to take over Continuing Health Care (CHC) Nursing Home payments at a date to be confirmed. The details of the proposed transfer of responsibility for health funded payments are yet to be finalised. In any event, a significant portion of health funded payments will continue to be processed through the Payments Systems Data Team, including Supported Living placements and some nursing home placements.

Governance

Responsibilities across OCC and the ICB are defined within the Section 75 agreement. Roles and responsibilities within the Payments Systems Data team and the Finance Business Partnering team are reflected in job descriptions which include assurance and control processes and segregation of duties. Further detail on the arrangements between the two parties should be set out in a Memorandum of Understanding however this is currently under development and has not yet been finalised.

Management information regarding the timeliness, accuracy and completeness of payments, including health funded payments, is captured, monitored and reported on regularly. Recent improvements have been made to the reporting arrangements including the ability to show separate statistics for health funded and council funded people. Review of meeting notes at various levels including the Joint commissioning Executive (JCE), Performance Finance Group (PFG) and the recently implemented "3Ps" meetings (Practice Performance Pounds), showed that there is meaningful discussion of performance information (amongst other things) and that the information is used to drive improvements in performance and in quality of data.

Payment Accuracy & Timeliness

Processes to communicate health funded provisions to the Payments System Data team to enable the correct payments to be made are inefficient, time consuming and cumbersome, increasing the risk of delays and errors.

It is not possible to verify that payments are adequately approved as there is no evidence of an approved scheme of delegation setting out who within the BOB ICB is authorised to approve care. It was also noted that documentation setting out the details and approval of care is often provided several months after the care has started.

During 2023/24 there have been reconciliations between Council and ICB data, which have identified a large number of cases where providers had continued to receive payments for clients who were no longer receiving health funded care. In May 2023, a list of clients had been identified by the ICB as being deceased but were still receiving payment. This included one client who had died in 2015, 20 clients who had died between 2018 and 2021, and 61 clients who had died during 2022. It is noted that, upon receipt of the appropriate notifications from the ICB, Council records have since been corrected and the resulting overpayments recovered from the providers. This is with the exception of 1 case where payments are continuing to be made, and requires further investigation and action. The Payments System Data team are reliant on the information they are provided with by Health. It has not been possible to determine whether the cause of these errors has been due to providers not routinely notifying health of deceased clients or whether there is a weakness in the process for Health notifying the Council of these updates.

Providers receive remittance advice with each payment, with clear details of which clients they are being paid for. A total of 32 different providers were still receiving

payments in May 2023 for clients that had died during or prior to 2022, of which 19 providers had multiple cases. One provider had a remittance in April 2023 which included payment for 54 clients, 10 of whom were deceased, including one who had died in 2020. Another provider had a remittance advice in April 2023 for 32 clients, 4 of whom had died between 2018 and 2021.

The overpayments arising from the May 2023 list, relating to deaths which occurred in 2022 or earlier, are estimated to be in excess of £1.1M. As these are health funded payments, the cost of these payments is met by the ICB.

There is some evidence within individual case notes on LAS that providers have been questioned by the Payments Systems Data team about why they had continued to receive payments after the clients have died. However there has been no overarching reporting to senior management on this issue, there has not been any review of whether there has been any deliberate fraud or irregularity by the providers in continuing to receive these payments and there is no confirmation of how this should be being addressed with providers in relation to contract management or in ensuring processes are improved to minimise the risks of this happening again. It is noted that should any further action be required in terms of fraud, this would be the responsibility of the ICB.

Budget Monitoring

The funding for health payments is held within pooled budgets for Live Well and Age Well. At the start of the financial year, both parties sign a "Section 75 agreement" which includes details of each partner's contribution to the pools, and where the financial risk is held for each element of the pools. In accordance with this agreement, OCC raises a monthly invoice for the BOB ICB contribution to the pools. Audit testing noted that arrangements for forecasting and budget monitoring are working well.

Proactive Review of Expenses 23/24

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

Opinion: Amber	
Total: 14	Priority 1 = 0 Priority 2 = 14
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	14

Oxfordshire County Council operates a system where employees can be reimbursed for expenses that they necessarily incur in doing their job. Employees are instructed to make expense claims under £1,000 using the employee self-service (ESS) tool, operated by the IBC (Integrated Business Centre). This tool allows the expense claim to be reimbursed to the employee in their next pay slip, without the need for direct manager approval. Where the total monthly claim is over £1,000, or the employee

cannot access ESS, a paper travel and expenses claim form must instead be completed, approved and sent to the IBC Payroll Support Team.

Managers are responsible for reviewing expenses claimed by their team members and are able to access reporting on expenses via an IBC report. The use of the employee self-service tool in the claiming of expenses offers benefits including a streamlining of the expense claim process for low-cost items, and a centralised form of control and visibility for managers.
The audit focussed on a review of expense claims that excluded vehicle mileage claims. The total value of expense claims over the period covered by the analysis as part of this review, from April 2022 to December 2023, was £870,844.

This review has identified that, from the sample of transactions tested, supporting invoices / receipts were provided for 61% of the sample. Supporting documentation for 39% of transactions sampled could not be provided as is required by the Council's Travel Expenses Manual. Issues were also identified with incorrect VAT coding and a lack of appropriate supporting documentation in relation to VAT.

Other areas for improvement have been identified as part of this audit, including the need to remove an obsolete VAT code from the system, and improving corporate oversight of compliance in relation to the claiming of expenses.

Full Population Testing and Sample Testing Methodology
This audit has used data analytics to undertake full population testing and target a sample of expense claims. The full population testing covered over 45,000 individual expense transactions across 21 months from 1 April 2022 to 31 December 2023.

Data matching with data supplied by IBC, HR, and RBS (for purchasing card transactions used in reviewing potential duplicate transactions with expenses claimed), enabled comprehensive compliance checking across internal control areas. A sample of 100 expense claims were chosen for further review which covered all directorates.

Key Findings
Clarification of Roles and Responsibilities – HR, the Chief Accountant Team and the Financial Systems team have a role in relation to the processing and oversight of employee expenses. However, it is noted that roles, responsibilities and oversight would benefit from review and clarification.

Receipt Retention – There was generally a high level of response to requests for receipts in the sample testing at 83%. However, a valid VAT invoice or receipt could only be provided for 61% of expense claims tested. There is not the functionality to be able to upload receipts to a centralised system and at present there is no mechanism to provide any assurance, at a corporate level, that supporting documentation (particularly important in relation to transactions which include VAT) is being retained in accordance with the Travel Expenses Manual. It is understood that there is an automated compliance checking function within the IBC system which could be implemented, however to date this has not been felt to be required.

VAT – When entering expense claims on the IBC system, employees select expense types which are either for specific expenses (e.g. accommodation, eye test,

subsistence) which have VAT coding built in or broad 'other' categories allowing the VAT level to be selected manually. Approximately 60% of expenses within the period tested were coded to an 'other' category. The system is set up so that the claimant does not enter any VAT figures themselves, these are automatically calculated within the system. There were a number of examples noted where there were errors in self-assigned VAT codes and where claimants were not able to provide appropriate supporting documentation in relation to the VAT code processed. There are also concerns relating to the automatically allocated VAT coding for expenses like subsistence, where there could be different VAT coding within one transaction.

In addition, two 'other' expense types with a 12.5% VAT code, a designation which should have been removed from March 2022, were live on the system at the time of testing. Analysis over the testing period identified 68 expense claims which had been coded to these expense types and so where VAT is not correctly coded. These expense types have since been removed from the system.

Compliance Checks and Monthly Reporting – The IBC currently conduct limited compliance checks relating to VAT transactions on a monthly basis. VAT receipts are requested from the employee, and where they are not provided, the VAT is removed from the transaction. There is limited feedback to the Council on these checks and on instances of non-compliance identified. The Chief Accountant Team has identified that these checks are not sufficiently comprehensive and are in discussions with the IBC VAT Team over coverage and reporting on these checks.

Analysis of Duplicated Purchasing Card Transactions – It is positive to note that data matching with purchasing card transactions (from the period April 2022 to April 2023) did not identify any significant instances of duplicate claiming between expenses and purchasing card expenditure. 2 instances were identified where we were able to confirm that an employee has made a purchase on a Council purchasing card, and then reclaimed it as an expense. Both were reported as accidental duplicates, and additional analysis of these employees expense claims and purchasing card transactions over the testing period did not identify any further transactions of concern.

There is no corporate oversight of expenses spend, and it is currently the responsibility of line managers to review the expenses claimed by their direct reports using an IBC HR report. Work is underway within corporate finance to review and develop management reporting to improve visibility in areas including expenses.

Adults Safeguarding 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
Governance, Policies & Procedures	**G**	**0**	**1**
Operational Processes	**A**	**0**	**1**

Management Information & Performance Reporting	**G**	**0**	**3**
		0	**5**

Opinion: Amber	
Total: 5	Priority 1 = 0 Priority 2 = 5
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	5

The Adult Safeguarding Team receive, review and triage safeguarding concerns which can come from members of the public or professionals. If a concern is assessed as meeting a defined threshold it becomes a formal Section 42 enquiry which is investigated further to establish what action should be taken to remove or otherwise manage the risk, with a focus on supporting the adult to achieve their desired outcomes. Concerns that do not meet the threshold for a Section 42 enquiry will be closed but where relevant will be referred or signposted to other teams or services to assist with resolving the concern.

Between 1 April 2023 and 6 March 2024, 6162 safeguarding contacts were received by the Council, of which 1391 progressed to formal Section 42 enquiries. The Oxfordshire County Council Policy for Safeguarding Adults sets out the Council's approach to the safeguarding of vulnerable adults. This policy provides a framework to support professionals and others to take appropriate and timely safeguarding action and it is aligned with the Care Act 2014.
The Adults Safeguarding team take a 'making safeguarding personal' approach to ensure the individual is at the centre of the enquiry and that their wishes are taken into consideration when the Adults Safeguarding team are making decisions about how the enquiry can be resolved. The Adults Safeguarding team take a multi-agency approach in order to complete enquiries, this involves working with other agencies and professionals who are involved with supporting the individual, in order to gather all the relevant information for the enquiry.
There are ongoing issues with the timeliness of response to safeguarding concerns and enquiries. The audit noted that clear mechanisms have been introduced to monitor performance of processing of safeguarding cases which includes regular and detailed reporting up to Deputy Director level. It is noted that performance has improved significantly over the last six months.

Governance, Policies & Procedures
Roles and responsibilities within the Adults Safeguarding team are clearly defined within job descriptions. Documented policies and procedures for the Adults Safeguarding team have been reviewed and an updated Safeguarding Process document is currently at draft stage and needs to be formally finalised. It is noted that members of the Adults Safeguarding team should already be following the process described. There is detailed guidance available to professionals and members of the public through the Council's public website and the Oxfordshire Safeguarding Adults

Board (OSAB) website on what to do if they have a safeguarding concern. There is also information available to Council staff on SASHA about what do to if they have a safeguarding concern.

Operational Processes

Following the appointment of the Safeguarding Mental Health Service Manager in mid-2023, processes and timeliness targets have been reviewed and an action plan has been developed to improve performance in dealing with safeguarding concerns and enquiries. Audit sample testing evidenced improvements in timeliness of response. It was also noted that there are daily reporting arrangements in place with escalation of delayed cases up to Deputy Director level and that further improvements continue to be a priority for the team.

The current version of the action plan, from February 2024, highlights concerns including timeliness of triage and progression of safeguarding enquiries and delays in cases being allocated once triaged. The action plan has clear actions in place which are being monitored by the Deputy Director for Adult Social Care through daily reporting, and as part of weekly Meaningful Measures meetings. These meetings include review of individual cases to ensure themes and opportunities for improvement to process are identified and acted upon.

Testing confirmed that information gathering forms are being completed, including the section on 'wishes and outcomes'. From a sample of closed enquiries reviewed, it was confirmed that the closure forms were appropriately completed including documenting the outcomes of the enquiry and whether the individual's wishes had been met.

Where appropriate, strategy meetings are taking place, and the Adults Safeguarding team are taking a multi-agency approach to conducting safeguarding enquiries. From the sample of enquiries reviewed, it is clear that the Adults Safeguarding team have embedded a 'making safeguarding personal' approach and are ascertaining individual's wishes at the start of the enquiry and working towards implementing those wishes wherever possible and appropriate. A sample of cases where the individuals' wishes and outcomes were not met, was reviewed and the explanations were clearly documented.

For a sample of organisational safeguarding cases reviewed, they all appeared to have appropriate actions being taken in order to improve their service, where necessary providers are being referred to Quality Improvement. There is evidence that Adult Safeguarding and Quality Improvement are working collaboratively with providers to ensure the service improves, and this is being recorded on LAS.

Management Information & Performance Reporting

Management Information regarding the timeliness of review and processing of concerns and enquiries is reported daily to key safeguarding contacts, this information comes from the Social Care Performance Information team and shows all the safeguarding cases open that day and how long they have been open for, all the cases are colour coded with cases not triaged or completed within the defined timescales flagged for review by management.

One anomaly was found with the "Safeguarding Daily Activity Report" which impacted on reporting on the timeliness of triage decisions from contacts however this has been flagged and will now be corrected.

It was highlighted both by the Deputy Director Adult Social Care and within the current action plan, that have been issues with cases which have been triaged but then not allocated promptly. Processes have now been put in place to identify and monitor these cases and ensure that there is appropriate visibility over allocation, and it is reported that performance has now improved.

Supported Transport 23/24

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Contract Procurement	**R**	**4**	**1**
B: Contract Management	**R**	**2**	**8**
		6	**9**

Opinion: Red	
Total: 15	Priority 1 = 6 Priority 2 = 9
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	14

A: Contract Procurement

The Supported Transport unit of the Council is responsible for the provision of transport of pupils to schools or college, and for pupils who live some distance away from their educational provision. Most of the Supported Transport provision is outsourced to taxi and coach firms. The unit is overseen by the Head of Supported Transport who has direct reports from a team responsible for contract management activities (i.e., Service Planning) and a team responsible for contract procurement activities (i.e., Contracted and Fleet Services).

We noted several weaknesses in the contract procurement processes and controls. Procurement processes are not documented nor consistently followed. There is a lack of segregation of duties, monitoring processes, and service level KPIs have not been defined.

We tested a sample of supported transport contracts and noted instances whereby the call-off contract had either not been signed by the Council or by the supplier or in some cases not signed by either party. There were also instances whereby the call off contract could

not be located. We also tested a sample of 10 direct awards and in all cases, no evidence of the signed contract or agreement was available for review.

B: Contract Management

The Service Planning team are responsible for managing contracts and providers on the DPS (Dynamic Purchasing System) framework as well as contracts relating to direct awards. Contract management activities include monitoring the performance of suppliers, reviewing the split of spend across DPS and direct awards and completion of financial risk assessments where annual and lifetime supplier spend limits have been exceeded. We identified the following contract management control weaknesses within the management of contracts for Supported Transport:

- Annual and lifetime spend limits are not currently being reviewed on a regular, ongoing basis to determine their appropriateness and also to ensure financial risk assessments are completed where limits have been exceeded. Based on testing performed, where limits had been exceeded, we noted that financial risk assessments were not performed for most of our sample.
- The contracts register is not formally reviewed on a regular basis to ensure the accuracy and completeness of data contained within it, including data around financial limits and financial risk assessments.
- Supplier performance is monitored and reported on, however we noted that particularly for establishment checks, which involve a member of the team physically monitoring the start or end point of a particular route, the target number of checks have not been achieved.
- Direct award spend levels are not regularly reviewed and reported on in a formal manner to determine if internal spend thresholds between direct award spend compared to DPS spend is being adhered to.
- There are control gaps relating to a lack of oversight and review over DPS and direct award contract changes. In addition, the LIFT (the system used to log the cost of services) and EYES (the system used to log routes and passengers) systems do not interface with each other resulting in it being necessary to manually extract data from one system and manually enter it into another. Both issues ultimately present the risk that inaccurate payments may be made to suppliers.

Follow up of Actions from the 2018/19 Supported Transport Audit

We followed up on the implementation of the 24 actions arising from the Supported Transport review in 2018/19.

- 22 out of 24 actions are reported as fully implemented by management.
- 1 out of 24 actions was confirmed by management as no longer applicable/no further action required.
- The remaining 1 action was not found to have been effectively implemented and has been superseded with new actions in this report. This action related to reviewing management reporting arrangements for provider performance to ensure sufficient information is produced to the level of visits being undertaken against targets.

Follow up of Actions from the 2021/22 OCC Provision Cycle Audit

We followed up on the implementation of the 5 actions from the OCC Provision Cycle review in 2021/22.

- All 5 actions were not found to have been effectively implemented.
- 3 out of 5 actions have been superseded with new actions in this report.
- The remaining 2 actions will continue to be monitored for implementation.

Follow up of Actions from the May 2022 Supported Transport Investigation

We followed up on the implementation of the 7 actions from the May 2022 Supported Transport Investigation.

- 1 out of 7 actions has been reported as fully implemented.
- The remaining 6 actions have not been implemented. These actions will continue to be monitored for implementation.