AUDIT AND GOVERNANCE COMMITTEE
11 MAY 2022
ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR
Report by Sarah Cox, 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 2021/22, 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 2021/22 which is that there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control. It is positive to note that the number of audits reporting significant weak internal controls and graded overall Red, has reduced over the last few years from five in 2018/19, two in 2019/20, one in 2020/21 and one* (see paragraph 38) in 2021/22.

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 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. This was undertaken by CIPFA in November 2017 and the results were reported to the Audit & Governance Committee in January 2018. This confirmed that the "service is highly regarded within the Council and provides useful assurance on its underlying systems and processes". The next external assessment is due Winter 2022.

13. The Monitoring Officer last conducted a survey of Senior Management on the effectiveness of Internal Audit in 2019. The results from this survey were presented to the March 2019 Audit & Governance Committee meeting. The conclusion from the survey was that management find the internal audit service effective in fulfilling its role. The next survey was planned for 2021/22. This was not completed during 2021/22 but has been flagged for 2022/23.

14. The Internal Audit Strategy and Annual Plan for 2021/22 was presented to the June 2021 Audit and Governance Committee. The Committee then received quarterly progress reports from the Chief Internal Auditor, including summaries of the audit findings and conclusions. The Audit Working Group also routinely received reports from the Chief Internal Auditor, highlighting emerging issues and for monitoring the implementation of management actions arising from internal audit reports.

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 a designated 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 2021/22 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 enabled us to build a more sustainable team with the skills and capacity resilience to help embrace current and future challenges. The audit management team strongly believe that working as an in-house internal audit function in any organisation drives an increased quality of output, as not only do the in-house team members have a good strategic and operational understanding of the organisation, but also have an ongoing commitment to organisational improvement and adding real value.

20. Throughout the year the Audit and Governance Committee and the Audit Working Group were kept informed of staffing issues 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 2021/22.

Opinion on System of Internal Control

Basis of the Audit Opinion

22. The 2021/22 revised plan has been completed, subject to 4 audits at draft report stage which will be finalised during May.

23. The plan is intended to be dynamic and flexible to change. 26 audits were undertaken in the year (22 in 2020/21). Since the last report of amendments to the plan at the January 2022 Audit and Governance Committee meeting, there have been 3 further amendments; 2 audits (Direct Payments, deferred until Q1 of 2022/23 and Family Solutions Plus) were removed from the Q4 internal audit plan due to unforeseen resourcing issues, with a Senior Auditor being on long term sickness absence. The third audit, (Music Service follow up) was started, however due to staff sickness within the service it was agreed to defer the completion until May 2022. These amendments are recorded in appendix 1, with the 2021/22 plan update.

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 2021/22, one* (see paragraph 38) was graded as RED: Facilities Management – Cleaning Asset Management. In 2020/21, one audit was graded red, in 2019/20, two audits were graded as Red and in 2018/19 five were graded 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, Senior Leadership Team (formally CEDR – Chief Executive Direct Reports) and the Audit Working Group. The Chief Internal Auditor's opinion set out in below takes into account 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 2021/22 has been shared with the Director of Finance and the Chief Internal Auditor. This report provides assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. The report concludes that the controls related to the control objectives were suitably designed and operated effectively, with no exceptions noted.

31. The anti-fraud and corruption strategy remains current and relevant. In 2021/22 the Audit and Governance Committee 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 2021/22 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 2022, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

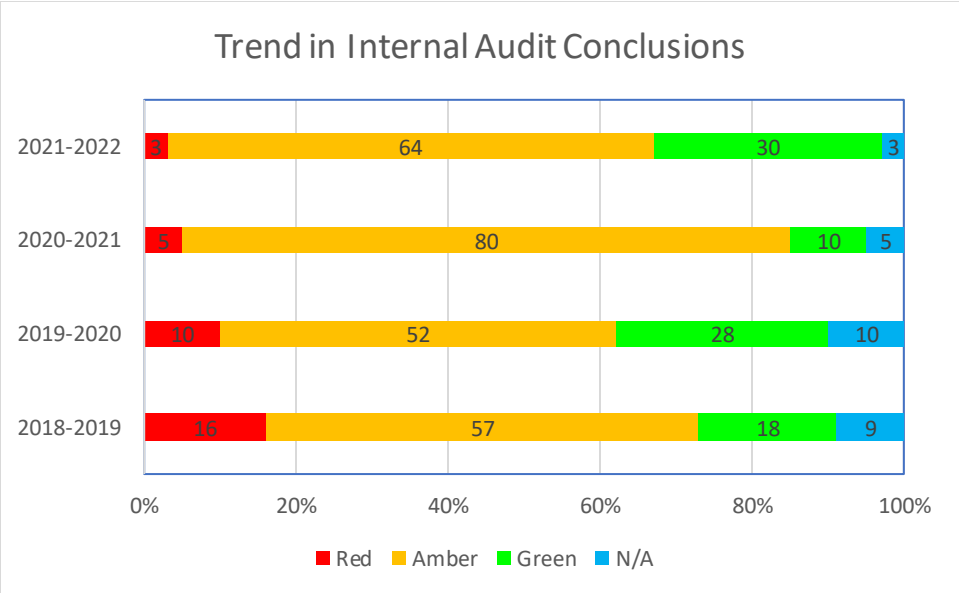
Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective action and timescale for improvement.

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. It is pleasing to note the positive position, including the number of audits with an overall Green grading has increased and the number of audits with the overall grading of Red has decreased.



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 2022) are attached as appendix 3.

- S106 – Spend
- Gartan Payroll & HR processes
- IT Data Centre
- Pensions Administration
- Treasury management
- Supporting Families – Claim 3
- Five Acres Primary School
- Money Management
- Growth Board – Accountable Body Role
- Provision Cycle – Prepare, Tender, and Implement
- Provision Cycle – Manage and Review
- Facilities Management – cleaning asset management
- Well-being / Sickness management

38. The following audits are currently at exit meeting / draft report stage. The outcomes of the audits are included within the annual opinion, the executive summaries of the reports once finalised will be included in the next internal audit quarterly update to committee.

    * All overall opinions for the 4 outstanding audits are "to be confirmed" at the point of submitting this report. However, it should be noted that the Audit of Childrens payments via Controcc may result in an overall conclusion of Red or Amber – this is to be confirmed. If an overall Red opinion is given then this will mean the overall number of Red reports for the year 2021/22 will be two, currently it is reported as one.

    Exit meetings / draft report stage:

- Childrens payments via Controcc*
- Education Safeguarding
- Payments to providers
- Highways contract management

39. The overall conclusion for the audit of Facilities Management – Cleaning Asset Management has been graded Red. The executive summary from the Internal Audit Report is included within appendix 3. As this is a Red graded report, we have provided a response from management:

Management Response: Facilities Management – Audit of Cleaning Asset Management 2021/22:

During the transformation program in 2021 it was highlighted that the cleaning service has challenges that needed to be addressed and following an incident of theft it was decided by the Corporate Director to commission an independent detailed audit of the services operational processes and procedures.

The report highlighted concerns in key areas of the service, including non-compliance with correct policies and procedures in relation to consumables, purchasing, procurement, asset management, disposals and areas of Health & Safety checks. All areas of concern highlighted in the report are being addressed in the short term with manual mandated processes to reduce the risk and improve the management processes by the end of May 2022. Further improvements around storage and tracking of assets and consumables will be implemented by September 2022.

Internal Audit Performance

40. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2021/22 performance.

41. Performance in achieving the target date for the exit meeting for each audit assignment has been impacted upon due to several resourcing issues within the year. This is an area we will continue to focus on and improve. The performance for the issue of draft reports has stayed the same as the previous year, however for the issue of finals this had reduced. We have reported in year to the committee that this was due to a positive reason whereby Corporate Directors, Senior Manager are now fully engaged in the audit report process and there is additional time needed now to fully engage with everyone and ensure a robust and quality management action plan is developed. For 2022/23 we will propose a change in the performance indicator to reflect this.

42. We are pleased to report the continued improvement with the implementation of management actions, with the majority implemented or not yet due. Our customer satisfaction questionnaires continue to provide positive feedback.

Measure	Target	Actual Performance 2021/22 – as at 26/04/2022
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	59% of the audits met this target. 2020/21 50% 2019/20 61% 2018/19 69%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	86% of the audits met this target. 2020/21 85% 2019/20 74% 2018/19 82%
Elapsed time between issue of draft report and the issue of the final report	15 Days	66% of the audits met this target. 2020/21 80% 2019/20 74% 2018/19 85%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2021.	87% of the plan was completed by the end of April 2021 (including grant certification work). 2020/21 74% 2019/20 70% 2018/19 100%
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at 27 April 2022: 640 actions being monitored on the system. • 78% implemented • 15% not yet due • 4% partially implemented • 2% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2 1 - Good 2 – Satisfactory 3 – Unsatisfactory in some areas 4 – Poor	Average score was 1.1 2020/21 1.06 2019/20 1.17 2018/19 1.07
Directors satisfaction with internal audit work	Satisfactory or above	The review of the effectiveness of internal audit is undertaken by the Monitoring Officer - results of this was reported to the March 2019 Audit & Governance Committee – Satisfactory. Next review was planned for 2021 – this was not completed. This will be flagged for 2022/23.

Financial Implications

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

Legal Implications

44. There are not direct legal implications arising from this report.
Comments checked by: Sukdave Ghuman, Head of Legal
sukdave.ghuman@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 2022.

Annex:	Annex 1: Progress with completion of 2021/22 Internal Audit Plan 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 2021/22 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 25/04/2022
Corporate / Cross Cutting				
Provision Cycle - Prepare, Tender and Implement.	Final	Amber	19	19 not yet due
Provision Cycle - Manage & Review	Final	Amber	*	* report and actions combined with above.
Childrens				
Children's Payments via ContrOCC / LCS recording	Exit Meeting / Draft	TBC	TBC	TBC
Childrens Education System – Implementation of New IT System – Stage 1 & 2 IT controls	Final	Green	4	2 implemented, 2 not yet due
Supporting Families – 3 claims during 2021/22	Certified	-	0	-
Education Safeguarding	Exit Meeting / Draft	TBC	TBC	TBC
Addition: Five Acres Primary School – Financial Management Audit	Final	Amber	11	7 implemented, 3 partially implemented, 1 not yet due
Adults & Housing				
Payments to Providers	Exit Meeting / Draft	TBC	TBC	TBC
Client Charging	Final	Amber	5	4 implemented, 1 not yet due
Money Management	Final	Amber	6	2 implemented, 4 not yet due

Customers, OD & Resources – HR				
Well-being / Sickness Management	Final	Amber	6	6 not yet due
IR35 (off-payroll rules)	Final	Green	2	2 implemented
Customers, OD & Resources – Finance				
Treasury Management	Final	Green	2	1 implemented, 1 not yet due
Growth Board – Accountable Body Role	Final	Green	1	1 not yet due
Pensions Administration	Final	Green	5	1 not yet due, 4 due
Customers, OD & Resources – Finance / IT				
Payment Card Industry Data Security Standard (PCI-DSS)	Final	Green	5	2 implemented, 2 not yet due, 1 due
Customers, OD & Resources – IT				
Cyber Security	Final	Amber	13	11 implemented, 2 not due
IT "business as usual" Change Management	Final	Amber	5	4 implemented, 1 due
Software Asset Management	Final	Green	2	1 implemented, 1 not yet due
Data Centre	Final	Green	3	2 implemented, 1 not due
CDAI – Fire & Rescue & CODR – HR / Finance				
Gartan Payroll & HR Processes	Final	Amber	35	8 implemented, 3 partially implemented, 20 not due, 4 due
CDAI				
GDPR	Final	Amber	12	3 implemented, 8 not due, 1 due
Property & FM – Cleaning Asset Management	Final	Red	9	9 not yet due
CDAI / Corporate / Cross Cutting				
Fleet Management – Compliance	Final	Amber	5	4 implemented, 1 not due
Environment & Place				

Highways Contract Management	Exit Meeting / Draft	TBC	TBC	TBC
S106 – Spend	Final	Amber	6	6 not due

Grant Certification work completed during 2021/22:

- Building Digital UK – certified end of June 21 & April 22.
- Local Transport Capital Funding (included Integrated Highways Maintenance Grant and Pothole and Challenge Fund) – certified end of Sept 21.
- Additional dedicated home to school and college transport grant.
  Tranches 5 & 6 - certified end of Sept 21
  Tranche 7 – certified end of Oct 21
- OCC Disabled Facilities Grant – certified end of Oct 21
  Bus Subsidy Grant – certified Nov 21

Amendments to the 2021/22 Internal Audit Plan (since last update to Audit and Governance Committee January 2022)

Childrens	Family Solutions Plus	Due to issues with Internal Audit Resources for 21/22 (maternity leave and long-term sickness) two audits had to be removed from the plan during quarter 4.
Adults	Direct Payments	Due to issues with Internal Audit Resources for 21/22 (maternity leave and long-term sickness) two audits had to be removed from the plan during quarter 4. The audit has been deferred until quarter 1 of 22/23 internal audit plan.

Customers, OD & Resources	Music Service – follow up audit	The audit was started in March 2022, however due to staff sickness of key staff, and the resulting workload issues, it was agreed with the service that the completion of the audit would be deferred until May 2022. The service report good progress with implementation of actions agreed in the previous 2020/21 audit – this will be tested and confirmed in the follow up audit, now included within the 2022/23 internal audit plan.

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 2021/22 Audits since last reported to the Audit and Governance Committee - January 2022.

S106 Spend 2021/22

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

Introduction

Previous audits of S106 carried out in 2017/18 and 2018/19 focused on the determination and receipt of funding, identifying weaknesses around governance and internal controls. It is acknowledged progress has been made to address these weaknesses, including the ongoing implementation of a new IT system covering the whole S106 process. The focus of this audit was therefore on the second half of the S106 process, providing assurance over the systems in place across the Council for the spending of funding secured via S106 agreements.

Overall Conclusion

The overall conclusion of this audit is **Amber**. The sample testing carried out as part of the audit found that an effective process is in place for the release of S106 monies, with all spend sampled appropriately authorised and in line with the relevant agreement(s). Weaknesses were noted however with the recording and monitoring of expenditure and with the monitoring of longstop dates. Gaps in the provision of management information were also noted, although it is acknowledged this is pending the full implementation of the new ICT system, DEF, at which point performance information will be reviewed and new reports developed. It is intended that the new system will also improve the oversight of secured, held, and allocated contributions, particularly for service areas who have historically relied on the Planning Obligation Team's manual updating of Developer Funding Accounting Statements (DFACS) spreadsheets.

Key Findings

Reconciliation of Expenditure

While supporting documentation including forecast project costs is required at the business case and sign off stage, there are no subsequent checks or reconciliations carried out to confirm final costs were in line with the budget/available S106 funds, and that spend was in line with the agreement. Audit sample testing of 14 projects identified two instances in which project costs exceeded the value of secured contributions. This had not been picked up as part of project monitoring and governance.

It was also noted that services are not informed of project underspends / surpluses until the final account is complete and, for forward-funded projects, until all contributions are held (as opposed to secured), so services cannot start considering options for utilising forecast underspends, increasing the risk of the need to return funds to developers should longstop dates be reached. This was found to be the case for two of the education projects sampled.

One instance was also identified in which a contribution held by a District Council until the County Council could demonstrate the funds were being used for the purpose stated within the agreement (the agreement was between the developer and District Council, rather than OCC), had not been requested, despite the Council having entered into a 16-month contract. The Council has therefore incurred costs without obtaining the funds.

Recording of Contributions and Expenditure

Sample testing carried out as part of the audit identified errors and inconsistencies in the recording of expenditure on the DFACS spreadsheets. This was reportedly due to the inherent risk of manual data input and human error, with instances including one year's spend not being recorded against an agreement; a county wide project drawing on funds from 12 different agreements being recorded against one single agreement; and a contribution being received and spent, but not recorded on the spreadsheet.

It was reported the new system is intended to lead to improvements in this area, providing service areas with oversight of when an agreement is signed, the secured contributions, held contributions, and allocations to projects, with an interface between SAP and DEF to show received contributions in real time, rather than relying on the updating of DFACS spreadsheet.

Monitoring of Longstops

Weaknesses were noted with the monitoring of S106 agreements' longstop clauses, which state if received contributions are not spent or allocated within a specified period of time, the developer can request the contributions be returned. The dates are currently entered onto the team's DFACS spreadsheets and highlighted to services when reviewing contributions held, however sample testing identified several instances where this is not working or has not worked effectively, including two instances where spend occurred after the longstop date, and one in which a long stop date was linked to the opening of school, but was not being monitored as the team were not aware the school had opened.

Management Information

While there was awareness across the services reviewed of S106 funds secured, held, allocated, and spent, owing to cross service meetings, the shared DFACS spreadsheets (soon to be replaced by the DEF system), and bi-annual locality reports summarising the above information, there was found to be little performance monitoring in terms of S106 spend. This was acknowledged by the team, who reported that there is the intention to agree and implement KPIs in this area, following the completion data migration to the new system and subsequent development of reports.

Follow Up

Following the 2018/19 Audit of Section 106, 19 management actions were agreed or outstanding: 15 from the 2017/18 Audit and 4 from the 2018/19 Audit. All 19 have since been reported as fully implemented by management. A review of these as part of this audit found nine to have been implemented effectively and two to have been superseded (one as a result of the new ICT system and one due to changes to Government legislation). One action, relating to the introduction of a new KPI, was found to have not been implemented, however it is acknowledged performance reporting is being reviewed as a whole following the introduction of the new ICT system. The remaining seven were not tested as part of this audit as they fell outside of the scope, relating to the Single Response stage of the S106 process.

Garten Payroll and HR Processes 2021/22

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
Policies, Procedures, Roles and Responsibilities	**A**	**0**	**4**
Starters, Leavers and Temporary Variations	**G**	**0**	**2**
Accuracy of Garten Pay Data Input	**A**	**1**	**9**
Accuracy of Payments Made	**A**	**0**	**9**
Management Information	**A**	**0**	**5**
IT Controls	**A**	**0**	**5**
		1	**34**

Opinion: Amber	
Total: 35	Priority 1 = 1 Priority 2 = 34
Current Status:	
Implemented	8
Due not yet actioned	4
Partially complete	3
Not yet Due	20

The Gartan Payroll system is used by Oxfordshire Fire & Rescue Service (OFRS) for the logging of on-call firefighter activity. Data from Gartan Payroll is uploaded for payment to on-call staff on SAP / IBC via the Business Data Upload (BDU) process

Policies, Procedures, Roles and Responsibilities – The audit found that there are clear policies and procedures in place for on-call staff and managers covering key processes in relation to input to Gartan for on-call activity. It is noted that prior to the start of the audit, the Service reviewed existing guidance and have identified some inconsistencies and updates required and are working on these. The audit also noted some additional areas for improvement (for example inclusion of recording of sickness absence on Gartan and more detailed guidance on claiming for bank holiday activities). It was also found that guidance for managers on the Gartan payroll activity checking and approval process was limited. Current guidance, whilst explaining responsibilities for authorisation and that review of records is required, does not cover the level of checks expected prior to authorisation or what records / systems are expected to be used to carry out the checks to ensure a thorough and consistent approach.

It was noted that there was a gap in documented guidance for the Employee Resourcing and Relationship Team (ERRT) on the key processes carried out within that team in relation to on-call pay and HR processes, for example the BDU upload and failure process, accuracy checking of pay runs, responsibilities around the leaver process and the processes around the setting up and changing of permissions of Gartan users.

Starters, Leavers and Temporary Variations – Sample testing on variations identified one case where an employee had been underpaid due to incorrect information being provided on a training completion date. The controls in place for the recording, evidencing and notification of these types of promotions have been reviewed and improvements agreed with the service to prevent reoccurrence. There were also examples noted of delays in provision of information about changes to employee circumstances or roles which had impacted on the accuracy of payments made. These examples had already been identified and resolved prior to audit testing. It is noted that there is work ongoing between ERRT and the HR Manager Business Systems to enable OFRS to complete more of their indirect hire processes directly on IBC. Currently some moves can be processed on IBC, but promotions are processed using a separate spreadsheet. IBC app functionality (indirect hire app) is being developed which should enable promotions to be processed directly on IBC.

Other than the issues noted under the IT Controls section below on the disabling of Gartan accounts for leavers, no significant issues were identified in relation to the on-call starters or leavers processes.

Accuracy of Gartan Pay Data Input – From review of the processes in place for recording on-call activity on Gartan for approval and then for payment, the following control issues were identified.

It was found that Level 1 approvers (Crew Managers or Watch Managers who review and complete the first stage authorisation for all activities in their area prior to payment) are able to add and authorise their own activity increasing the risk of financial loss due

to error or fraud. There was one example noted where a L1 had added and approved their own activity, this was reviewed with the Group Manager and found to be a legitimate activity / payment.

There were several areas where it was noted that staff guidance and management oversight need to be enhanced to ensure that on-call payments are accurate. This includes claims for time voluntarily worked on bank holidays which, unless the claim is for an incident, needs to be recorded in a specific way in Gartan so that overtime is not paid in error. Staff need to be aware of the correct process and management need to check that the correct process is being followed. There were also areas where concerns were raised by the ERRT in terms of consistency in approach, guidance and management oversight in relation to tasks completed for the Resource Management Team which can be paid at a different grade, and also on the way in which TOIL is accrued in some circumstances.

During the audit, ERRT reported that a number of unauthorised activity reports had been found. These reports, going back to 2015, may include transactions that Level 1 or 2 managers have determined should not be paid (although this is not clear from the reports) as well as transactions which have been overlooked (potentially due to manager absence, or incorrect date ranges being used during the management checking and approval process) and do need to be reviewed and approved. Audit testing on a small sample of transactions has identified examples where payment needs to be made. The same issues were identified during the previous audit. ERRT have, during the course of the current audit, changed their processes so that unauthorised activity reports are identified and followed up promptly going forward. Management actions have been agreed in relation to clarifying the reporting and checking process and requirements with managers and in ensuring that the backlog of reports are reviewed with any payments due being made.

Accuracy of Payments Made - From review of the BDU upload process used to transfer information on the number of hours paid from Gartan Payroll to IBC / SAP where the payroll payments are calculated, it was noted that ERRT have recently made a number of improvements to the process. Control total checks on the total number of lines uploaded from Gartan to the total number of lines processed by the BDU are now undertaken as are sample checks on the accuracy of payments made. ERRT are working with the Finance Helpdesk to improve BDU processes further in areas including dealing with lines that fail during the upload.

ERRT also reported two issues which have resulted in incorrect payments being made to staff. A Gartan system issue has resulted in some staff not being paid correctly when providing cover for dual stations. It has been reported that payment errors have now been corrected and that a system fix is being pursued with Gartan. Pending that, there is an interim process in place to ensure staff are paid accurately. Accuracy issues were also reported (identified by the service prior to this audit) in relation to on-call holiday pay. Significant delays in obtaining average earning information meant that a number of staff have been either over or under paid for their on-call holiday entitlement for the 2020/21 and 2021/22 financial years. These inaccuracies in payment are in the process of being resolved. There are now clear processes in place for ensuring the required information can be obtained on a timely basis going forward.

Management Information – Issues with the assurance the cost centre manager has over the management checking and approval process were identified during audit testing. Lack of awareness of management responsibilities in relation to on-call payment checks was noted from audit testing, along with inconsistencies in checking and documentation of checks. Immediate action was taken by the cost centre manager to clarify responsibilities and process and make improvements so that assurance was improved. There is now clarity over expectations of management checks and processes from level 1 approvers upwards, and these clarifications and amendments will now be incorporated into the relevant staff guidance.

From review of budget monitoring information, it was noted that there were some wholetime costs included in on-call budget lines. This is being investigated by the service to establish why this is and whether there is any impact on the accuracy of pay and / or budget monitoring. It has been reported by ERRT that initial indications are that these are errors with coding which do not have an impact on pay or budget monitoring.

There is also work ongoing to improve the detailed checking and oversight of payroll transactions and to clarify processes in relation to some aspects of the monthly budget monitoring routines.

IT Controls – From review of Gartan Payroll and user permissions, it was noted that there are a number of people within ERRT, the Data Systems Team and Resource Management Team, in addition to the members of staff who are directly involved in processing Gartan payroll who have the highest level of administration rights. It was ascertained that there hasn't been any review of user roles and permissions for some time and it has been agreed that it would be helpful to review current arrangements and rationalise this level of access.

Audit testing also noted that leavers user accounts in Gartan Payroll and Availability have not been disabled, it was reported that this was due to a misunderstanding over responsibilities. Although contracts have been ended on the system which reduces the risk of erroneous or fraudulent payments being made as this would mean that no activities could be assigned to that user, it is not clear whether there are any potential implications in relation to leavers who had administration roles. This issue goes back to when the system was introduced and is an issue that was raised as part of the previous audit. A full review of user ID's and permissions is to be undertaken with all leavers ID's disabled. There is also now clarity over roles, responsibilities and process for ensuring that leavers user ID's are disabled promptly going forward.

Follow up – 3 management actions were agreed following the 2015/16 Gartan Payroll audit, all were reported as fully implemented. Testing undertaken during this audit has noted partial implementation of these actions. Management actions have been raised within this report to fully address the remaining issues.

IT Data Centre 2021/22

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
IT Roles and Responsibilities	**G**	**0**	**0**
Documentation	**G**	**0**	**0**
Infrastructure Monitoring	**G**	**0**	**1**
Supplier Management	**G**	**0**	**2**
		0	**3**

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

The OCC data centre is co-located in Birmingham with an external supplier. A service fee is paid for space, power and cooling to house corporate computer infrastructure and networking components. There is a primary data centre for all production equipment and a secondary data centre for disaster recovery purposes.

The Technical Services Team within ICT Services are responsible for managing and monitoring all computer hardware in the two data centres. The team is led by the Technical Services Manager and structured around Principal Technical Consultants, Senior System Engineers and System Engineers. The roles and responsibilities of team members is documented within job descriptions and skills and expertise is available in relevant technologies e.g., Cisco, VMware, Microsoft, Dell etc. A skills matrix is also available to show the proficiency of team members in the different technologies.

A network schematic is documented and maintained for PSN compliance and other schematics are being developed. The supplier performs a weekly visual check of all equipment in the two data centres and provide details of this in a report to IT Services. The report shows all the equipment and highlights any with a warning or error light that needs to be investigated.

Performance monitoring of computer infrastructure and networking equipment within the data centre is undertaken using specialist tools designed for this purpose. For

infrastructure, testing confirmed that monitoring includes processing power, disk space and memory utilisation. Details on the configuration of infrastructure is available within the monitoring tool. The monitoring tools for infrastructure and networking equipment are both configured to send alerts of any potential faults or errors. For infrastructure, a sample review of the alerts identified no risk areas but for networking equipment we found there has been no recent review of the available alerts to confirm they cover all critical events and equipment. We also found that some of the alerts are only sent to the monitoring tool's management console and are not emailed to any person, which for critical alerts or equipment could lead to a delay in relevant technical teams being notified of a problem. The recent refresh of infrastructure in the data centre means there are no current capacity issues. Capacity is reviewed on a monthly basis, primarily to ensure there is sufficient compute and storage available at the secondary data centre for recovery purposes.

There is a formal contract with the supplier for the provision of data centre services, which runs until February 2023. A review of the contract found that it does not define any service level targets or key performance indicators. Service levels are defined within a separate "Operations Manual" and reported against in the monthly service management report. Confirmation should be sought that these service levels are covered under the terms and conditions of the contract to ensure they are enforceable. Service review meetings were held with the supplier when the data centre was initially established but they are no longer held as they stopped being useful. This is on the basis that IT Services are happy with the service and are in regular contact with their Service Delivery Manager should any issues need to be raised. IT Services have confirmed that the supplier is very reactive to issues that are raised with them.

The contract states that the supplier should maintain a business continuity plan which should be tested at least annually. We found that evidence of this has not been confirmed to provide assurance that the supplier has effective arrangements to recover services in the event of a major incident at their site.

Pensions Administration 2021/22

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Regulatory Framework	**G**	**0**	**0**
B: Scheme Member Lifecycle	**A**	**0**	**3**
C: Scheme Employers	**G**	**0**	**0**
D: Debtor Management	**A**	**0**	**2**
		0	**5**

Opinion: Green	
Total: 5	Priority 1 = 0 Priority 2 = 5
Current Status:	
Implemented	0
Due not yet actioned	4
Partially complete	0
Not yet Due	1

Overall, audit testing found that controls and processes in relation to Pensions Administration are strong and working well.

Whilst there have been some resourcing issues which have meant that temporary changes to SLA targets have been needed, performance is now improving, and standard SLA targets will be back in place from the start of the new financial year. There have also been some delays in completing vetting checks on scheme employer data, however these are being managed, monitored and reported on regularly. It is expected that all checks required will have been completed in time for year-end processes.

There have been delays in the implementation of the Administration to Pay system. Three of eight areas have now been implemented, with the other five due to have been implemented by the end of January 2022. This timetable has slipped, and the project has been put on hold whilst the team complete the strategic planning process which will cover future developments and projects including the implementation of the remaining parts of Administration to Pay. It is intended that this process will introduce strengthened governance which will increase scrutiny and oversight in terms of delivery and will look at resourcing and timescales to ensure successful implementation.

The Payjour reporting and sign off process, which demonstrates that there has been sufficient review of activities completed in running the pensions payroll by those officers with the highest levels of system access rights, is currently stalled due to technical difficulties in running the report.

There were some improvements in debtor management and debt recovery over the year. Following the successful recruitment of an Office Administrator, with responsibility for debt monitoring and recovery, outstanding debts were followed up between August and October 2021. Unfortunately, following the resignation of the Office Administrator in late 2021, these processes have paused while recruitment of a replacement is progressed.

Follow up – of the three actions followed up on as part of this audit (two from 2020/21 and one from 2019/20), one had been reported as fully implemented but was not found to have been effectively implemented and two have been partially implemented. Where appropriate, re-stated or revised actions have been agreed within this report. Where implementation is ongoing and the original action is still relevant, Internal Audit will continue to monitor implementation through the standard audit follow up process.

Treasury Management 2021/22

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
IT Systems	**G**	**0**	**2**
Strategy, Policy & Procedures & Reporting	**G**	**0**	**0**
Investments	**G**	**0**	**0**
Hardware Disposal	**G**	**0**	**0**
Borrowings*	**n/a**	**n/a**	**n/a**
Cash Flow Management	**G**	**0**	**0**
		0	**2**

** No borrowings have taken place during the last 12 months, so no testing has been undertaken in this area as part of this audit.*

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

Overall, audit testing has found that the key controls and processes in relation to Treasury Management are strong and working well.

Since the previous audit, the Council's online banking system has changed, Lloyds Commercial Banking Online (CBO) was implemented in November 2021. The Treasury Manager identified a change to the functionality in relation to being able to freeze transactions which meant that there was a loss of system control which would prevent changes to investment transactions prior to authorisation. An interim solution was implemented immediately to address this, and a permanent solution has been identified and is in the process of being implemented. This will move the documenting of the dealer to verifier to authoriser process on to the Lloyds CBO system. The team have also adapted their processes to move from manual paperwork to support the

dealing, verification and authorisation process to electronic evidencing via email. Although this was initially driven by the changes needed to working practices at the start of the pandemic, the solution the team are implementing to move the verification process online will mean that there is a more robust and streamlined audit trail covering the investments entered into by the team.

Review of access to shared folders identified some examples where access arrangements were not appropriate. These arrangements have been changed without the approval of the Treasury Manager who last confirmed access requirements with ICT in May 2021. Current arrangements are being reviewed and updated.

Management Letter on Supported Families March 2022 Claim

Introduction

The current claim consists of 150 families for **Significant & Sustained Progress (SSP),** however due to the high number of families already claimed for this year, the maximum that can be claimed for March is 138. This brings the total for the year to the MHCLG's target of 498 families. The MHCLG has previously confirmed that remaining families (12) can be submitted at the start of April when the window reopens, forming part of next year's claim.

The audit of the previous claim (October 2021) identified no issues or management actions, owing to the previous improvements to the process for identifying duplicate claims and updates to the Think Family Outcome Plan. All previous actions from previous audits have been implemented.

Scope of work

The audit checked a sample of 10% of the total SSP claim (15 families) to ensure that they met the relevant criteria for payment and had not been duplicated in the current or previous claims. Their initial eligibility criteria for inclusion in the Programme were also checked.

Overall Conclusion

The audit noted the improvements in the internal processes for data checking and validation made following previous claims have remained effective. Testing for duplicates found no families that have previously been claimed for, and no issues were identified with the eligibility or sustained progress of the families sampled.

Due to satisfactory responses having been received for all queries raised by Internal Audit, this claim can be signed off for submission.

As such, no audit findings or management actions are required.

Five Acres Primary School 2021/22

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: Financial Management Governance	**A**	**1**	**2**
B: Budget Management	**A**	**1**	**0**
B: Procurement	**A**	**0**	**1**
C: Income	**A**	**0**	**3**
D: Payroll	**A**	**0**	**3**
		2	**9**

Opinion: Amber	
Total: 11	Priority 1 = 2 Priority 2 = 9
Current Status:	
Implemented	7
Due not yet actioned	0
Partially complete	3
Not yet Due	1

The audit focussed on key financial management processes, including budget management, procurement, income and payroll. There have been some changes in key members of the Governing Body, with the new Chair keen to review and improve governance and financial management. Weaknesses noted included issues with the delivery of the deficit reduction plan, evidencing of decisions by the pay committee, approval of purchases, bank reconciliations, treatment of VAT and approval of expense claims. Appropriate management actions were agreed to address all the weaknesses identified and, since conclusion of the audit, a significant number of these actions have already been reported as implemented.

Money Management 2021/22

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: Policies & Procedures	**A**	**0**	**1**
B: IT Systems	**A**	**0**	**1**
C: Service Provision	**G**	**0**	**0**
D: Management of Service Users' Finances and Bank Accounts	**A**	**0**	**4**
		0	**6**

Opinion: Amber	
Total: 6	Priority 1 = 0 Priority 2 = 6
Current Status:	
Implemented	2
Due not yet actioned	0
Partially complete	0
Not yet Due	4

The audit confirmed appropriate guidance is in place for social care teams and the general public in relation to the Money Management Service. There is also comprehensive guidance for Money Management staff although it was noted parts of the main piece of guidance, the Money Management manual, have been superseded by newer guidance, and therefore guidance available to staff requires review and update to reflect current processes and systems.

Review of the two main IT systems used by the Money Management Team found the CASPAR system to be operating effectively, with work underway to commission and implement a new Cloud based CASPAR system. In relation to the payment system, issues were reported with the functionality of the new Lloyds CBO system, which has recently been rolled out by Lloyds to replace the decommissioned LloydsLink. It was confirmed issues experienced across the Council are being recorded centrally and reported back to Lloyds for resolution.

The security arrangements for both systems were found to be appropriate, although the review of user accounts on CASPAR did identify inconsistencies in access permissions for Money Management Officers (who all carry out the same role). This should be resolved with the implementation of the new CASPAR Cloud system which

include roles with predefined permissions to be set up, which the team members will be allocated to.

A review of the Money Management waiting list noted the positive performance in regard to managing referrals, with the average number of service users on the list per month reducing from 78 in August 2021 to 38 in January 2022. Analysis showed the average number of days on the waiting list as of March 2022 is 224. This is reportedly due to delays caused by Covid and is expected to improve as pressures relax. The audit also noted the improvements in managing the waiting list, with service users graded from 1-5 for prioritisation and any urgent cases highlighted.

A review of processes within the Money Management service found service users' finances are being handled effectively. Each service user sampled had a payment plan in place to ensure bills / charges are being paid as necessary, and the service user is in receipt of a suitable personal allowance. Those with no expenditure recorded or where expenditure is higher than income were queried with Money Management Manager who confirmed there were suitable reasons. Samples of debt, cash / cheque income, the setting up and closing down of accounts and direct debits confirmed processes are operating adequately.

All BACS and cheque payments reviewed during the audit were found to have been authorised appropriately, although it was noted in relation to cheque payments, four of the ten sampled did not have a payment request form recorded on LAS. In relation to Deputyship and Appointeeships, all relevant documentation could be located as required.

A review of Pre-Paid Cards (PPCs) and Companionship Cards (CPPCs) found that assessments on suitability are not consistently being recorded on CASPAR. It was also found that reviews on expenditure and balances of PCCs and CPPCs were not being carried out. This was queried with the Money Management Manager who confirmed that assessments on suitability are not consistently being recorded as the process has developed and reviews on expenditure can be difficult as most PPCs are only used to withdraw the full amount available in cash. Pre-Paid Cards are now the main method for service users to receive funds and the Money Management team have acknowledged that this is an area for improvement and are currently reviewing the PPC process.

Money Management was audited last in 2016/17. Of the three management actions agreed, it was found that two had been fully implemented with controls (or adequate controls if the process had changed) in place and operating effectively. The remaining action was in relation to Pre-Paid Card checks which has been highlighted above.

Final Management Letter – Growth Board Accountable Body Role 2021/22

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

Introduction

The Oxfordshire Growth Board, now called the Future Oxfordshire Partnership, was established in 2014 for the purpose of facilitating and enabling collaboration between Oxfordshire local authorities and other bodies operating in Oxfordshire in relation to economic development, strategic planning and growth. The Future Oxfordshire Partnership is a joint committee of the six councils of Oxfordshire together with key strategic partners. It plays a key role in coordinating local efforts to manage economic, housing and infrastructure development in a social and environmentally beneficial way in Oxfordshire. It also secures funding to achieve its aim of infrastructure development. Oxfordshire County Council is the designated Accountable Body for the Growth Board providing Section 151 and Monitoring Officer related services to the Committee in accordance with the Memorandum of Understanding between Oxfordshire County Council and the Oxfordshire Growth Board / Future Oxfordshire Partnership.

The Housing and Growth Deal funds infrastructure and affordable housing and supports Oxfordshire's ambition to plan and support the delivery of up to 100,000 new homes across Oxfordshire between 2011 and 2031.

Scope of work

The audit was focussed on the Council's role as Accountable Body rather than as a delivery partner.

An audit of Capital Programme – Major Infrastructure will be completed as part of the 2022/23 Internal Audit Plan. This audit will provide assurance over the governance and processes in place for a sample of major infrastructure schemes that are funded by the Housing and Growth Deal.

Conclusion / Key Findings

Our overall conclusion is "Green", it was found that there is a strong system of internal control in place and risks are being effectively managed.

Governance – It was found that there are sufficient governance arrangements in place for the Council to be able to discharge its responsibilities as Accountable Body and the Council's responsibilities as Accountable Body were found to be clearly defined. Reporting requirements were clearly specified and were found to be operating as expected.

It was confirmed that there is a Memorandum of Understanding (MOU) which was approved by each local authority's Cabinet or Executive in July or August 2020.

Although it was not possible to confirm that this was reviewed or updated in 2021, no omissions were noted in terms of what is required of the Council in carrying out it's role as Accountable Body.

Financial Management & Procedures – The audit found that adequate financial management process and procedures are being applied, including the monitoring and reporting of funding received, compliance with grant conditions, and the payment of funding to delivery partners.

Final Management Letter on Provision Cycle – Prepare, Tender, and Implement and Provision Cycle – Manage and Review

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

Introduction

In January 2021 the Council established a new provision cycle structure, with the aim of providing a streamlined and consistent approach to procurement, commissioning, and contract management activities, and, with a focus on type of spend rather than source, reduction of duplication, improved strategic oversight, and consistency of processes.

The 2021/22 Internal Audit plan included two audits to provide high level assurance over the implementation of improvements through the provision cycle work: one on contract procurement and one on contract management. While these pieces of work were carried out separately, a number of weaknesses were found to cover both areas, so findings have been combined into one overall audit report.

Overall Conclusion

The overall conclusion of the two audits is **Amber**. In relation to contract procurement, sample testing confirmed the procurement methods used were appropriate in all cases. Supporting documentation to evidence compliance to the CPRs and established procedures could also be demonstrated in the majority of cases, with minor exceptions noted including non-financial due diligence checks (e.g. confirmation of relevant insurance cover), and arrangements in relation to conflicts of interest and confidentiality statements.

In relation to contract management, testing identified varied levels of activity across the sample reviewed. For some contracts, evidence to support good contract governance, monitoring of contractor performance, and management of risks could be provided upon request. For others, contract monitoring activity was found to be minimal, with regular contract meetings not taking place, performance measures either

not being established or monitored, and other requirements included in the contract not being enforced, such as annual due diligence checks, review of business continuity plans, and obtaining assurance around information governance. In one area reviewed, weaknesses were also identified around monitoring actions assigned to contractors, such as requests for documentation.

It is acknowledged that a number of weaknesses in contract management fall within the recent Health, Education & Social Care Commissioning (HESC) restructure, where large staff turnover as well as reacting to the Covid-19 pandemic to ensure continuity of service, has meant business as usual has not been possible. This is recognised within the relevant services, with action being taken to address known issues.

Sample testing across both audits noted an inconsistent approach to the use of Atamis, the Council's contract management system, including the recording of contracts, uploading of supporting documentation, and accuracy of listed contract managers. This reduces the strategic oversight and support the procurement hub are able to provide.

Guidance was found to be available to all staff and accessible via the intranet, although requires review and update to ensure it reflects current practice.

Further audits focusing on specific areas of the provision cycle will be carried out as part of the 2022/23 Internal Audit Plan.

FM – Cleaning Services Asset Management 2021/22

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: Procurement	**R**	**2**	**2**
B: Asset and Stock Control	**R**	**1**	**3**
C: Disposals and Losses	**R**	**0**	**1**
		3	**6**

Opinion: Red	
Total: 9	Priority 1 = 3 Priority 2 = 6
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	9

Background

The in-house Cleaning Service within Facilities Management was established following the collapse of Carillion in 2018. It has a budget of £1.5m, comprises of 5 Managers, 102 cleaners employed by OCC and also engages an external cleaning firm to provide additional cleaning provision for OCC's estate.

At the request of the Corporate Director, the audit reviewed the robustness of the asset management controls following a theft of hoovers in Q3 2021 by an employee (who has been dismissed). Overall, the audit identified some improvements to asset control processes following the theft, however noted weaknesses in this area still existed, resulting in an ongoing risk of fraud, theft or wastage. There are no service procedures in place to clarify responsibilities and to guide Officers on the correct process to follow with regards purchasing cleaning products and equipment, receiving, recording and monitoring assets and stock. The Facilities Management service are aware there are weaknesses and have plans in place to address these during the course of the year.

The audit reviewed the full cycle of asset management, from asset procurement to asset controls through to disposals.

Procurement

The Cleaning Service procures cleaning equipment and consumables from a local supplier. The audit noted that a procurement exercise to engage this supplier (in use by the Council since 2016) was not undertaken by the Service. There is no contract in place with this supplier. The Council's Contract Procedure Rules require a full tender process for contract values over £75k.

Audit testing identified that whilst orders with the supplier should be placed by the Cleaning Managers, in reality these are also being placed by the Cleaners direct with the supplier, with little oversight or control within the Service over the volume and values being ordered.

The oversight of purchase orders and budget monitoring is blurred as the purchase orders are not raised and approved within the Cleaning Service. Audit testing identified Purchase orders raised retrospectively because previous Purchase order values had been exceeded without the Service's knowledge.

Asset and Stock Control

The new Asset Register developed in November 2021 following the theft of hoovers is one of the first steps towards improving asset control. It is still a work in progress, however the audit testing identified errors including missing or duplicate serial and asset numbers, assets missing from the Register and assets not located in their expected location. There is no management oversight or spot checks of the Register to ensure it is comprehensive, up-to-date and quality controlled. Of the 30 new hoovers purchased in January 2022 to replace the stolen hoovers, only 1 had been asset tagged and logged on the Asset Register.

There are no stock control records at the main storage site, which is accessed by multiple staff. At this site there are large volumes of cleaning stock which have been there for over two years. Stock counts and usage analysis is not routinely undertaken so the Service do not know the quantity of stock available and in use.

Disposals and Losses

According to the Asset Register, of the 268 assets listed, 16 have been marked 'disposed' (mostly hoovers). The audit checked the process followed for disposal but there were no records available to document how or where the assets were disposed of or who had signed off. The process was informal, with some Officers verbally informing Internal Audit that in some cases assets were disposed of to charity or sold for a nominal amount.

Wellbeing and Sickness Management 2021/22

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: Policies & Procedures	**A**	**0**	**4**
B: Sickness Recording	**G**	**0**	**0**
C: Sickness Management & Monitoring	**A**	**0**	**2**
D: Staff Wellbeing	**G**	**0**	**0**
E: Management Information & Reporting	**G**	**0**	**0**
		0	**6**

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

The Council aims to have the healthiest and highest attending workforce possible for both the benefit of the Council as a whole and individual employees. There is a "Monitoring and managing sickness absence policy" which sets out the responsibilities and procedures which aim to achieve this. The Council also provides comprehensive wellbeing support, guidance and resources to managers and staff.

It is noted that there has been an internal project within HR which has covered the sickness absence reporting and management process. This was initially focussed on a specific service area, but also considered the effectiveness of corporate policy and procedures. It is understood that this project (separate from this audit) has recently been reported on to HR management, with actions resulting from this to include an updated Sickness Absence Policy, additional clarification on roles and responsibilities of employees, managers and HR and production of improved training materials and template documents to assist in the management of sickness absence. There will also be changes to the way in which sickness absence cases are monitored, managed and overseen within HR.

Sickness absence is an area which is kept under review by senior HR management with changes to process implemented where issues are noted, for example the move to managers being made responsible for recording the start of their employee's sickness absence to improve the timeliness of recording (employees are still able to record their own sickness absence as well). The latest report to Cabinet identifies that there have been positive improvements in timeliness of recording since this change was implemented and, as a result of this, the Council is able to monitor levels of sickness absence and working time lost more effectively. This is supported by the testing and analysis completed as part of this audit.

The audit noted that there is clear guidance available to managers and staff on the process for reporting sickness absence. In relation to the management of sickness absence, there is guidance which sets out the process, although the informal absence management process (where sickness absence triggers have been reached, but prior to the commencement of the formal process) could be enhanced with more detail and direction on the expectations of management. There is training available for managers on management of sickness absence, this includes training delivered as part of an essential (mandatory) training programme for new managers. The take up of this training is not currently monitored and reported on, however manager training for both existing and new managers will be reviewed and refreshed as part of the Leadership & Management workstream within the Delivering the Future Together programme. This will include sickness absence training and will cover both new and existing managers. As noted above, training materials are also being developed for use in the training of line managers in the interim, which will feed into the training being developed under the DTFT programme.

Non-compliance and inconsistencies in the approach to the management of sickness absence was identified from the testing undertaken as part of this audit. Testing on routine sickness absence process recording found examples where return to work discussions had not been documented. It is the expectation of HR Management that return-to-work discussions are documented for all sickness absences. Enhancements to policy guidance and manager training will assist in making these requirements explicit and should improve compliance. The process followed once employees hit sickness absence triggers was also found to vary, there were cases where absence review meetings, which must be conducted as part of the sickness management process when triggers are reached, had not taken place and examples where improvements to the support provided by managers to enable their staff to return to work could be made. It is the responsibility of managers to support their staff and manage the sickness absence process, however HR also have a role. It was noted that HR Advisers were aware of and were involved in most of the cases sampled, however there were some inconsistencies in approach and involvement.

A clear and comprehensive approach, resources and guidance in relation to staff wellbeing was noted with regular reminders to staff about specific wellbeing issues, the availability of

the Employee Assistance Programme (EAP) for staff and managers, wellbeing newsletters and training courses and seminars on a variety of topics. A draft strategy has been produced, and the Council are going through the Thrive accreditation process. The stress risk assessment and Wellbeing Action Plan documents have been reviewed and combined, with their use being promoted amongst managers through managers briefing emails. It has also been reported that HR Business Partners and Advisers and the Health & Wellbeing Manager are promoting the use of this tool where appropriate.

Management information on sickness absence was found to be produced and reported on frequently. There is appropriate reporting to Cabinet, and to DLTs. It was observed that HR are analysing the information available and reviewing this against other information, for example Occupational Health (OH) referrals, to identify where there could be a need for additional improvements. Workforce data is being published as expected. Managers also have the relevant information available to them on staff sickness absence.

Follow up – of the 4 management actions reviewed, 3 have been reported as implemented and 1 is no longer relevant.