Division(s): N/A

AUDIT & GOVERNANCE COMMITTEE – 9 JANUARY 2019

INTERNAL AUDIT 2018/19
PROGRESS REPORT

Report by the Director of Finance

EXECUTIVE SUMMARY

1. This report provides an update on the Internal Audit Service, including resources, completed and planned audits. A separate update is made on counter-fraud activity, which will be reported to the March Audit & Governance Committee.
2. The recent recruitment activity within Internal Audit was unsuccessful and an update on the recruitment strategy will be made at the meeting. With a combination of the current bought in resources and some audits needing to be deferred to the 19/20 plan (as more appropriate timing for those audits to be completed), the remaining plan is on track for delivery.
3. The report includes the Executive Summaries from the individual Internal Audit reports finalised since the last report to the September Committee. Two of these reports have been graded Red. The first is Health & Safety, the full report was considered by the October Audit Working Group and officers have been invited back to the February Audit Working Group meeting to provide an update on the implementation of actions. The second, is the Audit of Contingency Care, this will also be considered at the February Audit Working Group meeting when officers will attend.

RECOMMENDATION

The Committee is RECOMMENDED to note the progress with the 18/19 Internal Audit Plan and the outcome of the completed audits.

PROGRESS REPORT:

RESOURCES

4. As reported to the A&G Committee in November, the two Principal Auditors have been re-designated as Audit Managers, with one also taking on the management of the counter-fraud activity.
5. The Senior Auditor post was advertised and interviews undertaken however no appointment was made. An update will be made to the meeting regarding Internal Audit recruitment strategy going forward.
6. The two auditors continue with professional studies, as well as the Audit Manager, all are on track to complete their professional exams by Summer 2019 when they will have achieved the Chartered Internal Audit qualification.

2017/18 INTERNAL AUDIT PLAN - PROGRESS REPORT

7. The 2018/19 Internal Audit Plan, which was agreed at the April Audit & Governance Committee, is attached as Appendix 1 to this report. This shows current progress with each audit.
8. There have been 9 amendments to the plan for 2018/19, 2 additions to the plan and 7 audits that have been deferred until 2019/20. These are also recorded in Appendix 1. The plan and plan progress will be reviewed again with the individual directorate leadership teams during January and February.
9. There have been 7 audits concluded since the last update (provided to the September meeting of the Audit and Governance Committee); summaries of findings and current status of management actions are detailed in Appendix 2. The completed audits are as follows:

Directorate	2018/19 Audits	Opinion
Corporate / Cross Cutting	GDPR	Amber
Communities	Income	Amber
Corporate / Cross Cutting	Health & Safety	Red
People – Children's	Thriving Families – September Claim	n/a
People – Children's	Early Years Census	Amber

People – Children's	Children's IT System Implementation Review 2018/19	Amber
People – Adults	Contingency Care	Red

The following grants were reviewed and signed off by Internal Audit at the end of September 2018:

- Disabled Facilities Grant (DFG)
- National Productivity Investment Fund Grant (NPIF)
- Highways Maintenance Challenge Fund Grant (HMCF)
- Integrated Transport (IT) and Highways Maintenance (HM) Block Grant
- Safer Roads Fund Grant
- Pot Hole Action Fund (PAF) Grant
- Flood Resilience Fund Grant
- Bus Subsidy Revenue Grant

PERFORMANCE

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

Performance Measure	Target	% Performance Achieved for 17/18 audits (as at Dec 18)	Comments
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc)	75%	Previously reported year-end figures: 2017/18 80% 2016/17 60% 2015/16 58%
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	75%	Previously reported year-end figures: 2017/18 95%

			2016/17 94% 2015/16 96%
Elapsed Time between issue of Draft report and issue of Final Report.	15 days	68%	Previously reported year-end figures: 2017/18 92% 2016/17 75% 2015/16 48%

The other performance indicators are:

- % of 2018/19 planned audit activity completed by 30 April 2019 - reported at year end.

- % of management actions implemented (as at 5/12/18) - 70%.
  Of the remaining there are 19% of actions that are overdue and 11% of actions not yet due.

  (At September 2018 A& G Committee the figures reported were 60% implemented, 17% overdue and 23% not yet due)

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

COUNTER-FRAUD

11. The 2018/19 Counter-Fraud Plan progress update was presented to the November 2018 Audit & Governance Committee, the next update will be reported to the March 2019 Audit and Governance Committee.

Sarah Cox
Chief Internal Auditor

Background papers: None.
Contact Officer: Sarah Cox: 07393 001246

APPENDIX 1 - 2018/19 INTERNAL AUDIT PLAN - PROGRESS REPORT

Audit	Planned Qtr start	Status – as at 19/12/18	Conclusion
People:			
People: Financial Management	Q1/Q2	CIPFA Self- Assessment review complete Small number of FM audits at establishment/ service level been undertaken	FM action plan produced
People: Contract Management - Supplier Resilience	Q2	Fieldwork	
Adults: Payments to Providers (Home Support and Residential)	Q1	Final Report	Amber
Adults: Waiting List	Q1/Q2	Exit Meeting	
Adults: Client Charging (including ASC debt)	Q3/Q4	Fieldwork	
Adults – Contract Management – Reablement – Contingency	Q1/Q2	Draft Report	Red
Adults – Implementation of pre-paid cards for direct payments	Q4	Scoping	
Children – Implementation of IT system	Q2-Q4	Final Report	Amber
Children: Retention, including training and development	Q2	Fieldwork	
Children: Foster Payments	Q4	*Deferred to 19/20 plan	n/a
Children: Children's Social Care Payments	Q4	*Deferred to 19/20 plan	n/a
Children: Thriving Families	Q2/Q4	Sept claim – complete March claim – Q4	n/a
Children: Thames Valley Adoption Service	Q3/Q4	Scoping	
Children: EDT (Emergency Duty Team)	Q1	Final Report	Green
Children: Care Placements	Q3/Q4	Scoping	
Children: Census Team	Q1/Q2	Final Report	Amber
Communities			

Communities: Financial Management	Q1/Q2	CIPFA Self- Assessment review complete Small number of FM audits at establishment/ service level been undertaken	FM action plan produced
Communities: Financial Management – Income	Q1	Final Report	Amber
Communities: Security Bonds reconciliation	Q3	*Addition to plan 1st stage - Complete	n/a
Communities: Highways Contract Payments	Q2/Q3	Scoping	
Communities: Waste - Contract Management	Q3	Fieldwork	
Communities: S106	Q4	Fieldwork	
Communities: Property - Facilities Management	Q3/Q4	Scoping	
Communities: Broadband Project	Q3	*Addition to plan Fieldwork	
Communities / Resources:			
Communities / Resources: Capital Programme – Governance and Delivery	Q3	Fieldwork	
Communities / Resources: Oxfordshire Housing and Growth Deal – Accountable body	Q4	*Deferred to 19/20 plan	n/a
Resources:			
Resources: Financial Management	Q1/Q2	CIPFA Self- Assessment review complete Small number of FM audits at establishment/ service level been undertaken	FM action plan produced
Finance - Pensions Administration	Q3	Fieldwork	
Finance - Purchasing / Procurement (covering pre-paid cards – see adults above)	-	-	-
Finance - Payroll	Q4	Scoping	

Finance - Accounts Receivable	Q4	Scoping	
Finance - Treasury Management	Q3	Fieldwork	
ICT – Back-up and Recovery	Q3	*Deferred to 19/20 plan	n/a
ICT - IT Incident Management	Q3	*Deferred to 19/20 plan	n/a
ICT - Data Centre Refresh	Q3	*Deferred to 19/20 plan	n/a
ICT - Network Management	Q1	Final Report	Green
ICT - Internet and Email Access (Cyber Security)	Q4	Scoping	
Corporate / Cross Cutting – Governance:			
Fit for the Future – governance arrangements	Q1	Final Report	Amber
Fit for the Future – new Target Operating Model	Q3 onwards	*Deferred to 19/20 plan	n/a
GDPR – General Data Protection Regulation	Q1/Q2	Final Report	Amber
Health & Safety	Q1	Final Report	Red
Business Continuity	Q2	Draft Report	
Grants:			
Grant Certification	Q1-Q4	8 now complete	n/a

Amendments to 2018/19 plan:

Directorate	Audit	Status
Communities / Resources	**Deferred to 19/20: Oxfordshire Housing and Growth Deal – Accountable body** This audit will look to provide assurance that Oxfordshire County Council has robust processes in place to deliver its role as the accountable body.	Agreed with Lorna Baxter to defer this audit until early 2019/20 Internal Audit Plan. The Audit & Governance Committee will be provided with a briefing on Growth Deal governance arrangements at the March 2019 meeting.
Communities / Resources	**Addition to Plan: Security Bonds Reconciliation** Following the audit of Security Bonds 2017/18, graded red, there was some uncertainty over the total value of cash bonds held and a lack of assurance as to whether they were properly accounted for. A full reconciliation was therefore required to confirm what cash bonds the Council should have and where this cash is held. Internal Audit have been asked to verify the reconciliation process.	Complete
Communities	**Addition to Plan: Broadband Project** At the request of the Director for Planning and Place, the audit will review the governance arrangements in place for delivery of this project.	Fieldwork
Resources – ICT	**Deferred to 19/20: ICT – Back-up and Recovery** The audit will follow up on the review undertaken in 2017/18 and will review the procedures and processes for taking, securing and testing backups of corporate ICT systems and data.	Agreed to defer this audit until 19/20: Internal Audit reviewed the arrangements for back-up and recovery in February 2017 which identified that the current system for back-up had been out of support for a number of years and was causing operational issues. The audit also reported that there was no formal corporate policy on ICT backup, procedure documents were out of date and recovery testing not performed. At

Directorate	Audit	Status
		the time, Internal Audit were informed that management action was planned to address these weaknesses which was going to involve buying back-up and recovery services from a public sector shared service provider. It was therefore agreed that Internal Audit would undertake a full audit of the new arrangements during 2018/19. However, the planned procurement did not go ahead and therefore there has been no change in the arrangements since Internal Audit last reviewed this. The agreed actions remain outstanding. Management recognise the risk exposure of running the existing system and there is now a project being initiated to identify and procure a back-up solution going forward. It has therefore been agreed that the audit will be deferred until the 2019/20 plan. It is anticipated that the new arrangements will be in place from July 2019. It is anticipated that the backup-solution will form part of the Datacentre future project.
Resources – ICT	**Deferred to 19/20: ICT - IT Incident Management** A new IT service management tool is being implemented in 2018. The audit will review how incidents and service requests are reported to the IT service desk and managed through to resolution.	It has been agreed to defer this audit until 19/20 when the project, now approved by FFF, will be implemented.
Resources ICT	**Deferred to 19/20: ICT - Data Centre Refresh**	It has now been agreed to defer this audit until 19/20 when the project will be implemented.

Directorate	Audit	Status
	There is a planned review of the strategy to refresh ICT infrastructure.	
Corporate / Cross Cutting / Governance	**Deferred to 19/20: Fit for the Future – new Target Operating Model** In implementing a new operating model for the Council, assurance will be required that effective governance, risk management and control arrangements are designed and implemented.	Agreed with Lorna Baxter to defer internal audit work until 19/20. Audit & Governance Committee to continue to receive regular briefings.
People: Children	**Deferred to 19/20: Foster Payments** The audit will follow up on the audit completed during 2017/18 and be undertaken following the implementation of the new Children's Social Care IT system when the finance system will be integrated into the new system. The audit will include the accuracy, validity, timeliness and authorisation for both payments to internal and external foster placements.	The new Children's IT system implementation has been deferred until March 2019. The audit has been deferred until 19/20 audit plan and will be undertaken following go live.
People: Children	**Deferred to 19/20: Children's Social Care Payments** The audit will follow up on the audit completed during 2015/16 and be undertaken following the implementation of the new Children's Social Care IT system when the finance system will be integrated into the new system. The audit will look to review the processes for children's social care payments to ensure that payments are valid, correctly authorised, that the appropriate procurement method is being used and that spend is effectively monitored.	The new Children's IT system implementation has been deferred until March 2019. The audit has been deferred until 19/20 audit plan and will be undertaken following go live.

APPENDIX 2 - EXECUTIVE SUMMARIES OF COMPLETED AUDITS

GDPR 2018/19 – (General Data Protection Regulation Review)

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Corporate Policy	G	0	1
Governance Structure	A	0	3
Information Audit	A	0	4
Privacy Notices	A	0	2
Data Subject Rights	A	0	2
Data Breaches	G	0	0
Privacy by Design	G	0	0
		0	12

Opinion: Amber	Final Report: 10 September 2018	
Total: 12	Priority 1 = 0	Priority 2 = 12
Current Status:		
Implemented	5	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	7	

There is a documented Data Protection Policy that was reviewed and updated in June 2018 for GDPR and the Data Protection Act 2018. A data retention schedule is also documented, however, there is no assurance that data in service areas is being held in accordance with its defined retention period and this presents a GDPR compliance risk. The Council has a valid registration with the Information Commissioner’s Office which expires on 15 November 2018.

The County Leadership Team have been made aware of the changes to data protection laws and the work being carried out to ensure compliance with the new GDPR requirements. Various other workshops have also been held at a manager level and there is a continual awareness and update programme

across the organisation. All staff are required to undertake mandatory training on data protection and those that have not completed it are being followed up and will shortly be informed that their user accounts will be disabled if they don't complete the training within a stipulated timeframe.

The Director of Law and Governance is the designated Data Protection Officer (DPO) as required under Article 37 of GDPR. However, the Director's job description does not define specific responsibilities attributed to the DPO under Article 39, and in practice many of the responsibilities are performed by the Information Management team. On this basis, the assignment of the DPO role should be reviewed.

Members of the Information Management team received data protection training in 2015 but have not received any update training on GDPR. This should be arranged to ensure they have the skills to support the organisation with its ongoing compliance programme. There are no defined data protection responsibilities within service areas and hence a risk that corporate policies and requirements are not being adhered to a local level. Maintained schools are deemed to be their own data controllers and hence responsible for GDPR compliance. The Information Management team have provided them with briefings and awareness sessions and are developing plans to offer formal advice and support from September 2018.

An information audit has been undertaken to identify all processing of personal data across the organisation but further work is required to validate it and ensure that all service areas have been covered. The work to identify all data processors and ensure agreements are in place remains ongoing; around 80 processors have been identified so far. The standard supplier contract has been revised with new clauses that cover the new GDPR requirements but we found that the amendments being made to existing contracts are not using the same clauses and hence some required areas have been omitted. Whilst the Council can rely on the 'public task' basis for most of their processing, this should be confirmed and documented as part of the information audits. The way in which consent is being recorded is inadequate and existing consents have not been reviewed by service areas. Marketing have reviewed their activities for GDPR compliance and ensure that explicit consent is sought.

Privacy notices need to be improved to ensure the individual's right to be informed about the use of their data is respected. A revised privacy notice has been added to the corporate website but it is generic and hence does not cover the specific processing of personal data within service areas. Furthermore, testing has identified that a number of data collection forms in Adult's and Children's have no privacy notice or are still using old notices that refer to the Data Protection Act 1998.

The process for dealing with individual right's, including subject access, are documented but have yet to be formally approved. All individual rights requests are received and validated by the Information Management team before being forwarded to service areas for actioning. The Information Management team monitor requests to ensure they are actioned within one month, with the exception of requests involving social care and SENS which are dealt with by a local team. The audit found that the completion of these requests were not reported back to Information Management and hence there was no assurance

that they were being actioned within the required timescales. However, from 3rd September the processing of all individual rights requests has been centralised with the Information Management team and they are reviewing the processes for dealing with all such requests.

There is a documented Information Security Incident Policy, which covers the handling of data breaches. Further information is available on the Intranet where there are examples of security incidents and those that are classed as a data breach. A log of all security incidents is maintained and includes details of the actions taken and lessons learnt. Relevant incidents are reported to the Information Commissioner's Office (ICO) in accordance with GDPR requirements.

Privacy by design is ensured through Data Protection Impact Assessments (DPIA's) which form part of the existing Information Management Risk Assessment (IMRA) process. The DPIA's are based on guidance issued by the ICO and have to be submitted to the Information Management team for review and sign-off. The template Project Initiation Document used by the Programme Management Office identifies the need for an IMRA and DPIA within section 6 on risk and issue management, ensuring they are considered as part of each new project.

Communities Income 2018/19

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 and Procedures	A	0	1
B: Charging of Income	G	0	0
C: Income Collection and Recording	A	0	2
D: Fraud & Error	A*	0	0
E: Monitoring	G	0	0
		0	3

**Management actions agreed under risk area C and E.*

Opinion: Amber	Final Report: 18 October 2018	
Total: 3	Priority 1 = 0	Priority 2 = 3
Current Status:		
Implemented	1	
Due not yet actioned	2	
Partially complete	0	
Not yet Due	0	

A: Policies and Procedures

Guidance available to staff on how to collect income (how to raise invoices, collect and bank cash / cheques, and managing bank transfers) is clear, up to date and accessible, however it does not specifically cover when an invoice is required, over other methods of collection. As identified below, audit testing found inconsistencies in when invoices are raised, both across teams and within teams, indicating staff are unclear on when an invoice is needed.

B: Charging of Income

Income charged across the sample of 10 teams within the Communities Directorate appeared in line with the fees & charges approved annually by Cabinet, and charges had been raised promptly in the majority of cases. Coding all appeared appropriate for the sample of transactions reviewed.

C: Income Collection and Recording

Inconsistencies in the method used to raise charges were identified both across and within teams. While in some cases different methods makes practical sense, in other teams, customers are given the option of being invoiced or not. This varying approach to charging could result in income not being charged, or unpaid charges not being escalated appropriately (however the audit did not identify any examples of this from sample testing).

Consideration of future arrangements around digitalisation and how to make processes more efficient could be seen across some areas reviewed (for example implementing online payments for customers) and other high-volume areas are being reviewed under Fit for the Future projects. However, this is happening on a team-by-team basis rather than corporately. The implementation of the new target operating model could provide a Council-wide strategy to offer streamlined and efficient ways for teams to collect income.

D: Fraud & Error

Across the teams reviewed, sufficient processes were in place on receipt of income to minimise the risk of fraud and error, ensuring the segregation of duties between those charging, collecting, and banking income. However, issues were identified within one team with time taken to bank cheques, meaning in some cases cheques were held in the office for up to 3 months before being taken to the bank. Also noted in the audit, the inconsistency in invoicing practices also increases the risk of fraud and error, as without transparent invoicing processes, expected income may not be received and banked to the Council as it should.

E: Monitoring

All cost centre managers responsible for the 10 teams sampled reported carrying out monthly budget monitoring at a high level, reviewing income and expenditure, with staff within the teams carrying out more detailed checks to confirm all income has been correctly received and coded. This is in line with corporate guidance, which states all cost centre managers should ensure a monthly reconciliation is conducted of all expected income to the SAP financial ledger for the cost centres they are responsible for.

Health & Safety 2018/19

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: Governance, Roles & Responsibilities	R	7	10
B: Risk Identification & Management	A	1	5
C: Management Information & Communication	R	3	1
		11	16

Opinion: Red	Final Report: 09 October 2018	
Total: 27	Priority 1 = 11	Priority 2 = 16
Current Status:		
Implemented	13	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	14	

This audit has not looked at areas being covered as part of the Statutory Compliance Review or review of Carillion build legacy issues currently being completed within the Communities Directorate. Prior to the collapse of Carillion, it was identified that there was a lack of assurance regarding health & safety compliance across our corporate estate. Since the transfer of property management responsibilities previously under Carillion, it is now a priority to assess compliance and take action where required.

From review of the implementation of management actions agreed as a result of the last Internal Audit of Health & Safety undertaken in 2012/13, it was found that of 14 management actions agreed, 11 have not been fully implemented or are not working effectively (4x Priority 1 actions and 3x Priority 2 actions), 1 action is no longer applicable (Priority 1) and 2 have been confirmed as effectively implemented (1x Priority 1 and 1x Priority 2). This audit has identified a repeat of issues identified in the previous audit in relation to roles and responsibilities, weak governance arrangements (especially in relation to the H&S Governance Group), risk management and completion of mandatory training.

Overall Conclusion is Red

Governance Structure - The audit has identified a weak governance structure which does not currently provide appropriate strategic assurance over the management of health and safety arrangements across the Council. Although there are Part 1, 2 and 3 documents in place which set out the Council's strategy, approach to health & safety and roles and responsibilities from Chief Executive level downwards, these do not fully reflect current arrangements, there are also insufficient reporting mechanisms in place to provide assurance that arrangements in place are in accordance with this. The Corporate Health & Safety Framework document, produced following the previous audit to ensure that governance arrangements were clearly defined and communicated, is out of date and includes a number of key controls and processes which are no longer in place. These changes to key controls and processes would have been expected to have been formally agreed by CLT / Senior Management, but were not.

Health & Safety Governance Group - The Health & Safety Governance Group was formed in response to the control weaknesses identified during the last Internal Audit of Health & Safety in 2012/13. It was agreed that this group should include appropriate membership from across the Council and at an appropriate level of seniority to enable this group to act effectively in overseeing the governance of health & safety arrangements across the Council. However, it has been noted that the group formed following the previous audit stopped meeting in October 2016. A new group has now been created, but does not have representation from across all the necessary parts of the Council. The only core members are the Corporate Health & Safety Team and the Schools Health & Safety Manager. Property / Facilities Management and Fire & Rescue who have significant responsibilities and / or experience of health and safety at the Council are not part of the documented core membership and there is no representation from directorates other than the school's health and safety manager. Although the Corporate Lead for

Health & Safety is listed as a core member of the group, it was reported that he is not expected to attend.

Corporate Lead Statement - A number of issues were noted in relation to the accuracy of the 2017/18 Corporate Lead Statement on health and safety which feeds into the Council's Annual Governance Statement. Reference is made to controls which are no longer in place, for example H&S Governance group reporting to CLT, reference is made to updates and reporting to directorates on health & safety issues, accidents and incidents, but this is not taking place consistently. The Statement of Opinion highlights one significant matter in relation to assurance, covering property compliance, control weaknesses that have been identified as part of this audit (for example weak governance arrangements and failure of staff to complete mandatory health & safety training) have not been picked up. Furthermore, two areas were identified where improvements were required, however there is no clear plan in place to ensure that improvements are made in this area and there is no clear owner for progressing improvements in these two areas.

Roles & Responsibilities for Property Compliance - A lack of clarity was noted regarding roles and responsibilities around property compliance for maintained schools in terms of what should be the responsibility of Facilities Management and what should be the responsibility of the Schools Health & Safety Team. There is no clear route or process established between the directorates for raising and resolving these issues. Additionally, it is noted that FM property responsibilities across the corporate estate have yet to be formally documented following the function being brought back in house.

Health & Safety Training - Staff training provision on health and safety is ineffective. Audit testing found that mandatory health & safety training is not being completed as required in terms of both routine e-learning for all staff (53% of permanent new starters from 2017/18 were not recorded as having completed the mandatory training) and in relation to the one-day training for managers course (1 manager of 41 new starters with line management responsibilities from 2017/18 was recorded as having attended the one-day course during 2017/18). There is no management reporting which provides any assurance over the level of completion of this training. Although it is the responsibility of line mangers to ensure that training is completed, training is not being completed and there is no awareness or visibility of this either within directorates or corporately within the Health & Safety team. Discussions during the audit have also found that it is hard to pin point what additional health and safety training is required for individual roles. Again, this is the responsibility of the line manager, but other than an annual Health & Safety report showing the number of staff who have completed each course (not how many should have), there is no assurance that specialist health and safety training is being completed by those who need it.

Health & Safety Training for Ex-Carillion Staff - Health & safety training arrangements were considered for ex-Carillion staff who transferred over to the Council at the start of 2018. Although consideration has been given to health & safety training needs and some training has been provided (for example catering staff have all had an induction which covers health and safety, and have had some service specific health & safety guidance), needs have not yet

been fully assessed, existing training has not been considered and there is not yet a clear plan in place with defined timescales to ensure that these staff have appropriate health and safety training for their role and are aware of their responsibilities in relation to health & safety (to include consistent and prompt reporting of accidents and incidents). FM acknowledge that there is further work to be done across the different groups of ex-Carillion staff particularly in relation to ensuring that there is a consistent approach to accident and incident reporting.

First Aid Provision - Responsibility within the Council for ensuring that there is appropriate first aid provision within Council buildings is not clearly assigned. Although it appears that first aid coverage is being managed locally at individual sites, there is no corporate oversight of this and there is no mechanism to provide assurance to senior management that first aid provision is appropriate or that appropriate training has been undertaken and is being kept up to date. A sample check on first aid and fire marshal arrangements undertaken by the Corporate Health & Safety Manager during the audit, identified a lack of fully qualified first aiders in some areas and identified significant non-compliance regarding specialist paediatric first aiders at some children and family centres. The results of this work were reported to FM staff and the County HR Manager and it has been reported that steps have been taken to address these gaps and train on site staff. It was reported that courses are planned for October and November 2018. Communications were issued to try and recruit more first aiders, but the issues relating to management and oversight of provision have not been resolved.

There is also currently no assurance as to whether supplements being paid to staff for being first aiders are being paid to the right people / whether these people have up to date training.

Risk Management - In terms of risk management, there are currently no agreed strategic health and safety risks included on the CLT risk register. A risk has been agreed with the risk owner (Corporate Lead for Health & Safety), however this has yet to be formally approved by CLT. This is scheduled for CLT review.

From review of directorate risk registers, it was noted that there are no health & safety specific risks on the Communities risk register in relation to property specific health & safety risk, this risk register was last updated in April 2018, 3 months after the property management function was brought back in house.

Risk Assessment Process - There is a lack of assurance and reporting on the risk assessment process. Managers and staff are responsible for ensuring that risks are assessed and managed in their areas / in relation to processes and tasks they undertake. These responsibilities are stated within the mandatory health & safety training (as discussed earlier, mandatory training is not being completed by all staff). There is currently no mechanism in place for reporting on or providing assurance to Directorates or CLT, that risk assessments are being completed where required and being completed appropriately.

Internal Audit testing identified that Display Screen Equipment (DSE) assessments are not being completed by all relevant staff. 6/10 new starters reviewed, reported that they had not completed a DSE assessment. One of the

areas for improvement in the 2017/18 Corporate Lead Statement was issues relating to musculoskeletal disorders and potential links to agile working. Whilst the guidance on the intranet was found to be clear and up to date, testing suggests that relevant new starters are not aware of the need to complete DSE assessments. It is likely that this lack of awareness is linked to the low completion rates for mandatory health & safety e-learning.

Reporting of Accidents & Incidents - Delays were noted in the reporting of accidents and incidents. Testing found that accidents and incidents are being reported, on average, 18 days after the occurrence of the accident or incident (this covers reporting corporately as well as by schools). Performance is slightly better for serious and moderate incidents, which are reported on average 11 days after occurrence. Guidance states that accidents and incidents should be reported as soon as possible after the incident takes place. Over the course of 2017/18 it was found that there were also 30 incidents (all schools) which took over 200 days to report including one serious incident which wasn't reported for 205 days. There is no follow up action taken or routine reporting to directorates in relation to promptness of reporting of accidents and incidents. It has been reported that promptness of reporting of incidents is considered as part of the Schools H&S Team Monitoring Visits for maintained schools.

Corporate & Directorate Management Reporting - There is a lack of clear review and monitoring of health & safety objectives both corporately and at directorate level. Whilst some corporate actions are being tracked by the H&S Governance Group, this group does not have the decision-making powers to ensure that corporate actions are implemented. At a directorate level, it was intended that health and safety actions would be covered through the directorate risk management process, however as noted earlier, health and safety risks are not recorded on all directorate risk registers.

There is a lack of formal reporting to CLT on health and safety outside of the annual health and safety report. There is also a lack of clarity on what should be reported to CLT. Significant issues identified during this audit, including mandatory health and safety training not being completed, inadequate first aid and fire marshal arrangements and key assurance mechanisms no longer working effectively have not been reported to CLT.

The County Health & Safety Manager does not attend DLTs for all Directorates and there is a lack of regular routine reporting to all Directorates. For Adult Services the County Health & Safety Manager was asked to attend the Internal Care Governance group rather than DLT. Since the audit, for Communities Directorate the County Health & Safety Manager has been asked to report to the management tier below COMT (Communities Management Team). Senior management within directorates therefore do not have any way of obtaining routine assurance over the arrangements for health & safety within their directorates (including maintained schools). Audit discussions with Directors / Strategic Directors as part of this audit confirmed that routine reporting to provide assurance on the effective operation of key controls in this area is a gap and would be welcomed going forward.

Communications - Whilst it was noted that there is good information on the intranet on health and safety policies and procedures (acknowledging that some areas need to be reviewed and updated) and news items on some

issues, there is a lack of communications to staff reminding them of key health and safety roles and responsibilities. For example, managers briefings don't include health and safety updates reminding managers about the need to complete mandatory training, undertake risk assessments and report accidents and incidents promptly. It is reported that a managers briefing is now planned to start in September / October and will be issued quarterly thereafter.

Troubled Families - September 2018 Claim

Opinion: n/a	Final Report: 27 September 2018	
Total: 7	Priority 1 = 0	Priority 2 = 7
Current Status:		
Implemented	3	
Due not yet actioned	1	
Partially complete	0	
Not yet Due	3	

Since Phase 2 of the government's Troubled Families programme began in September 2014, OCC has submitted between 2 and 3 claims per year. The claim due to be submitted by the 28th September consisted of 170 families for Significant & Sustained Progress (SSP), covering the period from December 2017 to May 2018, and 15 families for Continuous Employment.

In line with the requirements of the Financial Framework for the Expanded Troubled Families Programme the audit checked a sample of at least 10% for both claims 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.

Two instances of duplication were identified during the audit (within the claim and with a previous claim), and these have since been corrected. Issues were also identified in relation to the tracking of eligibility criteria (which did not result in any families being removed from the claim) and with families initially being included under the SSP, rather than CE, claim in error. These issues had been identified prior to the audit, however the claim has since been re-checked by the Troubled Families team and no further issues were found. Internal Audit were therefore able to sign off the claim.

Early Years Census Returns 2018/19

Opinion: Amber	Final Report: 08 November 2018	
Total: 11	Priority 1 = 1	Priority 2 = 10
Current Status:		
Implemented	0	
Due not yet actioned	1	
Partially complete	0	
Not yet Due	10	

As a result of the queries raised by Finance following their initial review of the January 2018 Early Years Census results, it was apparent that data checking processes to ensure that the data submitted to the DfE was accurate had not worked as intended and were not sufficient. Following queries raised by Finance in relation to the accuracy of the figures reported, instances were identified where pupil numbers had been understated. In the case of the overstatement of pupil numbers identified relating to prior years, it was reported that this was not identified until after they had been used by the DfE to calculate DSG funding to the Council. The DfE then had to be contacted and the overpayment repaid. Management had reported that there were resourcing issues during this period which have now been resolved.

It has been acknowledged that checking processes required review and since the workshop held in May 2018, a checklist has been produced by the Data Team to ensure that the figures reported as part of future census returns are robust. Finance have also suggested a number of checks which should be completed, aimed at ensuring that issues noted with accuracy during the January 2018 early years census do not recur.

There is also a lack of routine sense checking across the cohort. By reviewing early years pupil numbers across the Schools and Early Years Census and comparing this with previous years and taking into account changes in demographics, it would indicate whether numbers were as expected or whether further review is required.

Issues were identified with not understanding changes and additions to DfE guidance. Although the example of this identified by Finance did not affect the relevant funding stream for 2018/19 in the end, the process in place for ensuring that these figures were calculated and reported accurately, in line with the guidance, did not work as it should have done and the different teams involved in data collection did not appear to liaise as they needed to.

Instances were identified where data upload errors had resulted in records not transferring correctly into the COLLECT system (part of the reason for the understatement of pupil numbers referred to above). Going forward control total checking between the two systems as part of the upload process would enable any similar issues to be identified and raised promptly.

There is currently no formal sign off process by those completing data accuracy checks to confirm that all appropriate checks have been undertaken and that there is confidence that the figures being reported are accurate.

It was noted that team process guidance for roles undertaken in relation to compilation, checking and submission of Early Years Census data and Schools Census data is out of date.

From review of the process for communicating with providers / settings on the information they are required to submit as part of the Early Years census, it was noted that communications are currently sent separately from the Data Team and the Early Education Funding Team. Joint, co-ordinated communications would be more efficient and would help settings see the Early Years Census as one process. This could also improve response rates.

It has also been reported that improvements to the data collection process for setting level information for the Early Years Census are planned. An online portal using a different module of the same system used for collection of pupil level data from settings is to be developed and implemented.

Contingency Home Care 2018/19

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
Risk Area A: Commissioning & Contract Management	R	4	3
Risk Area B: Operational Management	R	2	12
Risk Area C: Payments & Charging	A	0	4
		6	19

Opinion: Red	Final Report: 11 December 2018	
Total: 25	Priority 1 = 6	Priority 2 = 19
Current Status:		
Implemented	3	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	22	

Introduction

Contingency home support care is provided to Service Users as a ‘stop gap’ whilst long term care is sourced, for example after a period of Reablement care following discharge from hospital. It is intended to be short-term, so Service Users can move to stable long term care as soon as possible. The Council pays more than twice the standard hourly rate paid for long term care services, so it is in the Council’s financial interest to keep contingency care packages as short as possible. This audit was undertaken at the request of the Deputy Director for Commissioning, as it was recognised that contingency arrangements had developed over time in a piecemeal manner from different budgets, as a response to the pressures in the home care market and issues with the whole system flow.

A: Commissioning and Contract Management

There are 4 contracts in place with 3 providers that include an element of contingency care services. The audit found that the contract monitoring activities at an operational level for the separate contracts were satisfactory, as regular contract meetings were held, issues and risks identified, discussed and followed through. However, there is an absence of strategic oversight and management reporting of the contingency process as a whole; it is overseen at an individual separate contract monitoring level rather than as an end-to-end process across the contract services. For example, the total cost of contingency care is not tracked and managed, due to costs being allocated to separate cost centres for the different contracts, with contingency costs not being easily identifiable. Whilst some key performance indicators are monitored, these are inconsistent between the separately commissioned and managed contracts and some important indicators are missing. For example, a daily report monitors the number of service users in receipt of contingency care and awaiting long term care for one of the providers, but not another, so it doesn’t give the full picture.

The average length of stay in contingency care is not monitored, albeit for one of the providers where the number of Service Users over 50 days is reported upon. From Internal Audit’s analysis of one of the providers where the duration isn’t monitored but which has a target maximum duration of 28 days in contingency care, Service Users were staying for an average of 125 days (as at the end of July 2018). This is significant, as the costs to the Council are double that of long term care.

Without ongoing high-level overview of the costs and key indicators of contingency care to understand the full number in receipt of contingency care and their average length of stay, it is not possible to know whether there is an increasing trend in contingency care, the financial impact of this, what the underlying causes are and therefore make evidence-based decisions on how to address any issues. It is thought that the number and costs of contingency care packages are increasing.

One of the contracts started in December 2017 but had not been signed at the time of the audit over six months later. The audit highlighted a lack of oversight to manage an issue of a provider with both contingency and long-term care contracts, as well as a lack of assurance over value for money from the core payment paid irrespective of the number of care packages picked up.

It is acknowledged by management that there are known areas of improvement with the commissioning approach in relation to this service area.

B: Operational Management

The audit reviewed the contingency process across the different contracts and identified a number of key blockages resulting in delays with moving Service Users onto longer term care. There are known issues with insufficient or inadequate data and lateness of some referrals from the Reablement provider to the Council, resulting in delays in commencing the long-term sourcing process, however these are being addressed via the contract monitoring processes. The bigger challenge is the actual sourcing of long term care, which is subject to challenging market conditions in Oxfordshire.

The audit sought to track whether adequate processes were in place to routinely re-attempt sourcing long term care packages where Service Users have been in contingency care for a lengthy period. Although the audit noted that this was taking place, the transparency and consistency of recording sourcing attempts was insufficient, however this is actively being addressed by moving the recording of sourcing information from a manual spreadsheet system to the LAS social care online system.

In some cases identified during the audit, Service Users in receipt of contingency care had no ongoing care needs and so should not have been referred into contingency in the first place. A further issue identified by the audit was 'self-funders' in receipt of contingency care whilst privately sourcing their own care, without a Council assessment or sourcing support. The 3 cases identified in the audit samples had not been referred for financial assessments so were not paying any costs towards their care. There is no documented policy or procedure for identifying and logging this category of Service User at referral stage, for clarifying their eligibility for receiving contingency care, the duration of this and their charging treatment. As the Council has no control over when their care is sourced, we could in effect be subsidising their care for longer than necessary.

C: Payments & Charging

The audit identified process delays and administrative errors relating to client charging, resulting in financial assessments not being completed in all cases and correct charges applied (charges had not been backdated to the start of contingency care).

Children's IT System Implementation

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
Project Governance	A	0	2
System Security	G	0	1
Data Migration	G	0	1
Testing	G	0	1
User Training	A	0	2
		0	7

Opinion: Amber	Final Report: 19 December 2018	
Total: 7	Priority 1 = 0	Priority 2 = 7
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	6	

Our previous audit of this area was undertaken in February 2018 and identified a number of risks, especially in the areas of project governance and system security. Whilst the majority of agreed actions from this review have been addressed, three remain outstanding and they are referenced below.

The Project Initiation Document (PID) and terms of reference for the Implementation Board have now been approved. We previously reported that the risks contained in the monthly Highlight Report for the Implementation

Board did not have the highest scoring risks from the risk log and our testing has found that this weakness still exists. The Highlight Report also does not contain any details on the top issues facing the project and hence the Implementation Board will not have visibility of what they are. A proposal has recently been submitted to make organisation changes to ensure there are consistent financial processes in place to support the new IT systems. As processes should be mapped and signed-off prior to the IT systems going live, the Implementation Board should agree a cut-off date by which a decision on the proposal is required along with alternate options should the proposal not get approval. Internal audit has further work planned to review business processes.

All user authentication to LCS is now subject to single sign-on, based on network authentication, whereas previously this was only the case for primary login accounts. LCS user access levels have been documented and are being tested and will be formally signed-off by the Operational Lead. ContrOCC access levels have not been documented or formally signed-off to confirm that they are correct and reflect user roles.

The Data Migration Strategy has now been approved but the processes and procedures for managing data quality defects has not been documented as agreed in our original audit. Completing this action at this late stage of data migration is of little value, however, the Implementation Board should satisfy themselves that the actual processes and procedures used are effective. Testing has confirmed that reconciliation reports are used to identify any data errors and confirm data accuracy; all issues are logged on a designated system for resolution. The results of each data migration cycle are reported to the Implementation Board.

A Testing Strategy has now been documented but it still needs to be formally signed-off. A number of testing cycles have been completed and formal user acceptance testing (UAT) started on 26 November 2018. Formal test scripts have been developed for UAT and all testing with be signed-off by the Operational Lead and the Implementation Board.

There are two lots of training for users; “MeLearning” which is mandatory and gives users a basic competency to access LCS and classroom-based training that will be the main training on the new system. Some elements of the MeLearning training is already underway and the main classroom training is scheduled to start on 4th February 2019. The classroom training is being delivered by LiquidLogic and there is risk that they are not planning to issue user guides as part of their training, although we understand this has been addressed since the audit was undertaken. Users attending training is key to the successful delivery of the system. Some areas of system training will be delivered internally by staff and formal plans for how this will be managed still need to be developed.