**Oxfordshire County Council**

**Internal Audit Services**

# Annual Report of the Chief Internal Auditor

# 2013/14

**Date Issued: June 2014**

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# 1 INTRODUCTION

## 1.1 BACKGROUND

1.1.1 The Accounts and Audit Regulations 2011 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 2013 (the Code), 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 of the internal control environment.

## 1.2 RESPONSIBILITIES

1.2.1 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.

1.2.2 The role of the Internal Audit Service is to provide management with an objective assessment of whether systems and controls are working properly. 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.

## 1.3 INTERNAL CONTROL ENVIRONMENT

1.3.1 The Code defines the control environment as comprising of the Council's systems of governance, risk management and internal control, the key elements of which include:

- Establishing and monitoring the achievement of the organisation's objectives.
- The facilitation of policy and decision-making ensuring compliance with established policies, procedures, laws and regulations – including how risk management is embedded in the activity of the organisation, how leadership is given to the risk management process, and how staff are trained or equipped to manage risk in a way appropriate to their authority and duties.
- Ensuring the economical, effective and efficient use of resources, and for securing continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.
- The financial management of the organisation and the reporting of financial management.
- The performance management of the organisation and the reporting of performance management.

1.3.2 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 Auditors annual statement on the System of Internal Control is considered by the Corporate Governance Assurance Group when preparing the Council's Annual Governance Statement.

## 1.4 THE AUDIT METHODOLOGY

1.4.1 The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards; however, there are currently three areas of non-conformance with those standards:-

- The Chief Internal Auditor has operational management responsibility for the Risk Management and Strategic Insurance functions, so is not wholly independent. The risk of conflict of interest is managed where audit activity is undertaken in areas where the CIA has operational responsibility as the Audit Manager reports directly to the Chief Finance Officer (S151 Officer);
- An Internal Audit Charter is to be drafted and presented to the Audit and Governance Committee; and,
- A Quality Assurance and Improvement Programme is being drafted and will be presented to the Audit and Governance Committee with the Internal Audit Charter

1.4.2 In accordance with the requirements of the Accounts and Audit Regulations 2011, the Monitoring Officer has carried out a review of the effectiveness of the System of Internal Audit. The scope of the review included the self-assessment against the code completed by the CIA, reporting to the Audit and Governance Committee, and a survey of Senior Management on the effectiveness of Internal Audit. In the report to the Audit and Governance Committee it was concluded the Internal Audit Service overall continues to be effective.

1.4.3 The Internal Audit Strategy and Quarterly Plans for 2013/14 were approved by the Audit and Governance Committee, who received quarterly progress reports from the CIA, 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.

1.4.4 The quarterly Internal Audit Plans 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.

1.4.5 Internal Audit reports provide a conclusion for each of the following, as well as an overall conclusion on the system of internal control:

- The adequacy and effectiveness of the risk assessment process
- The adequacy and effectiveness of the controls designed to manage the risks
- The adequacy and appropriateness of management action designed to remedy any failings or weaknesses in the internal control system
- The adequacy and effectiveness of management assurance processes for monitoring the system of internal control.

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 (12 June 2014) of management actions against each audit, (based on information provided by the responsible officers). The definitions of each conclusion are attached as appendix 2.

1.4.6 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 to perform quality reviews at four stages of the audit assignment: the terms of reference, file review, draft report and final report stages.

## 1.5 THE AUDIT TEAM

1.5.1 During 2013/14 the Internal Audit Service was delivered by a mixture of an in house team, and audit professionals from Deloittes PSIA, and Wokingham Borough Council who supported the service with specialist staff for counter-fraud and investigation work; they also provided audit days undertaking key financial systems audits. The specialist area of IT audit has also been outsourced. The in house team also provided services to external organisations, Thames Valley Police Authority and Buckinghamshire County Council.

1.5.2 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.

1.5.3 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:

- The Chief Internal Auditor and the Senior Auditor who leads on counter-fraud in the team are related. To manage that conflict, the CIA has no direct management of the Senior Auditor, and their line manager reports directly to the CIA's line manager on all personnel and performance matters.
- In addition to the above, a close relative of those staff also works for Oxfordshire County Council as a Manager within Social and Community Services. The CIA and the Senior Auditor, are not involved

in any audit activity where they could be conflicted. This conflict occurred during 2013/14 when it was necessary to undertake an investigation into financial irregularity in the service area where the relative is a manager. For this audit the Audit Manager reported directly to the Chief Finance Officer, and to the Monitoring Officer; she also reported independently to the Audit Working Group.

- The Chief Auditor has operational management responsibility for the Risk Management and Insurance functions, so is not wholly independent. The risk of conflict of interest is managed where audit activity is undertaken in areas where the CIA has operational responsibility as the Audit Manager reports directly to the Chief Finance Officer (S151 Officer)

# 2 OPINION ON SYSTEM OF INTERNAL CONTROL

## 2.1 BASIS OF THE AUDIT OPINION

2.1.1 The 2013/14 Internal Audit Plan has been completed; however the plan was revised during the year, and five audits originally planned have been cancelled or deferred:

- CEF Assurance Mapping - Safeguarding

  It was intended to undertake a pilot project, mapping all the management assurance processes for this key service. The pilot was commenced, and led by the CIA and the Audit Manager, however it was suspended due to capacity. This will be picked up again in 2014/15.

- Integrated Transport Unit: Carried forward to 14/15, currently scoping.

  This audit was deferred whilst a restructuring of the service was being completed.

- Capital Programme Management & Delivery: Carried forward to 14/15, planned for Q2.

  This audit was deferred due to capacity within the team.

- Property and FM Contract (Deep Dive): Carried forward to 14/15, currently testing.

  This audit was deferred due to capacity within the team.

- SCS Social Care Fund

  This audit was cancelled following the decision to cease the activity.

2.1.2 The substantial completion of the planned internal audit activity enables the Chief Internal Auditor to provide an objective assessment of whether systems and controls are working properly. 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 their work.

2.1.3 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

2.1.4 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 presented to Directorate Leadership Teams, and the Audit Working Group. The Chief Internal Auditors opinion set out in section 2.2.1 takes into account the implementation of management actions.

2.1.5 The Anti-fraud and corruption strategy remains current and relevant. During 2013/14 there has been an increase in the amount of reported fraud, or attempted fraud, including external fraud. The Council has recently been subject to an unsuccessful, attempted procurement fraud by external fraudsters requesting changes to vendor master data. Internal controls prevented the fraud, with an estimated value of £275000, from occurring. The zero tolerance to fraud has been demonstrated in the year, with an ex-employee being prosecuted for theft of cash. The monies have been repaid in full and the individual received a suspended sentence. Another employee was dismissed for fraud.

2.1.6 There appears to be an increase in minor fraud and financial irregularity, which could be an indication of poor management control. The results of some of the establishment audits being undertaken are also highlighting financial management processes as a weakness. The S151 Officer and the CIA have undertaken Head of Profession briefings and fraud awareness briefings to the Finance Function and Directorates to remind the staff of their responsibility to be vigilant to the risk of fraud; in addition the S151 Officer has identified additional resource for financial management checks to be undertaken across a larger sample of establishments during 2014/15. This will be undertaken by Internal Audit in conjunction with the Finance Business Partners. The National Fraud Initiative (data matching exercise) has been completed, with no major issues or concerns noted for reporting.

2.1.7 The National Fraud Initiative data matching reports have been reviewed and key matches investigated. This work has highlighted one potential area of concern which is currently being reviewed by Internal Audit; there were a small number of overpayments to residential care homes identified. The overpayments have been recovered, but the controls are being reviewed.

2.1.8 It should be noted that it is not internal audit's responsibility to operate the system of internal control; that is the responsibility of management. 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 Committee.

2.1.9 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.

2.1.10 In arriving at our opinion we have taken into account:

- The results of all audits undertaken as part of the 2013/14 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;
- The affects of any material changes in the Council's objectives or activities; and,
- Whether or not any limitations have been placed on the scope of Internal Audit – of which there have been none.

## 2.2 CHIEF INTERNAL AUDITORS OPINION ON THE SYSTEM OF INTERNAL CONTROL

2.2.1 In my opinion Oxfordshire County Council's overall system of internal control continues to facilitate the effective exercise of the Council's functions and provides a **reasonable** assurance regarding the effective, efficient and economic exercise of the Council's function. There have been some areas of weakness identified by management and Internal Audit, but these have all resulted in positive action plans to address them, with appropriate timescales, demonstrating a commitment to maintaining effective governance and internal control. Whilst this is a positive assurance the organisation continues to operate under significant financial pressure, and in a state of continuous change. Governance is strong which provides a good foundation for managing these pressures effectively, but there is an inherent risk to the control framework when capacity within an organisation becomes stretched.

2.2.2 There have been 56 audits completed in 2012/13, of which only three resulted in an opinion of "unacceptable" control.

2.2.3 The three "unacceptable" audits have all been well received by management, and there has been good engagement with implementing management actions such that based on the positive assurance received by Management on the implementation of actions as at 12 June 2014, the opinions have been updated for the purposes of this report.

2.2.4 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 (23 April 2014) are attached as appendix 3

## 2.3 INTERNAL AUDIT PERFORMANCE

2.3.1 The following table shows the performance targets agreed by the Audit Committee and the actual 2013/14 performance.

| Measure | Target | Actual Performance 2013/14 |
|---|---|---|
| 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 | 70% of the audits met this target. (2012/13 this was 55%)<br>11 audits exceeded the PI by more than 10 days. |
| Elapsed time for completion of the audit work (exit meeting) to issue of draft report | 15 Days | 82% of the audits met this target. (2012/13 this was 74%)<br>10 audits exceeded the PI by more than 10 days. |
| Elapsed time between issue of draft report and the issue of the final report | 15 Days | 65% of the audits met this target. (2012/13 this was 86% and 2011/12 this was 57%)<br>8 audits exceeded the PI by more than 8 days. |
| % of Internal Audit planned activity delivered | 100% of the audit plan by end of April 2014. | 86% of the plan was completed by the end of April 2014. (2012/13 this was 89%). |
| % of agreed management actions implemented within the agreed timescales | 90% of agreed management actions implemented | 362 Management Actions agreed in 2013/14: 66% implemented, 26% not yet due, 8% overdue or partially implemented.<br>350 Management Actions agreed in 2012/13: 95% implemented, 5% not yet due, overdue or partially implemented.<br>513 Management Actions agreed in 2011/12: 98% implemented, 2% overdue or partially implemented. |
| Customer satisfaction questionnaire (Audit | Average score < 2 | Based on 13 questionnaires returned the average score was |

| **Measure** | **Target** | **Actual Performance 2013/14** |
|---|---|---|
| Assignments) | | 1.24<br>(12/13 and 11/12 were both 1.32). |
| Directors satisfaction with internal audit work | Satisfactory or above | Achieved – Review of System of Internal Audit |

Ian Dyson

Chief Internal Auditor

June 2014

**APPENDIX 1 Audit & Governance Committee July 2014 - Implementation status of 2013/14 management actions.**

Note implementation status is reported by management. Internal Audit has not yet undertaken any further testing to confirm.

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 12 June 2014. |
|---|---|---|---|---|
| CEF | CEF Governance and Financial Management - Main Directorate Report | ISSUES | 9 | 2 implemented, 7 not yet due |
| CEF | CEF Governance and Financial Management - Abingdon Hub | ISSUES | 21 | 17 implemented, 2 not yet due, 2 partially implemented |
| CEF | CEF Governance and Financial Management - Roundabout Centre | UNACCEPTABLE | 32 | 27 implemented, 3 not yet due, 1 due |
| CEF | CEF Governance and Financial Management - Programme Governance | ISSUES | 4 | 3 implemented, 1 partially implemented |
| CEF | CEF Thriving Families Grant (Summer claim) | ACCEPTABLE | 0 | n/a |
| CEF | SEN Funding | ISSUES | 18 | 9 implemented, 1 partially implemented, 8 not yet due |
| CEF | Outdoor Centre Shops | n/a - no conclusion grading | 12 | 11 implemented, 1 partially implemented |
| CEF | Child View System | ISSUES | 9 | 5 implemented, 1 not yet due, 2 partially implemented, 1 due |
| CEF | CEF Thriving Families Grant (Winter Claim) | ACCEPTABLE | 3 | 3 implemented |
| SCS | SCS Governance and Financial Management - Main Directorate Report | ISSUES | 7 | 2 implemented, 5 not yet due |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 12 June 2014. |
|---|---|---|---|---|
| SCS | SCS Governance and Financial Management - LD Day Centre | ACCEPTABLE | 4 | 4 implemented |
| SCS | SCS Governance and Financial Management - OP Day Centre | ISSUES | 6 | 6 implemented |
| SCS | SCS Governance and Financial Management - Programme Governance | ISSUES | 4 | 4 implemented |
| SCS | NHS Information Governance Toolkit (IGT) | ISSUES | 5 | 5 superseded |
| SCS | Adult Social Care Management Controls | ISSUES | 14 | 2 implemented, 1 partially implemented, 11 not yet due. |
| SCS | SCS Contract Management | ISSUES | 10 | 10 not yet due |
| SCS | Review of Management Controls - Print Unit | n/a - no conclusion grading | 18 | 6 implemented, 12 either partially implemented or not yet due |
| OFRS | OFRS Governance and Financial Management - Main Directorate Report | ISSUES | 2 | 2 implemented |
| OFRS | OFRS Governance and Financial Management - Fire Stores | ISSUES | 15 | 11 implemented, 2 partially implemented, 2 not yet due. |
| CEO | CEO Governance and Financial Management - Main Directorate Report | ISSUES | 5 | 2 implemented. 3 not yet due |
| CEO | CEO Governance and Financial Management - Museum Audit | ISSUES | 15 | 15 implemented |
| CEO | Treasury Management | ACCEPTABLE | 0 | N/A |
| CEO | Pensions Fund | ACCEPTABLE | 0 | N/A |
| EE | EE Governance and Financial Management - Main Directorate | ISSUES | 10 | 2 implemented, 6 not yet due, 2 due |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 12 June 2014. |
|---|---|---|---|---|
| | Report | | | |
| EE | EE Governance and Financial Management - Adult Learning Centre (OCS) | ISSUES | 15 | 14 implemented, 1 partially implemented |
| EE | EE Governance and Financial Management - Programme Governance | ISSUES | 3 | 2 implemented, 1 not yet due |
| EE | Property and Facilities Management Contract (Year End Closedown) | ISSUES | 5 | 5 implemented |
| EE | Highways Contract | ISSUES | N/A | No management actions raised, issues being addressed through the Highways Contract Action Plan |
| EE | Local Enterprise Partnership arrangements. | ISSUES | TBC | Management actions yet to be agreed. Response due by the end of July. |
| EE (OCS) | Transforming Oxfordshire Customer Services (Part 1) | ACCEPTABLE | 1 | 1 implemented |
| EE (OCS) / CEO | Schools Finance & Technical Team (Part 2) | ACCEPTABLE | 0 | N/A |
| EE (OCS) | Mobile Computing | ISSUES | 11 | 9 implemented, 2 partially implemented |
| EE (OCS) | Microsoft Dynamics (Part 1) | ISSUES | 7 | 7 implemented |
| EE (OCS) | Transforming Oxfordshire Customer Services (Part 2) | ACCEPTABLE | 0 | N/A |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 12 June 2014. |
|---|---|---|---|---|
| EE (OCS) | Microsoft Sharepoint | ISSUES | 15 | 15 implemented |
| EE (OCS) | Pensions Admin | ACCEPTABLE | 1 | 1 implemented |
| EE (OCS) | Hosted Services (Part 1) | ISSUES | 4 | 4 implemented |
| EE (OCS) | Hosted Services (Part 2) | ACCEPTABLE | 3 | 2 implemented, 1 partially implemented |
| EE (OCS) | Procure to Pay (incl. Accounts Payable) | ISSUES | 8 | 8 not implemented |
| EE (OCS) | Payroll | ACCEPTABLE | 2 | 2 implemented |
| EE (OCS) | Accounts Receivable (incl. Cash Receipting) | ISSUES | 3 | 3 not implemented |
| EE (OCS) | General Ledger and Main Accounting | ACCEPTABLE | 5 | 5 not implemented |
| EE (OCS) | Microsoft Dynamics (Part 2) | ISSUES | 10 | 9 implemented, 1 not implemented |
| EE (OCS) | Hosted Services (Part 3) | ISSUES | 4 | 3 implemented, 1 not implemented |
| EE (OCS) | PSN | ISSUES | 5 | 3 implemented, 1 partially implemented, 1 not implemented |
| PH | Public Health Contracts | ISSUES | 1 | 1 implemented |
| PH | Public Health Governance and Financial Management - Main Directorate Report | n/a - no conclusion grading | 2 | 2 implemented |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 12 June 2014. |
|---|---|---|---|---|
| All / Corporate | Budget Setting (as part of G&FM programme) | ACCEPTABLE | 4 | 3 implemented, 1 due |
| All / Corporate | Review of Fees and Charges (as part of G&FM Budget Setting Programme) | ISSUES | 7 | 7 implemented |
| All / Corporate | Information Governance - Corporate Issues (as part of G&FM programme) | UNACCEPTABLE | 13 | 6 implemented, 7 either partially implemented or not yet due. |
| All / Corporate | Risk and Performance Management - Corporate issues (as part of G&FM programme) | ISSUES | 5 | 3 due, 2 not yet due |
| All / Corporate | Authority and Governance - Corporate issues (as part of G&FM programme) | ISSUES | 7 | 7 not yet due |
| All / Corporate | Budgetary Control - (as part of G&FM programme) | ISSUES | 10 | 10 not yet due |
| Proactive Fraud | Cash handling within the Gypsy & Traveller Service | ACCEPTABLE | 1 | 1 implemented |
| Proactive Fraud | Review of cash handling within the Union Centre & procedures established at other centres | UNACCEPTABLE | 4 | 4 implemented |

## APPENDIX 2

## DEFINITION OF CONCLUSIONS

| **Grading:** | **ACCEPTABLE** | **ISSUES** | **UNACCEPTABLE** |
|---|---|---|---|
| **Conclusion on:** | **Wording** | | |
| **Overall conclusion on the system of internal control being maintained** | There is a sound system of internal control in which risks are being managed to acceptable levels | There is generally a sound system of internal control. Risks are being mitigated to acceptable levels, except for the significant risks noted and there is therefore the possibility that some objectives will not be achieved | The system of internal control is generally weak, and the exposure to risk is such that it is probable that objectives will not be, OR are not being achieved. The system is open to the risk of significant error or abuse. |
| **Risks have been identified, evaluated and managed** | Thorough processes have been used | Processes have been used, but there are some deficiencies | Inadequate, or no, processes have been used |
| **Internal controls are adequately designed to reduce risks to acceptable levels** | There are adequately designed controls to mitigate the risks identified to acceptable levels (although some action may be required). | In general there are adequately designed controls to mitigate the risks identified, except for the significant risks noted in the report. | The design of internal controls is unacceptable as risks are not being mitigated to an acceptable level |
| **Internal controls are operating effectively in reducing risks to acceptable levels** | The controls in place are operating effectively, (although some action may be required ) | In general the controls in place are operating effectively, except for the significant risks noted in the report. | Generally the controls in place are not operating effectively leaving an unacceptable exposure to significant risks. |
| **The current levels of monitoring are sufficient** | No more monitoring is necessary than is done at present | Some additional monitoring is required | Major improvements are required to the monitoring of controls |
| **Action being taken to promptly remedy significant failings or weaknesses** | The action being taken will result in all risks being mitigated to acceptable levels | The action being taken will result in only some risks being mitigated to acceptable levels | No action is being taken, OR<br><br>Insufficient action is being taken to mitigate risks |

## APPENDIX 3 - Summary of Completed Audits, since last presented to Audit & Governance Committee 23 April 2014

### Pension Administration 2013/14

| | | |
|---|---|---|
| Opinion: Acceptable | 15 April 2014 | |
| Total: 1 | Priority 1 = 0 | Priority 2 = 1 |
| Current Status: | | |
| Implemented | 1 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

All actions are fully implemented.

Audit testing indicates that there are well established processes and controls in place throughout the pension administration process. The recommendation made in the 2012/13 report relating to the induction and training of new and existing staff was found to have been implemented. There is scope to strengthen risk management within the service, which may be addressed through a refresh of the service risk register. Undertaking quarterly reviews of the risk register, as expected, will ensure it is representative of the current service and that risks have been adequately identified. Controls in place to monitor, maintain and protect the IT Systems and integrity of service data were found to be robust. Processes to ensure consistent and widespread adherence to statutory regulations were in place and we found that communication with stakeholders was both comprehensive and timely.

We reviewed the lifecycle of a scheme member to verify the effectiveness of controls throughout the process. We found detailed procedure notes in place for all key processes and through sample testing of scheme entry, changes to membership, deferral of benefits and scheme closure we were satisfied that procedures had been followed. A management checking system is in place throughout the process, which provides a segregation of duties and minimises the risk of error.

Controls relating to the processing of monies or balances received were found to be robust with adequate processes in place for maintaining records and monitoring the rate of contributions from Admitted Bodies. Management reporting is undertaken on a timely basis and provides a sufficient route of escalation for resolution of pension-related issues.

**Payroll 2013/14**

| | | |
|---|---|---|
| Opinion: Acceptable | 15 April 2014 | |
| Total: 2 | Priority 1 = 0 | Priority 2 = 2 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

All actions are fully implemented.

Management actions raised during the previous audit, relating to appointment letters and leavers forms have both been implemented. Roles and responsibilities are clearly defined within the service with adequate training and induction arrangements in place for new starters. Guidance is comprehensive, accessible and up-to-date, and physical controls are acceptable. Processes for setting up starters and recording leavers were found to be robust. Controls around payments and revisions to payments are operating effectively, although a couple of issues were found in the processing of changes to standing.

**Accounts Receivable (incl. Cash Receipting) 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 4 June 2014 | |
| Total: 3 | Priority 1 = 2 | Priority 2 = 1 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 3 | |

Key weaknesses in the management of Adaptation loans were noted. Issues were noted over the retention of documentation, the application of interest against outstanding loans, and over the legal charges being secured against the property.

Invoice creation and debt collection & recovery were found to be well controlled, and reported on regularly. Cash receipting and reconciling the Abacus feeder system was also found to be well controlled, with the controls applied working effectively.

Write offs are managed well, with authorisation levels being adhered to. Debts passed to legal are also being chased efficiently, to ensure the Council is minimising its losses through unpaid debts.

There were seven actions raised in the previous audit. Of those seven, five have been completed and closed.

**Procure to Pay (incl. Accounts Payable) 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 5 June 2014 | |
| Total: 8 | Priority 1 = 3 | Priority 2 = 5 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 8 | |

An audit of Accounts Payable was last undertaken in the third and fourth quarter of 2011/12, which resulted in an 'Unacceptable' rating. Since then, the Purchasing Improvement Project, overseen by senior management, has been concluded which aimed to address the issues raised and implement improvement actions. Many of the project objectives have been achieved, however, as noted in the end of project review, the project progressed slower than expected and not all deliverables are complete. This was considered to be due to the challenge of combining business-as-usual with additional project work, and an under-estimation of the volume of the latter. Where change has happened as a result of the project, the effects are still bedding in. In some cases the benefits are becoming evident (e.g. the reduction in the number of RPO's), and in other cases sufficient positive change is yet to emerge (e.g. reduction in the use of One Time Vendors). The backdrop to this is the externalisation programme, and management are as yet unsure what the purchasing model will be under the new arrangements. This audit was undertaken assuming business-as-usual, however the prioritisation of the risks and issues raised will be assessed by management in the context of change.

A. Governance:

Clearly a significant amount of work has been done during the project, and overall the purchase to pay risks and processes are now better managed. There is improved oversight of KPIs via the Purchase to Pay Performance Dashboard reported monthly to the CSB. Whilst most of the Indicators have shown trends in the right direction, none of them have yet achieved their targets (however there has been discussion at CSB whether these targets are realistic and require review). Management recognise the inability to report on some of the indicators, and also that some of the data contained in the indicators may not be fully up to date. The Vendor Data Working group are currently looking into these Dashboard issues.

The operating model for purchasing activities has changed, with the reduction in number of requisitioners (local buyers), from 532 at the beginning of 2013/14 to 241 at the end. Along with the CBT, they now form the 'Buying Community' and are the only staff in OCC with the permissions to raise purchase orders in SRM. Under the new model, the 'Guidance and Gatekeeping' role has moved from the Purchase Order Specialists to the local buyers. Whilst the local buyers have been trained in the purchasing processes and systems, the challenge going forward will be to monitor their performance to ensure timeliness and adherence to correct procedures in the purchasing processes (this is currently not monitored nor reported on).

The review of policies and procedures was undertaken with the Central Buying Team (CBT) through workshops and use of an independent facilitator. Whilst much of the thinking has been completed, and most of the revised policies and procedures have been drafted, the majority of these are yet to be completed, signed off and updated

on the Intranet. Management are aware of this and plan to complete these as soon as possible.

B. Vendors:

Internal Audit sample tested the creation of 25 new commercial and 25 new non-commercial vendors. This demonstrated that the use of the Vendor Master Maintenance Form was consistent, and examples were evidenced of the CBT requesting staff to use the updated version. The CBT's response times for setting up new vendors were excellent, consistently doing so within 24 hours of the request being received. All of those sampled had sufficient documentation from the new vendor confirming their details on headed paper. However in 13/25 cases, although the Vendor Master Maintenance form contained the line manager's name, the email request to CBT did not copy in the manager. In effect therefore, these requests had no evidence of appropriate management authorisation.

A significant cleansing exercise to identify and block vendors that have not been used in the past 12 months has resulted in the number of live vendors reducing from 53,601 at the beginning of 2013/14 to 30,587 at the end (the figure was 32,331 at the time of the 2011/12 audit). This cleansing exercise is due to occur every six months; however a similar systematic process is not yet in place for routinely identifying duplicate vendors. It is worth noting that the figure does not include One Time Vendors (OTVs), as these are not logged in the Vendors Database (the number of OTVs paid during 2013/14 was 1,820).

There continue to be issues with the use of OTVs, as the number used more than three times during the year continues to be unacceptably high. This poses risks to the Council, as these vendors are not vetted in any way, as per the usual process when setting up a vendor. Furthermore, OTV purchases are not authorised before expenditure is committed, but often at the point of invoicing (from the sample of 12 OTVs reviewed during the audit, 7 were processed after the invoice date). The performance figures on OTVs in the Performance Dashboard are not up-to-date, so management do not have accurate oversight of their use.

C. SAP:

Purchasing and AP roles in SAP and SRM are adequately listed, and ensure segregation of duties. Requests for new staff to acquire these roles are authorised by appropriate managers, however this audit did not test a sample of recent requests.

D. Purchasing process:

From the sample testing of 25 purchases across Directorates throughout 2013/14 it was noted that all purchase orders were authorised appropriately, in accordance with SAP Approvers. Forms are available for staff to use to request a PO to be raised and to goods receipt the purchase, however these are not mandatory. As expected, therefore, a variety of means of communication were observed, and none had used the Goods Receipting form.

Retrospective Purchase Orders (RPO's) are monitored and reported on in the Performance Dashboard. Email notification is now sent to the relevant managers where RPO's have been raised, and this has seen a steady reduction in the number of RPO's, from 35% to 12% during 2013/14 (the target is 0%). Out of the sample of 25 purchases reviewed in this audit, 7 POs had been raised retrospectively, although six of these were in the first half of the year.

All purchases that go red route in SRM are now logged on a spread sheet by the Buying Specialists, detailing the actions taken, advice given and decisions made. This provides greater transparency and also allows analysis of red route trends. Performance on red routes is monitored on the Performance Dashboard, which shows that the figure has fallen (from 38% to 30%) but still hasn't reached its target of 10%. Duplicate payments are monitored and reported on a monthly basis by Accounts Payable; corrective action is taken where necessary. There is an adequate process in place for doing this, and the figures reported in the Performance Dashboard are within targets.

Ongoing issues with Basware were noted during the audit, however these were raised appropriately with management and with Basware, where necessary. The first time success of the three way match in Basware is reported on as part of the monthly performance reports (previously around 25%, it has now risen to around 33%, however the target is 80%). Management recognise that without further investment or a change in programme, it will be impossible to improve these performance figures. The percentage of invoices paid within vendor payment terms is not yet being reported in the Performance Dashboard (although the % of invoices paid within 28 days is monitored, and is within target). Out of the 25 purchases sample tested, 7 were paid later than the vendor's payment terms for standard vendors, and 3/12 for OTV purchases.

Follow Up:

The previous audit contained 32 actions, 9 of which were outstanding on the audit action recording system at the time of this audit. Of these 9 outstanding actions, 7 were reviewed as part of this audit (the two not reviewed were Monitoring of PO commitments and Value Orders not set up correctly, however management stated that these have now been completed).

## Treasury Management

| | | |
|---|---|---|
| Opinion: Acceptable | 23 June 2014 | |
| Total: 5 | Priority 1 = 0 | Priority 2 = 0 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 0 | |

Our overall conclusion is ACCEPTABLE. Internal Audit identified that there is a sound system of internal control in which risks are being managed to acceptable levels. This has been despite staff shortages and technological challenges which impact on the speed and efficiency with which tasks can be performed. The former has now been addressed with there now being a Trainee Financial Manager covering Treasury Management. The latter concerns two issues. The first is with regard to the connection to LloydsLink which is currently still via dial up although transfer to the more reliable online system is imminent after previous failed attempts. The second concerns the Lending Database which is an end user developed excel spreadsheet containing 49 worksheets.

There were no actions arising from the audit.

**Governance & Financial Management CEO Main Directorate Report 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 5 | Priority 1 = 0 | Priority 2 = 5 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 3 | |

Authority & Governance

There were 2 management actions agreed in relation to Authority & Governance in the 2012/13 CEO Governance & Financial Management Internal Audit Report. There was also 1 action raised in the 2011/12 CEO Governance & Financial Management Internal Audit Report which had not been implemented at the time the 2012/13 report was finalised. All 3 actions have been reported as fully implemented, however testing undertaken as part of this year's audit has identified that implementation has not been fully effective.

An action was agreed in relation to the updating and republication of the Scheme of Financial Delegation at least every 6 months. However, the current version of the Scheme on the intranet is dated July 2013. An action was agreed in relation to the review of unused or unallocated cost centres and the removal of live approval levels from these cost centres, two examples were identified where "not in use" was marked in the person responsible field however there were still found to be live approvers on both cost centres. It was also found that active and passive substitution arrangements had not been effectively reviewed. An example was noted a £500K approver had two different £5K approvers set up as active substitutes. Both £5K approvers would therefore inherit the £500K approval level and be able to approve outside of their delegated approval limit. Management actions from 2011/12 and 2012/13 have been restated or re-worded and are detailed in the main body of the report.

It was noted that the current CEO Scheme of Financial Delegation does not detail who has delegated authority to approve the write off of stock. This was a common issue across directorates and is also being raised corporately in relation to updating corporate guidance on content and format of the Schemes.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

During the establishment audit of the Oxfordshire Museum, two conflicts of interest were identified which had not been declared and recorded. A separate report with agreed management actions to address the weaknesses identified at the Oxfordshire Museum has been issued and finalised (6 March 2014).

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level.

The Information Governance Group was re-launched following the 2012/13 audit but this body, whilst making some progress, has not been fully effective in addressing previously identified weaknesses in this area. This group includes representation from CEO.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target date having been moved to 31/03/14 from 31/03/13. Across each directorate specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including client data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who the priority users for such software are or escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance, but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters but this suite of documents needs to be reviewed. Given the number of documents there is some overlap in content. There is confusion in relation to naming conventions and it is therefore not always possible to tell what document reference is being made to.

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered

by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

Business Continuity

Not tested in 2013/14. However, it was confirmed during the establishment audit of the Oxfordshire Museum that a plan was in place.

Risk & Performance Management

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two areas was split. The Chief Internal Auditor and the Head of Policy are now the corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

They author a quarterly Business Management Monitoring Report, versions of which go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate, but this does not include CEO performance. We did not undertake any detailed review of CEO performance in 2013/14.

The Audit Working Group usually meets monthly and at each meeting one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. To date the Chief Executive's Office has not been part of this process. Although there are departmental risk registers there is no consolidated directorate risk register. The Senior Policy and Performance Officer is currently producing one.

The corporate risk lead has undertaken a quality review of the risk registers including the various registers from CEO and, for 2014/15, corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged. Although our coverage of risk management within CEO was limited we noted an area of good practice with the Legal Department who have designed sound processes for identifying and monitoring new risks.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. It was noted that there is no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process in place for non-compliance. Corporate management actions were agreed to address this.

A separate corporate report on Fees and Charges has also been issued and finalised (22 August 2013). The overall conclusion was Issues. The audit identified

that the Charging Policy, set out in Annex 3a of the 18th December 2012 Cabinet papers, did not contain any documented information on the roles and responsibilities of relevant officers involved in the fees and charges process. Regarding the setting of fees, there were varying levels of evidence across the directorates from fully documented cost models to detailed methodology explained by service heads to support fees set.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Financial Compliance:

An establishment audit of the Oxfordshire Museum was undertaken. There had previously been a financial irregularity in respect of income in this area. Income processes were reviewed and whilst it was noted that systems of control in relation to café income have improved since the investigation, it was noted that the new till purchased does not enable receipts to be printed, it was also noted that there were a higher level of over rings and discrepancies between cash income and Z readings than was the case with the shop till. It was noted that income trends are being reviewed on a monthly basis by management to ensure expected income is received, however this was not documented and the stock in hand figure not considered. Weaknesses were identified in relation to the process for collection and counting of income from donations boxes. In relation to lettings, it was identified that there were no formal contracts or agreements with users hiring rooms at the museum which provide full letting terms and conditions. Copies of insurance documents were not always taken when letting the rooms and it was noted that hirers were not invoiced until after the letting has taken place. One instance was identified where the invoice was not raised until 4 months after the letting.

Review of payroll processes at the Oxfordshire Museum identified that the Museum Manager had signed off casual claims for Museum Assistant work undertaken by her daughter, which is not appropriate and a conflict of interest.

A separate report with agreed management actions to address the weaknesses identified at the Oxfordshire Museum has been issued and finalised (6 March 2014).

Procurement:

Review of procurement practices was undertaken during the establishment audit of the Oxfordshire Museum. Instances were noted where purchases had been made by procurement card where it may have been more appropriate to use e-procurement. Testing identified that there were some cases where insufficient evidence of goods receipting was available to support e-procurement purchases made. It was also noted that the number of suppliers for café and shop stock was relatively high.

Control of Assets:

For CEO this was reviewed during the establishment audit of the Oxfordshire Museum. From review of stock control processes for café and shop supplies, it was

noted that stock is stored in separate café and shop store rooms. There was no documented system of stock control in and out of these rooms.

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

For CEO, compliance with HR polices was tested during the establishment audit of the Oxfordshire Museum. It was identified that not all staff had up to date performance objectives and appraisals. Annual driving checks were found to be incomplete. One member of staff who had been identified as having claimed mileage from payroll testing, was not recorded as having had her details checked on the spread sheet. Gaps were also identified in the records recorded, for example, driving license numbers not recorded, no record of MOT etc. Instances were also identified where staff were not having regular 1:1s.

Programme Governance

Programme / Project Management arrangements for CEO have not been considered for 2013/14. A corporate management letter has been issued instead. Corporately it has been identified that there is no overall reporting of programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level.

**Risk and Performance 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 5 | Priority 1 = 0 | Priority 2 = 5 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | 3 | |
| Partially complete | | |
| Not yet Due | 2 | |

Risk Management

Our overall conclusion on Risk Management is ISSUES. Internal Audit identified that there is generally a sound system of internal control in place. Risks are being mitigated to acceptable levels, except for the significant risks noted below, and there is therefore the possibility that some objectives will not be achieved.

It was identified that the strategic risk register was last presented to Extended CCMT in May 2013 although there is a requirement for this to happen twice a year.

During this audit we noted some areas for improvement at the corporate and directorate level but are aware that much is currently being done to strengthen the risk management process.

Directorates all have an established process to capture key risks and from the high level review of the risk registers undertaken by Internal Audit most would appear to have been captured. There was however a general lack of health & safety and programme risk recorded in the registers.

Roles and responsibilities are fairly clear. Directorates have risk leads and the corporate risk lead is providing them with advice and guidance which will lead to consistency across the organisation and more effective risk management.

The detailed guidance on risk management on the intranet is currently being refreshed.

There is a sound method for reporting and escalation although in practice some weaknesses were noted in how this was being applied and as yet the Chief Executive's Office is not part of this process.

There is some room for improvement in the completion of the registers themselves. Weaknesses identified include a lack of recorded mitigation showing action plans to achieve the target score and dates by which this is to be achieved.

The corporate risk lead has been undertaking a quality review of the risk registers and is building on previously established good practices to further strengthen the Council's risk management processes. For 2014/15 corporate quality monitoring is to be introduced. This is to be welcomed as it should ensure that the key risks to OCC are more effectively identified, communicated and managed.

This new process includes a number of quarterly reviews of the risk registers. The Risk and Insurance Assistant will check for accuracy of completion, the Internal Audit Managers will challenge risk assessments based on Internal Audit reports, the Risk Lead and the Senior Policy and Performance Officer will review the registers together with the performance reports and the Finance leadership team, including the Finance Business Partners will review the finance risks.

There is a detailed section on Risk Management on the intranet and it is acknowledged that this needs to be updated. The plan is for it to be re-launched in April 2014.

We have noted some observations in the findings section of this letter which we consider would improve this guidance and reference material.

We recognise that much effort is being put into maintaining and improving the quality of directorate risk registers. Having reviewed individual directorate registers our findings broadly mirror those identified by the Corporate Lead's initial quality review.

<u>Performance Management</u>

Our overall conclusion on Performance Management is ISSUES. Internal Audit identified that there is generally a sound system of internal control in place. Risks are being mitigated to acceptable levels, except for the significant risks noted below, and there is therefore the possibility that some objectives will not be achieved. This overall conclusion is based on the combined findings of our audit that has looked at

both the overall performance management framework, and the management of performance data within the Directorates. The opinion is weighted to Issues based on the findings within the Directorates; however, it should be noted that we found the corporate performance management framework and reporting to be robust, with further enhancements already implemented in preparation for 2014/15.

The Council covers an extremely wide range of activity with some Directorates themselves having a diverse set of responsibilities. This makes performance reporting a challenging and time consuming process and the opinion has to be considered in this context.

Given that the various bodies to which the dashboards are presented agree the indicators at the start of the financial year this should ensure that the key indicators for each service are being monitored.

The system for reporting performance within Directorates, and to CCMT, Informal Cabinet, Performance Scrutiny Committee and Cabinet is generally sound but there is a need for some improvement in the presentation of the data in the dashboards to make it clear what is actually being reported. The Performance Scrutiny Committee appears however to be particularly effective in providing challenge to identify what the key issues are behind apparent poor performance.

Assurance levels as to the accuracy and integrity of the data are variable and for management to validate the data would be another time consuming exercise. Some of the information is relatively straightforward to extract for reporting purposes. The calculation of other indicators is however arrived at by using a combination of tools, such as Business Objects' Crystal Reports to extract data from various applications, spreadsheet manipulation, the use of pivot tables and some manual calculation and intervention.

There are known issues with some of the systems from which data needs to be extracted and at times this has meant that information needed for reporting purposes has not been available.

Some of the information used in the dashboards are provided by a third party and this is accepted at face value.

Each quarter the Directorates provide a Senior Policy and Performance Officer (SPPO) with their Performance dashboard and a narrative. The SPPO then consolidates this and creates the Business Management Monitoring Report referred to below. There may be some challenge to the content received but any changes are agreed with the Directors and Deputy Directors before finalisation.

Our detailed findings which are included in the findings section of this letter are with regard to the need for clarity of the information provided in the dashboards, target categorisation and assurance over data accuracy.

**Pension Fund 2013/14**

| | | |
|---|---|---|
| Opinion: Acceptable | 15 April 2014 | |
| Total: 0 | Priority 1 = 0 | Priority 2 = 0 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

There are no actions arising from this audit.

Audit testing found that fund governance, strategy and risk management arrangements are effective. There is also an on-going training programme in place for Committee Members. An Annual Report 2012/13 was produced and was reviewed by the Pension Fund Committee prior to acceptance of the Accounts, and the Committee has oversight of company engagement for all fund managers. Cash flow forecasting and monitoring arrangements are in place and reviewed by service management and the independent financial advisor during quarterly meetings. In conjunction with reports to the Pension Fund Committee, the in-house cash level was found to be within target limit and the actual cash flow position was up to date.

The controls in place to monitor the performance of fund managers were found to be effective. Fund Managers meet with management or update the Pension Fund Committee on a quarterly basis and WM Performance Services report annually on the fund manager's performance to the committee. We examined pension contribution returns and the reconciliation process, in-house accounting records maintained for non-custodian held investments and the reconciliation process for third party invoices, the new bank system and charging for inaccurate payments from admitted bodies and found controls to be effective. We examined the accuracy of transfers between fund managers by testing a sample of stock transfers. We established that detailed records are in place to verify that funds were accurately sent and received.

**Main Accounting 2013/14**

| | | |
|---|---|---|
| Opinion: Acceptable | 25 April 2014 | |
| Total: 5 | Priority 1 = 0 | Priority 2 = 5 |
| Current Status: | | |
| Implemented | 1 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 4 | |

Areas of good practice noted were:

- Clear procedures were being followed for uploading data from feeder systems into SAP. From the sample of five reviewed, these were adequately controlled and authorised. Reconciliation between SAP and the feeder data is made by checking the control totals in the requestor's email to a screen shot taken of SAP following the upload.

- Journals and Internal recharges are effectively processed, with appropriate authorisation and supporting documentation (except for the gap in supporting documentation for two internal recharges noted below).
- Good use is made of sample checking of feeder systems, journals and internal recharges. These are undertaken by teams independent from those responsible for processing the transactions and issues were appropriately followed up and resolved.
- The Dynamics system effectively maintains an audit trail of emails for processes managed by the Finance Service Desk, including journals, internal recharges and AP uploads.
- Control and suspense accounts are appropriately reconciled and checked by the Banking and Control team.
- From the sample of bank reconciliations tested, these were adequately completed, authorised and issues resolved.
- Clear procedures and template forms are available to staff on the Intranet for requesting journals, internal recharges and new or amended cost centre and GL codes.
- Numerous cases of the Finance Service Desk picking up on errors in journals, internal recharges and AP upload requests were noted by Internal Audit during the testing. These were adequately raised and resolved with the requestors.

However, the following issues were noted during the audit:

- Internal recharge authorisation: the supporting documentation, including the cost centre managers' authorisation remains with the requestor for Internal Recharges and journals under £50k. In two cases out of the 25 Internal Recharges sampled, the cost centre managers' authorisation could not be located due to staff turnover.
- Procedure notes: In a number of cases, procedure notes had not been updated or did not exist. Staff reported that due to work pressures, the task of updating procedure notes had been de-prioritised.
- Suspense account: The Unidentified Income (B1641) suspense account has items dating as far back as September 2012. Although attempts have been made to allocate these, so far the Banking team has been unable to clear them.
- Checks have not been undertaken to identify disused bank accounts this year. Management stated that there has not been enough time to do this and it has been de-prioritised.

Follow up: All three actions from the 2012/13 Main Accounting audit have been reported as fully implemented.

**Authority & Governance Corporate Findings 2013/14**

| | | |
|---|---|---|
| Opinion: Acceptable | 15 April 2014 | |
| Total: 7 | Priority 1 = 0 | Priority 2 = 7 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 7 | |

Within directorates further improvements have been noted since the 2012/13 audit. There is greater consistency between directorate Schemes of Financial Delegation and SAP approvers than noted in previous years and there were also less inappropriate substitution arrangements identified.

However, within some directorates there were outstanding actions from previous year's audits and there were also actions agreed in previous years which, although reported as implemented, were not found to have been implemented effectively from the testing undertaken by Internal Audit for 2013/14.

Within CEO, CEF and PH, it was identified that Schemes of Financial Delegation had not been updated and re-published every 6 months as required. CEO and PH Schemes had not been updated since mid-2013 and the CEF Scheme, although the Schedule had been updated in January 2014, had not been updated since August 2013. It was also noted that there are 2 actions outstanding from the 2012/13 E&E report in relation to updating of the Scheme to reflect the required text in relation to the use active and passive substitutes on SAP and at least 6 monthly review and republication of the Scheme. Responsibility for the implementation of these actions has now been reassigned and revised target dates provided. Internal Audit will continue to monitor and report on progress with implementing these actions via the 4action tracking system.

Management actions were agreed with directorates in relation to the process for the closing down of old and unused cost centres, the updating of the person responsible field on SAP and the removal of live approvers on these cost centres as part of that process. Testing undertaken this year identified instances where cost centres had been marked as old / unused / blocked, but still had live approvers. This was the case in CEO, CEF and SCS.

Although improvements were noted across directorates in relation to the amount of inappropriate SAP substitution arrangements in place (substitutes set up by approvers had a lower delegated approval level than the approver), it was identified from testing within CEO, CEF, E&E and SCS that there were inappropriate substitution arrangements in place, a number of them having been in operation since August 2013 indicating that checking and challenging of these arrangements, agreed as a result of last year's audits, has not been fully effective. Management actions have been agreed with directorates both in relation to the checking process and also to ensure that there is an appropriate escalation process in place going forward.

It was noted, as part of an audit undertaken earlier in 2013/14 that the authority to write off stock is not clearly stated in directorate Schemes of Financial Delegation.

Management actions have been agreed to resolve this with directorates with the exception of PH who do not have stock.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

Establishment audits undertaken within CEF and SCS identified some authorisation outside of the approved directorate scheme of financial delegation, for example inappropriate sign off of payroll claims including one instance where a cost centre manager had got an Administrator to authorise his expense claim. These issues have been summarised within directorate Governance & Financial Management reports and also reported on as part of a separate establishment report finalised and issued to the relevant directorate. Actions have been agreed to ensure that there is compliance with the approved scheme going forward.

Corporately, as part of this year's audit, the process for making changes to profit and cost centres on SAP has been reviewed and clarified considering the controls in place over the closing of old / unused cost centres and the approval of changes to authorisation limits. It was noted that the process reported as having been developed since the restructuring of finance is not yet documented and intranet guidance is currently incomplete.

Issues have been reported with the accuracy of updates being made by ICT on receipt of profit & cost centre amendment forms. Instances were reported where some tabs have not been updated and other instances were reported where not all changes requested on individual tabs had been made. Checks are being made by Assurance & Reporting staff, but errors have not been systematically logged or escalated as yet.

Whilst undertaking the programme of governance and financial management establishment audits throughout 2013/14, Internal Audit have identified potential gaps with the Corporate Policies and Procedures available on the intranet. Areas concerned include amenity fund / unofficial fund guidance, income collection, use of Ebay and PayPal, use of store points (e.g. Nectar, Clubcard), use of gift vouchers / cards.

**Budgetary Control 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 10 | Priority 1 = 1 | Priority 2 = 9 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 10 | |

Whilst the findings detailed in the management letter highlight weaknesses that need to be addressed, it is acknowledged that a great deal has been achieved during 2013/14. Ambitious timescales for the restructuring of corporate finance and the implementation of SAP BPC have been achieved. A number of senior finance staff have been key to the success of both parts of the project working on this as well as their day to day finance responsibilities. Although there are key processes that need to be fully developed and documented, the Assurance & Reporting Team is up and running and is providing support to cost centre managers.

Dashboard reporting is in the process of being finalised and rolled out across all directorates. Once content and format has been finalised and the reporting system implemented, Finance Business Partners will have a monthly reporting tool for feeding back to Directorate Leadership Teams on areas including the robustness of financial forecasts, areas where there are concerns over forecasting and the need to use high level adjustments. Initially, the dashboard will also contain details about the take up of SAP BPC training.

There are a number of areas where processes and roles need to be clarified and confirmed. For example, although there are informal systems in place for monitoring calls coming into the Assurance & Reporting Team, formal processes for prioritisation and allocation of team member's workload are being developed. Clarity is also needed in relation to when issues being dealt with by Assurance & Reporting Team staff should be referred to the Finance Business Partner. Information sharing processes between Assurance & Reporting and Senior Financial Advisers / Finance Business Partners are also being developed.

The process for annually updating the risk assessment of budgets in order to determine the level of financial support provided by the Assurance & Reporting Team is still to be formerly finalised and documented. An initial risk assessment exercise was carried out in November 2013 and current financial support arrangements are based on this.

Exception reporting is used for determining which medium and low risk budget forecasts are reviewed and challenged by staff within the Assurance & Reporting Team. Exception reports are being run and reviewed, however the process and methodology is not yet finalised. This is one of the areas under development in relation to dashboard reporting mentioned above.

Training in the use of SAP BPC has been offered to all cost centre managers, reviewers and approvers. Some follow up has been undertaken in relation to those who do not appear to have completed any training and this will be one of the areas reported on to directorates as part of the dashboard reporting mentioned above. It has also been reported that more comprehensive e-learning for cost centres managers is being developed (wider than SAP BPC forecasting) and that future training requirements specifically in relation to SAP BPC will be considered and agreed through a managers user group.

There are still several issues outstanding from the project implementing SAP BPC, these include resolution of problems found during testing of salary drill through (cost centre managers are currently receiving salary information direct to their SAP inbox rather than being able to access it in BPC), finalisation of automated audit trail reporting showing which cost centre managers have and have not completed their forecasts within the required timeframes, delivery of the training environment and issues with the creation of new cost centres in an old financial year.

Concerns have been raised in relation to changes requested to the SAP BPC structure. This area has not been tested by Internal Audit and there were no specific instances reported where changes to the BPC structure had not been made as requested. However, it was initially unclear how changes to the SAP BPC structure could be checked, who had access to be able to do this and who should be responsible for any checks. Since the issue of the draft management letter, it has been reported that the mapping of cost centres and service areas to managers within BPC will be available as part of the audit trail/reporting noted in finding 8. It is anticipated that this will be used to check and review changes, responsibilities and any associated training requirements as part of the dashboard reporting.

**Governance & Financial Management E&E Main Directorate Report 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 10 | Priority 1 = 2 | Priority 2 = 8 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | 2 | |
| Partially complete | | |
| Not yet Due | 6 | |

Authority & Governance

There were 6 management actions agreed in relation to Authority & Governance in the 2012/13 E&E Governance & Financial Management Internal Audit Report and a further management action from 2011/12 which had not been implemented at the time the 2012/13 report was issued. 5/7 management actions have been reported as fully implemented. Testing has confirmed effective implementation of 3 actions, however 2 actions in relation to the review of SAP approvers and monitoring of active and passive substitution arrangements on SAP were not found to have been implemented effectively. It was found that there were still a number of inappropriate substitution arrangements in place, many of which had been in place since at least

August 2013. The 2 actions outstanding from 2012/13 in relation to updating of the Scheme to reflect the required text in relation to the use active and passive substitutes on SAP and at least 6 monthly review and republication of the Scheme have not yet been implemented, this is highlighted in the main body of the report and both actions will continue to be monitored by Internal Audit until fully implemented.

It was noted that the current E&E Scheme of Financial Delegation did not detail who had delegated authority to approve the write off of stock. This was a common issue across directorates and is also being raised corporately in relation to updating corporate guidance on content and format of the Schemes.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes making changes to authorisation limits of SAP approvers. As part of this audit, the process for documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level.

The Information Governance Group was re-launched following the 2012/13 audit but this body, whilst making some progress, has not been fully effective in addressing previously identified weaknesses in this area. This group includes representation from E&E.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target date having been moved to 31/03/14 from 31/03/13. Across each directorate, specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including client data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who the priority users for such software are or of escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance, but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters but this suite of documents needs to be reviewed. Given the number of documents there is some overlap in content. There is confusion in relation to naming conventions and it is therefore not always possible to tell what document reference is being made to

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

Business Continuity

Not tested in 2013/14 for E&E.

Risk & Performance Management

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two areas was split. The Chief Internal Auditor and the Head of Policy are now the corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

Each quarter they author a Business Management Monitoring Report which is produced by the Senior Policy and Performance Officer based on information she has received from the Directorates. Versions of this report go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate. The Director and Deputy Directors present the E&E performance report to the Performance Scrutiny Committee each quarter. The Audit Working Group usually meets monthly and, at each meeting, one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. The E&E risk lead presented at the March 2014 AWG.

The corporate risk lead has undertaken a quality review of the risk registers including the E&E register and, for 2014/15, corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged.

We are aware that much work is currently being undertaken to refresh the risk management and performance reporting processes within the Directorate.

We found some issues with the E&E risk register which need to be improved. These are broadly in line with the findings of the corporate risk lead in his initial review.

Risk:

- We noted that the column in the risk register for recording current controls headed “Controls in Place to Mitigate Risk / Actions Already Taken / Contingency Plan if Materialises” at times does not actually list controls currently in place.

- Some Directorates have risk registers with a separate section on risk mitigation / contingency planning and this includes, if fully completed, specific actions to minimise risk, i.e. how to achieve the target score. The E&E register does not have this section and there is no clearly documented path showing how the target score will be achieved.

- Although there is no over-arching risk of individual programme or project failure recorded in the E&E risk register, a management action has been agreed as part of the Programme Governance Audit for this to be implemented by the end of this financial year. This has not yet been reported as implemented, but will continue to be monitored by Internal Audit.

- There are no over-arching risks covering health and safety risk in the register.

Performance:

- The performance indicators listed in the quarterly dashboard do not always clearly specify what is being measured nor is the information provided always clear and consistent. It is not always obvious from the performance measure whether the figure reported in the dashboard is cumulative or only relates to the latest quarter.

- Two indicators on the Q3 dashboard are shown as being green under the traffic light system even though the target has not been met. There is also a case where the target has not been achieved, but has been categorised amber and not red, based not on pre-defined criteria, but a subjective opinion.

- The E&E Performance Monitoring Team have not previously sought assurances on the accuracy and integrity of the data they have been provided with from systems such as EXOR, MS Dynamics and Single Response for reporting in the quarterly Dashboards. It should be noted that for 2013/14 Internal Audit testing within E&E did not include checking to source data and method of calculation to confirm figures entered on the dashboard.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. It was noted that there is no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process

in place for non-compliance. Corporate management actions were agreed to address this.

A separate corporate report on Fees and Charges has also been issued and finalised (22 August 2013). The overall conclusion was Issues. The audit identified that the Charging Policy, which is set out in Annex 3a of the 18th December 2012 Cabinet papers, did not contain any documented information on the roles and responsibilities of all relevant officers involved in the fees and charges process. Regarding the setting of fees, there were varying levels of evidence across the directorates from fully documented cost models to detailed methodology explained by service heads to support fees set.

In respect of the application of fees, sample testing in Highways identified that not all agreed fees were being applied at the correct rate. This was corrected immediately.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Financial Compliance:

From review of income at the Union Centre it was identified that all income is currently coded to one cost centre and not against the curriculum cost centre budgets to which the income relates. This makes it harder to track income against curriculum areas. This audit followed up on the 2013 cash handling review. Steps had been taken to minimise the risk of cash misappropriation, such as no longer charging for use of the vending machine and no longer allowing cash payments to be made at other sites (other than for ALD courses). However, the audit found that a key control to reconcile the cash income against the learner database, EBS, was still not being fully undertaken for all cash payments.

From review of lettings, it was noted that there is one routine letting at the Union Centre, however, at the time of the audit there was no formal documented agreement in place and it was not clear whether the appropriate public liability insurance was in place. The invoice is also unclear in relation to the number of sessions required and charge per session.

From a review of 20 payroll claims at the Union Centre, examples were identified where a member of staff had been underpaid by approximately £500, a claim had been signed off by an officer without the delegated authority to approve expenditure, home to work mileage had not been deducted, expenses had been reclaimed for food for a leaving party and receipts had not been provided to support train / tube travel. It was also noted that the mileage budget was overspent. The weaknesses identified indicate that payroll claims are not being appropriately reviewed and checked by management prior to authorisation.

A separate report with agreed management actions to address the weaknesses identified Union Centre has been issued and finalised (20 March 2014).

Procurement:

An audit was completed of Property and Facilities Management Contract (Year End Closedown) during 2013/14. A separate report with agreed management actions was finalised 15 May 2013. The main issues identified were as follows:

- Task Orders should be completed for all works instructions issued to CCS. As at March 2013, there were 114 works/projects where Task Orders had not been completed in full by OCC and CCS, and signed off. Work is on-going to ensure a full quota of project documentation, including Task Orders, is available. This will enable OCC to complete the necessary quality checks on the documentation and be assured invoices received are accurate and correct. There is a risk that CCS does not deliver the expectations of the customer, within budget and to the agreed timeframes. Additionally, without a full quota of relevant documentation, OCC staff are unable to agree and sign off any invoice received from CCS.

- As part of the quality assurance process, checks should be undertaken on completed works. During 2012/13, no quality assurance checks have been completed. It has been reported that checking processes are being introduced, although this has not been independently tested by Internal Audit as yet. There is a risk that completed works are not to the agreed scope, quality price and have not achieved value for money.

An audit was completed of Highways Contract during 2013/14. A separate report with agreed management actions was finalised 10 January 2014. The main issues highlighted as part of the audit are:

- The gateway review process has not always been followed or monitored at stages in the project management process. Management have stated that major work has been completed on the gateway review process and this will be included as part of the overall improvement plan.

- In reviewing task order values against SAP payments, testing found schemes where payments exceeded the task order values. Task orders are monitored by the Contract Management Team, who monitors the cost against the task order, but the visibility of cost apportionment in terms of commitment, committed and uncommitted expenditure along with a calculation is unclear. Management have stated that there is work to do in ensuring staff follow the correct financial approval process, but the Programme Delivery Group review both capital and revenue spend on a monthly basis.

- The Contract Management Team highlighted that there are a number of items, including disallowed costs, that impact on the end of year position. £2 million of accrued sub-contractor fees that Atkins has accounted for but had not paid to the sub-contractor as yet and therefore cannot bill OCC were viewed as items that could become year end accruals. At the time of the review we were informed that as of the 13 August 2013, the accruals for the Highways contract had yet to be fully confirmed after closedown. Management have stated that payments are only processed once the

necessary evidence has been obtained and that the team are working with Skanska UK to ensure closedown can be achieved more promptly.

There is an outstanding action in relation to the 2011/12 Knights Court Facilities Management audit regarding the issue and communication of the Local Finance Procedures. The officer responsible has been reallocated and the Finance Business Partners are now addressing the issue. Internal Audit will continue to monitor the implementation of this management action on the 4action system.

Procurement was reviewed as part of the establishment audit of the Union Centre. From sample testing undertaken, it was noted that one supplier had been paid late on a number of occasions, and in one example tested a late payment fee was added to the invoice. It was identified that one purchase order had been raised retrospectively and in one instance, it was found that there was no evidence to support goods receipting.

A separate report with agreed management actions to address the weaknesses identified Union Centre has been issued and finalised (20 March 2014).

Control of Assets:

As part of testing undertaken during the establishment audit of the Union Centre, an asset inventory was reviewed from June 2013. Asset numbers, serial numbers or make / model details were not consistently recorded for all items. It was found that there were a number of portable assets (laptops and 16 cameras) that could not be located. Whilst it was recorded on the inventory that 6/16 "flippy" cameras were on loan, there did not appear to be any loan records in place. It is therefore not known who had the cameras on loan although management state these were loaned to tutors. There were also obsolete assets (a number of portable projectors) that required disposal and 12 disused laptops which were in a locked cupboard which couldn't be accessed at the time of the audit. There was no disposals policy in place.

A separate report with agreed management actions to address the weaknesses identified Union Centre has been issued and finalised (20 March 2014).

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

During the establishment audit of the Union Centre it was identified that staff driving checks were incomplete. No other significant control weaknesses were identified in respect of HR processes at this centre.

Programme Governance

During 2012/13 an audit of Project Management was undertaken within SCS. Whilst this highlighted issues by reviewing specific SCS projects, it resulted in corporate

management actions intended to strengthen project management across all directorates.

The final report for SCS Project Management was issued on 19 February 2013, with 8 agreed management actions. Only 1 of these has been implemented, which was the responsibility of SCS. The remaining 7 management actions (including priority 1 and 2 actions) were due for implementation by the 30 April 2013, with one due on 30 September 2013. All were the responsibility of the Corporate Research and Major Programmes Team (now within E&E). The team have acknowledged the significant delay in implementation of these actions however are now making good progress with the implementation of these actions and have a plan in place for completion.

Follow up on the development of the introduction of the formal Programme Governance Structure has also identified that this has not been developed as first intended.

It has therefore been decided that Internal Audit would not do any detailed testing on individual projects for another 6 months to allow the full implementation of previous management actions, but to instead report on the current Programme / Project Governance in each directorate for 2013/14.

Corporately it has been identified that there is no overall reporting on programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level. Management actions have been agreed within the management letter issued for E&E and within the separate management letters to SCS and CEF to address this.

Within E&E, there has been no detailed review of current programme / project governance arrangements for 2013/14. This is because of the structural changes whereby the Service Manager Business Development & Fleet Management has recently joined E&E and jointly with Graham Shaw, Deputy Director, intend to review the current programmes and projects operating across the E&E directorate to ensure that project documentation is complete and appropriate project management methodology is applied and that monitoring and reporting of these programmes and projects is appropriate and being reviewed by Senior Management. A specific management action for E&E has been included within the corporate letter in respect of recording major programmes on the main directorate risk register.

**Governance & Financial Management SCS Main Directorate Report 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 7 | Priority 1 = | Priority 2 = 7 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 5 | |

Authority & Governance

There were 5 management actions raised in relation to Authority & Governance in the 2012/13 SCS Governance & Financial Management Internal Audit Report. All have been reported as fully implemented. Internal Audit tested the effectiveness of 4 of these actions during this year's audit. Testing has confirmed effective implementation of 2 actions, however the implementation of the other 2 does not appear to have been fully effective. It was found that there were still several cost centres marked as old or unused that had live approvers attached to them. It was also found that the review and challenge of substitution arrangements on SAP has not been fully effective. Internal Audit testing identified that there were still some inappropriate substitution arrangements in place, two of which had been in place since August 2013.

It was noted that the current SCS Scheme of Financial Delegation does not detail who has delegated authority to approve the write off of stock. This was a common issue across directorates and is also being raised corporately in relation to updating corporate guidance on content and format of the Schemes.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

An establishment audit undertaken at Abingdon Health and Wellbeing Centre identified examples where payroll claims had been authorised by the Assistant Manager. This is not in accordance with the SCS Scheme of Financial Delegation as the Assistant Manager is not a named authoriser. A separate report with agreed management actions to address the weaknesses identified at Abingdon Health and Wellbeing Centre has been issued and finalised (11 November 2013).

An establishment audit undertaken at West Oxon Daytime Support identified that in addition to the Assistant Manager, Project Leaders were able to authorise payroll claims. The Project Leaders identified were found not to be on the SCS Scheme of Financial Delegation and should therefore not be authorising payroll claims (other than employee self-service travel and expenses claims routed to them by workflow). A separate report with agreed management actions to address the weaknesses identified at West Oxon Daytime Support has been issued and finalised (5 November 2013).

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level.

The Information Governance Group was re-launched following the 2012/13 audit but this body whilst making some progress has not been fully effective in addressing previously identified weaknesses in this area. This group includes representation from SCS.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target date having been moved to 31/03/14 from 31/03/13. Across each directorate specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including client data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who are the priority users for such software or escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters but this suite of documents needs to be reviewed. Given the number of documents there is some overlap in content. There is confusion in relation to naming conventions and it is therefore not always possible to tell what document reference is being made to

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

Business Continuity

Not tested in 2013/14. However, it was confirmed at the establishment audits of Abingdon Health and Wellbeing Centre and West Oxon Daytime Support that plans are in place.

Risk & Performance Management

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two

areas was split. The Chief Internal Auditor and the Head of Policy are now the corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

Each quarter they author a Business Management Monitoring Report which is produced by the Senior Policy and Performance Officer based on information she has received from the Directorates. Versions of this report go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate. The Director presents the SCS performance report to the Performance Scrutiny Committee each quarter. The Audit Working Group usually meets monthly and, at each meeting, one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. The SCS risk lead presented at the March 2014 AWG.

The corporate risk lead has undertaken a quality review of the risk registers including the SCS register and, for 2014/15, corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged.

We found a number of issues with the SCS risk register which require improvement. These are broadly in line with the findings of the corporate risk lead in his initial review.

Risk:

- There was an instance where the listed “current control” was actually a work in progress and was therefore not yet providing any reliable control from which assurance could be taken.

- The Risk Mitigation section of the register had not been completed. It was therefore not clear how the target score was going to be achieved.

- Although there is no over-arching risk of individual programme or project failure recorded in the SCS risk register a management action has been agreed as part of the Programme Governance Audit for this to be implemented by the end of this financial year. This has not yet been reported as implemented, but will continue to be monitored by Internal Audit via the 4action system.

There is one action originally raised in 2011/12 with regard to risk management which is how risk management training is delivered within SCS which has not yet been fully implemented. This is detailed in the main body of the report and its implementation status will continue to be monitored by Internal Audit on the 4action system. 2 further management actions originally raised in 2011/12 were repeated in the 2012/13 report, along with 1 new management action. These actions have been reported as fully implemented.

Performance:

- The performance indicators listed in the quarterly dashboard do not always clearly specify what is being measured nor is the information provided always clear and consistent. It is not always obvious from the performance measure whether the figure reported in the dashboard is cumulative or only relates to the latest quarter. It is not always clear where the benchmark figure quoted comes from or the relevance of this figure with regard to current performance.

- When the information in the dashboard shows that a measure is not on target the decision under the traffic light system to categorise this as amber or red is subjective with there being no pre-defined criteria.

- We sample checked the source data and method of calculation of four performance measures and in three cases the re-performance produced a different result to that reported in the dashboard. This was because the source data had been updated after extraction for reporting purposes.

- We note that complex spreadsheets are being used to calculate some of the figures that appear in the dashboard. These spreadsheets have been developed by users over time with the use of macros and links to other spreadsheets. The more complex a spreadsheet the more it is prone to error with no assurance that results produced are valid.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. However, it was noted that there is no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process in place for non-compliance. Corporate management actions were agreed to address this.

A separate corporate report on Fees and Charges has also been issued and finalised (22 August 2013). The overall conclusion was Issues. The audit identified that the Charging Policy, set out in Annex 3a of the 18th December 2012 Cabinet papers, did not contain any documented information on the roles and responsibilities of relevant officers involved in the fees and charges process. Regarding the setting of fees, there were varying levels of evidence across the directorates from fully documented cost models to detailed methodology explained by service heads to support fees set.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Financial Compliance:

The audit of Abingdon Health and Wellbeing Centre identified that invoices being raised by the centre were not being raised on SAP. Testing also identified that

overdue debts were not being monitored and followed up corporately as the Income Team were not aware of them, an example was noted where a debt of approximately £570 was still owing but was not being actively chased. It was also identified that AMT (attendance, meals and transport) income collection records were not being maintained in accordance with operational management instructions.

At the Abingdon Health and Wellbeing Centre sample testing on payroll claims identified examples where claims had been authorised by the Assistant Manager. This is not in accordance with the SCS Scheme of Financial Delegation as the Assistant Manager is not a named authoriser.

A separate report with agreed management actions to address the weaknesses identified at Abingdon Health and Wellbeing Centre has been issued and finalised (11 November 2013)

The audit of West Oxon Daytime Support identified insufficient segregation of duties with the imprest account.

It was reported at West Oxon Daytime Support that in addition to the Assistant Manager, Project Leaders are able to authorise payroll claims. The Project Leaders identified were found not to be on the SCS Scheme of Financial Delegation and should therefore not be authorising payroll claims (other than employee self-service travel and expenses claims routed to them by workflow).

A separate report with agreed management actions to address the weaknesses identified at West Oxon Daytime Support has been issued and finalised (5 November 2013).

Procurement:

A SCS Contract Procurement and Contract Management audit is currently being undertaken and a separate report will be issued for 2013/14.

There is an outstanding action in relation to the 2011/12 Knights Court Facilities Management audit regarding the issue and communication of the Local Finance Procedures. The officer responsible has been reallocated and the Finance Business Partners are now addressing the issue. Internal Audit will continue to monitor the implementation of this management action on the 4action system.

No significant control weaknesses were identified with procurement testing at the establishment audits of Abingdon Health and Wellbeing Centre and West Oxon Daytime Support.

Control of Assets:

This was tested for SCS during the establishment visits to Abingdon Health and Wellbeing Centre and West Oxon Daytime Support. Neither of these establishments was maintaining an inventory list of items worth more than £1000 or items worth less than this but portable and attractive.

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

At West Oxon Daytime Support it was identified that whilst driving checks have been undertaken, instances were identified where employees, including 2 who were noted as having claimed mileage as part of the sample testing undertaken during the audit, did not have insurance covering them to use their cars for business use. One instance was also noted where driving license details had not been provided. Missing information had not been followed up.

There were no other significant control weaknesses in the areas of HR identified at either Abingdon Health and Wellbeing Centre or West Oxon Daytime Support.

Programme Governance

A separate management letter on SCS Programme Governance has been issued and finalised (9 December 2013). The overall conclusion was Issues.

At the time of the audit an Interim Programme Manager for SCS had recently been appointed. This enabled review and redefinition of the major programmes currently being managed by the directorate. All project management documentation was being reviewed and where gaps were identified this was being rectified. Project risk registers were also being developed, as these either were not in place or needed to be refreshed.

Each of the three major programmes within SCS and also the New ASC IT System project have dedicated Project Managers and also nominated Business Leads. A dedicated Project Manager resource has been recently allocated to map out and monitor the interfaces between different projects both within SCS and also across other directorates.

There is an ASIP Board (Adult Services Improvement Programme) which is responsible for major decisions/strategy in relation to each of the programmes and receives red and amber status reports on projects. The Board includes representation from outside the Directorate including Trading Standards, Major Programmes, It was noted that these are not always meeting monthly as planned however since the appointment of the new Interim Programme Manager, SCS Director John Jackson was given an informal update in early August and full Board meetings took place on 21 October and 18 November and monthly meetings are diarised going forward to June 2014. There is also an ASIP Leads meeting which meets fortnightly and reviews timeline reports for progress and highlight reports for all projects. The Interim Programme Manager also has a weekly meeting with all project managers. There is a separate Board for the Responsible Localities Project which will encompass LEAN which had started to meet.

Corporately it has been identified that there is no overall reporting of programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level. Management actions have been agreed corporately and also at a directorate level to address this. Four

management actions specific to SCS were agreed, 3 have been reported as implemented. The remaining action, due to have been implemented by 31 March 2014, is still outstanding. Internal Audit will continue to monitor implementation status of this action via the 4action system.

**Adult Social Care Management Controls 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 14 | Priority 1 = 4 | Priority 2 = 10 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | 1 | |
| Not yet Due | 11 | |

The 2012/13 Internal Audit of Adult Social Care Management Controls had an overall conclusion of unacceptable. This year's audit has included follow up on a number of the key management actions agreed as a result of the 12/13 Internal Audit in order to confirm whether the implementation of the management actions agreed has been effective in mitigating the risks highlighted.

11 management actions from the 2012/13 audit were followed up as part of this audit, 8 had been reported as fully implemented, 2 had not been reported as implemented, 1 has now been superseded. From testing undertaken, it was identified that although 4 management actions had been implemented effectively, 4 had not (previously raised as management actions 2a), 2b), 10a) and 10b)). New management actions have been agreed to address the weaknesses identified in these areas.

Key weaknesses were found in relation to supervision and key areas of the Supervision Policy are not being followed. These included issues with follow up on areas noted as poor by a supervision frequency audit undertaken by Strategy & Performance and reported on to the Operational Governance Group in December 2013, LD teams following different guidance, examples where insufficient records had been maintained of supervision discussions, examples where Swift records had not been updated with records of supervision discussions and Service Managers not undertaking the prescribed supervision quality audits. . However, through exit meeting discussions with the Deputy Director, it is clear that the Supervision Policy is unworkable and requires fundamental review and revision to ensure that standards can be applied in this area.

From follow up on the reporting and monitoring on safeguarding alerts, it was found that reports to operational teams showing open alerts over a month old are no longer being produced, there is also a lack of consistent comparable management information being produced for Operations Service Managers Meetings or OSAB to enable effective performance monitoring in relation to the timeliness of processing of open safeguarding alerts. Without reliable and timely management information in this area, there is a risk that safeguarding alerts will not be followed up on a timely basis or appropriately.

Due to significant system issues (for example different systems in use in mental health to adult social care, different versions of systems, problems with access to Swift, lack of training of mental health staff in how to use Swift) which have prevented mental health staff from being able to provide the required information to Adult Social Care, there are ongoing issues and significant concerns in relation to the way in which Mental Health teams are recording the processing of safeguarding alerts. There have been ongoing discussions between Mental Health and Adult Social Care during the financial year in an attempt to improve the situation.

Two management actions in relation to how Adult Social Care teams are notified of unpaid client contributions and what they do with this information have not yet been implemented. A client is accruing debt is a potential indicator of safeguarding issues including financial abuse. If the Income Team does not notify the relevant social worker, there is a risk that this information will not be acted upon at the earliest opportunity. Equally, where this information is communicated to the Social Worker but is not acted upon, there is a risk that safeguarding issues will not be identified and acted upon promptly. Both outstanding management actions are repeated in the main body of the report for information. These will continue to be tracked on Internal Audit's 4action tracking system and implementation status will be reported on to Adult Social Care Group and members.

**SCS Contract Management 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 4 June 2014 2014 | |
| Total: 14 | Priority 1 = 0 | Priority 2 = 10 |
| Current Status: | | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 10 | |

We specifically looked at the overarching arrangements for contract management within the SCS Directorate and selected two contracts and reviewed the contract management arrangements in detail, one Learning Disabilities Contract and one Older Person Residential Provision Contract.

We also considered the arrangements around Domiciliary Care (inclusive of Care Homes) and the new Learning Difficulties Framework and considered the adequacy of the Spot Purchasing Contract. Some matters arising from the work stem from the fact that contractual arrangements or development that span a number of years and this can mean that original requirements change alongside staff and internal structure changes.

Accordingly, the main audit findings are around how on-going monitoring can be refined and how non-compliance with the contract could be more effectively dealt with. It was noted that although the County Council have active monitoring and assessments tools, the Contract Monitoring forms need to be more effectively integrated with the contract clauses and an understanding of the best practice framework that covers health and social care. This may also require more detail training in NHS guidance and the NHS constitution.

Our overall conclusion notes the engagement that Commissioners and Contract Managers have with the Procurement Team and Legal Services. However, the transition and development of certain elements of contracts will require careful or innovative ways of monitoring at a senior level so that emerging risks are clearly identified and the resources or assistance needed to mitigate those risks can then be effectively deployed.

There is an overarching concern around developing generic contract monitoring forms that lead Contract Monitoring Officers to view a contract within a framework that may not always be a complete picture. Examples would be external dependencies such as another service contract developing alongside the monitored contract, or where there are other standards to be applied such as the NHS Constitution or emerging best practice advice that would require additional staff training. The key areas for consideration are:

1. There is no formal hand over from Commissioning to the Contract Management Phase showing key areas to be monitored and reported. This should be considered as the contract baseline;
2. Risk management is undertaken at a high level but is not part of the general overview of the contracts as they work through their lifecycles. An individual risk associated with a contract or group of contracts does not have a clear escalation process;
3. We found that contracts were not always fully congruent with the legislative or guidance framework at the time of signing and either omitted points such as relevant Acts or did not sufficiently acknowledge the NHS framework that the contract is operating within;
4. The three contracts we reviewed had minor issues around how an outcome would be met or reported. Specifically, how to assess appropriate visibility of how a contract is delivering and outcome and whether the outcome could be proven to be anchored to a specific best practice approach or given appropriate visibility. In particular we did not find that an underperformance of an outcome was not automatically a contract default;
5. There is not a clearly embedded understanding of risk within the contract documentation reviewed. It is documented as insurable risk or risk that could be retained by the authority. In particular, it should be noted that reliance is often placed on individual contractors to manage risk on behalf of the Council through policy and procedure;
6. The process of receiving information from the provider can be reconciled to internal systems as part of the internal payments process. However, a compensating control of reconciling actual persons on site at the care home to client records held by the Council is not undertaken by the Monitoring Officer during visits to Care Homes;
7. Certain aspects of all contracts rely on the provider to abide by standards that are outside the control of contract monitoring staff e.g. maintenance of equipment or require specialist knowledge. The Contract Monitoring Team currently operate without a formalised training process for new staff and have no manual of standards expected when visiting a contractor that can be referenced either to minimum standards expected under the contract or referenced to guidance or best practice. Where issues are encountered over the delivery of contract, reliance is

placed on working alongside the contractor as opposed to issuing a contract default notice with an action plan. Default notices are issued in extreme cases;

8. Many contracts will include within them a clause that covers savings, shared savings or benchmarking. National incentives such as Commissioning for Quality and Innovation (CQUIN) are seeking to incentivise service improvements that lead to savings through changes in the way a service is provisioned. Benchmarking is a method of understanding whether Value for Money is being achieved from the service. What is missing from the contracts reviewed is how the parties incentivised to deliver change;
9. We found that in some circumstances there are no external standards to monitor against or there are specific standards that need to be met by the contractor, then these are should be outlined as part of the monitoring standard. In areas such as staffing levels, that can have a direct impact on safeguarding, dignity or cleanliness, a clear understanding of how the contractor has risk assessed staffing levels needs to be provided; and
10. From our four sample contracts we found 2 anomalies in the way that the complaints process is presented in the contract. Each contract should have a clause concerning the complaints process and this should be congruent with the existing best practice or requirements of the Council.

In noting the above points we are aware that SCS have brought about a number of internal changes to the structure of Joint Commissioning and that the Quality & Contracts Service Manager will be focussing more clearly on the monitoring function and driving changes to working practices alongside producing more detailed support and guidance for the monitoring staff. In recent months, the Council has developed a Contract Management Framework (CMF); a roadmap of how the council conducts its contract management activities. The framework draws upon existing good practice as identified by the National Audit Office (NAO) and Government Procurement Service (now Crown Commercial Service) guidance, and recognises that contract management is a holistic process that combines a mix of strategic and operational tasks depending on the type of contract and the goods or services being supplied. Training in this area (Passport to Practice) and the development of a contract management system will also address a number of the points raised during the review and we recognise that there is a lead time for system change to become custom and practice.

**Governance & Financial Management CEF Main Directorate Report 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 9 | Priority 1 = 0 | Priority 2 = 9 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | 7 | |

Authority & Governance

3 management actions on Authority & Governance for CEF were raised in 2012/13, all have been reported as implemented. Effectiveness of implementation was tested

as part of this audit for 2 of the management actions. Neither action had been implemented effectively. It was identified that a number of cost centres marked as blocked or no longer in use still had live approvers set up on them. It was also found that there were still issues in relation to active and passive substitution arrangements, some of these had been in place since last August which indicates that the checking process aimed at resolving issues with inappropriate substitution arrangements has not been fully effective.

It was noted that the CEF Scheme of Financial Delegation had not been re-published since August 2013, although it is acknowledged that the Schedule accompanying the Scheme was re-published in January 2014. It was also found that the current Scheme did not detail who had delegated authority to approve the write off of stock. This was a common issue across directorates and is also being raised corporately in relation to updating corporate guidance on content and format of the Schemes.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP has been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

As part of a separate establishment audit of Abingdon Hub, an example was identified where the Service Managers' expense claim had been approved by one of the Administrators. This is not appropriate and is not in accordance with the CEF Scheme of Financial Delegation. A separate report with agreed management actions to address the weaknesses identified has been issued and finalised (25 February 2014). A separate establishment audit of the Roundabout Childrens Centre identified that the two staff members who were approving the majority of payroll claims did not have the authority to do this according to the current CEF Scheme of Financial Delegation. A separate report with agreed management actions to address the weaknesses identified has been issued and finalised (10 March 2014)

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level.

The Information Governance Group was re-launched following the 2012/13 audit but this body, whilst making some progress, has not been fully effective in addressing previously identified weaknesses in this area. This group includes representation from CEF.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target

date having been moved to 31/03/14 from 31/03/13. Across each directorate, specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including children's data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who the priority users for such software are or of escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance, was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters but this suite of documents needs to be reviewed. Given the number of documents there is some overlap in content. There is confusion in relation to naming conventions and it is therefore not always possible to tell what document reference is being made to.

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

There are three CEF specific management actions not yet implemented from the 2012/13 CEF Information Governance Audit Report. These relate to the Information Asset Register and also to the potential risk of SAP users, who have not been DBS checked, having access to sensitive children's placement data. These have not been restated in this report however they continue to be monitored for implementation through the 4action system.

Business Continuity

Not tested in 2013/14. However, it was confirmed at the establishment audits of Abingdon Hub and the Roundabout Childrens Centre that Business Continuity Plans were in place.

Risk & Performance Management

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two areas was split. The Chief Internal Auditor and the Head of Policy are now the

corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

Each quarter they author a Business Management Monitoring Report which is produced by the Senior Policy and Performance Officer based on information she has received from the Directorates. Versions of this report go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate. Within CEF, the Director and two Deputy Directors present the CEF performance report to the Performance Scrutiny Committee each quarter. The Audit Working Group usually meets monthly and, at each meeting, one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. The CEF risk lead presented at the October 2013 AWG.

The corporate risk lead has undertaken a quality review of the risk registers including the CEF register and for 2014/15, corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged.

We found a number of issues with the CEF risk register which need to be improved. These are broadly in line with the findings of the corporate risk lead in his initial review.

Risk:

- There was some recording in the current controls column of actions which are yet to take place.

- The Risk Mitigation section of the register had not been completed. It was therefore not clear how the target score was going to be achieved.

- There were instances where, even though the register showed that actions had been taken, this has not been reflected in amended risk assessments. There was one example where, despite actions having been taken, the likelihood of the risk materialising was recorded as having increased.

- Although there is no over-arching risk of individual programme or project failure recorded in the CEF risk register a management action has been agreed as part of the Programme Governance Audit due for implementation by the end of the 2013/14 financial year. This has not yet been reported as implemented, but will continue to be monitored by Internal Audit via the 4action system.

- There is no over-arching health and safety risk in the CEF register.

There is one action originally raised in 2011/12 with regard to risk management which is how risk management training is delivered within CEF which has not yet been fully implemented. This is detailed in the main body of the report and its implementation status will continue to be monitored by Internal Audit on the 4action system. 2 management actions were included in 2012/13 CEF Governance &

Financial Management report in relation to risk management. Both have been confirmed as fully implemented by Internal Audit.

Performance:

- The performance indicators listed in the quarterly dashboard do not always clearly specify what is being measured nor is the information provided always clear and consistent. It is not always obvious from the performance measure whether the figure reported in the dashboard is cumulative or only relates to the latest quarter. It is not always clear where the benchmark figure quoted comes from or the relevance of this figure with regard to current performance.

- When the information in the dashboard shows that a measure is not on target, the decision, under the traffic light system, to categorise this as amber or red is subjective with there being no pre-defined criteria.

- There have been times when, due to problems with both the One system and the new YOS system, CaCi,it has not been possible to report on performance against certain indicators as the necessary data could not be extracted. We recognise that these are operational issues for the service / ICT and as such have not raised them in the detailed findings below.

- We sample checked the source data and method of calculation of three performance measures and confirmed the accuracy of reporting in the dashboard. We noted that the processes necessary to arrive at the figures recorded are in some instances convoluted and time consuming. There are detailed written procedures for most of the indicators which provide practical guidance for anyone needing to perform these calculations. These however need to be updated.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. However, it was noted that there is no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process in place for non-compliance. Corporate management actions were agreed to address this.

A separate corporate report on Fees and Charges has also been issued and finalised (22 August 2013). The overall conclusion was Issues. The audit identified that the Charging Policy, which is set out in Annex 3a of the 18th December 2012 Cabinet papers, did not contain any documented information on the roles and responsibilities of relevant officers involved in the fees and charges process. Regarding the setting of fees, there were varying levels of evidence across the directorates from fully documented cost models to detailed methodology explained by service heads to support fees set.

In relation to the application of fees and charges, it was identified that Outdoor Learning had changed their fees and charges mid-year without Cabinet approval.

A further issue in respect of Fees and Charges was identified during the Roundabout Childrens Centre audit whereby attendance at sessions was being charged for however this had not been reviewed and agreed by Cabinet.

A separate CEF report on the audit of SEN has been issued and finalised (10 March 2014). This audit included review of Financial Processes & Budget Monitoring. The overall conclusion was Issues. A couple of instances were identified which could impact on the accuracy of budget monitoring, including overstated commitments and delay of payment, however there were no significant issues identified with the budget monitoring processes and despite the complexities involved, it appeared to be working well.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Weaknesses in respect of budgetary control were identified during the Roundabout Children's Centre audit. No forecasting had been completed in relation to the Childrens Centre budget this financial year. Testing undertaken by Internal Audit identified that income which should have been paid into the Day Nursery budget had been paid into the Childrens Centre budget and vice versa. Incorrect payroll costings coding a member of Childrens Centre staff to a day nursery GL code going back to early in 13/14 had not been identified and corrected. Instances were also noted where day nursery agency staff had been paid from the Childrens Centre cost centre. None of these anomalies had been identified or rectified, suggesting that any budget monitoring which had been taking place was not effective. A separate report with agreed management actions to address the weaknesses identified at the Roundabout Children's Centre has been issued and finalised (10 March 2014).

Financial Compliance:

The establishment audit of Abingdon Hub has identified a lack of segregation of duties in relation to the administration of the petty cash as the same officer controls and reconciles the account, with no evidence of any independent check on the reconciliations. Authorisation of payments was inconsistent and there were instances where receipts were not available to support expenditure. Weaknesses were also noted in the area of income collection whereby there was a lack of control over tuck shop purchases, sales and stock. With payroll, an example was identified where the Service Managers' expense claim had been approved by one of the Administrators. This is not appropriate and is not in accordance with the CEF Scheme of Financial Delegation. A separate report with agreed management actions to address the weaknesses identified at Abingdon Hub has been issued and finalised (25 February 2014).

At the Roundabout Childrens Centre significant control weaknesses were identified in relation to the administration and operation of the Amenity account, with a lack of segregation of duties and no management oversight of the account. Supporting documentation in relation to expenditure was found to be incomplete, including in

relation to payments which appear to have been made to staff members and also for gifts which appear to have been purchased for staff from the account. Income and expenditure records were not fully up to date and the account has never been independently audited. There was also evidence that official income had been banked in the unofficial account over a period of time.

Also at the Roundabout Childrens Centre controls in place in relation to income collection were found to be weak, with a lack of segregation of duties, all records not being retained and no evidence of management review or oversight in relation to income collected or any review of income expected to income received. Testing also identified mis-posted income. With payroll it was found that the two staff members who were approving the majority of payroll claims did not have the authority to do this according to the current CEF Scheme of Financial Delegation.

Procurement:

An audit of CEF Contract Procurement and Contract Management was undertaken at the end of the financial year 2012/13. This resulted in an overall conclusion of Unacceptable. Since the finalisation of the report, progress has been made to implement the agreed management actions. This has included a fundamental change in responsibilities for contract management with responsibility transferring to Joint Commissioning. A total of 17 management actions were agreed, 11 have been reported as implemented and 6 are outstanding with revised implementation dates. This will be followed up in an audit during 2014/15.

There is an outstanding action in relation to the 2011/12 Knights Court Facilities Management audit regarding the issue and communication of the Local Finance Procedures. The officer responsible has been reallocated and the Finance Business Partners are now addressing the issue. Internal Audit will continue to monitor the implementation of this management action on the 4action system. As part of this the CEF Finance Business Partner is reviewing the procurement guidance available to Social Workers who use the FM office to make payments.

At Abingdon Hub it was identified that a significant value of gift cards had been purchased - this is currently being investigated further by CEF management to review the appropriateness of the decision and to ensure that the amounts purchased can be fully accounted for.

At Abingdon Hub and at the Roundabout Children's Centre weaknesses were identified in relation to the use of procurement cards. This included a lack of management review and sign off of the monthly statements and receipts, a card not being held securely and examples whereby the more appropriate method would have been to used approved suppliers via the e-procurement system.

At the Roundabout Children's Centre it was identified that a high volume of purchase orders had been raised retrospectively. Therefore system controls aimed at ensuring expenditure is appropriately approved in advance of the Council being committed to paying for it, were being circumvented. Procurement sample testing also identified that the records held to support goods receipting were incomplete. This testing was not completed at Abingdon Hub.

Control of Assets:

This was tested for CEF during the establishment visits to Abingdon Hub and the Roundabout Children's Centre. At both establishments, it was noted that the level of detail recorded was insufficient (no serial numbers, make, model information etc was recorded). There did not appear to be any annual stock check of items listed or any clear process for disposals and write offs. At Abingdon Hub it was also identified that items were included which did not need to be, and items which are portable and attractive (i.e. ipods) were not listed

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

For CEF, compliance with HR Policies and Procedures was verified during the establishment visits to Abingdon Hub and the Roundabout Children's Centre.

From review of training records maintained at the Abingdon Hub, it was not possible to confirm whether staff had completed the required mandatory training, such as acceptable use of ICT etc, as this was not being monitored. Similar issues were identified at the Roundabout Centre. From review of entries in relation to safeguarding training, it appeared from local records that only 9 out of 29 Abingdon Hub staff had undertaken generalist safeguarding training.

At both Abingdon Hub and the Roundabout Children's Centre records of driving checks were found to be incomplete. There were instances where business insurance, driving license, MOT etc had not been confirmed as checked.

At Abingdon Hub and the Roundabout Children's Centre discrepancies were identified between locally maintained sickness records and SAP. It was also reported, at the Roundabout Children's Centre, that sick forms were not always completed for sickness absence.

At the Roundabout Children's Centre there was evidence that annual leave had been taken without prior approval / authorisation and for two members of staff, it was not possible to confirm that annual appraisals had taken place or that 1-1s or supervision sessions had been held during this financial year.

Programme Governance

A separate management letter on CEF Programme Governance has been issued and finalised (9 December 2013). The overall conclusion was Issues.

Within CEF Programme / Project Management is split between the Programme Manager (Kathryn Proudlock) and John McLauchlan who works within the E&E programme team and supports CEF on some of the major programmes / projects currently underway. Programmes and projects have been clearly identified and a register is maintained to show which programme manager is responsible. There is

one major programme recorded on the register which is not managed by either Programme Managers; the Corporate Parenting Programme.

Both Programme Managers have reported that they are reviewing all programmes and projects for which they are responsible and ensuring where gaps are identified with the project management documentation that these are rectified. Project risk registers are being developed, where they are not in place. Highlight reports are also being developed to improve monthly reporting on all programmes and projects. At the time of audit these were at the infancy stage of development and therefore no testing was completed in relation to the review of these.

There is no separate Programme Board within CEF however both of the Programme Managers are currently working on how reporting on major programmes and projects to CEF DLT can be best co-ordinated, which will include the new highlight reports and will enable all members of CEF DLT to have visibility and the opportunity to challenge the progress of major programmes/projects.

Discussions with the Corporate Parenting Manager highlighted that there are currently no project risk registers in place for the projects within the Corporate Parenting Programme. There is six monthly reporting to Cabinet which goes through DLT, CCMT and informal cabinet first.

Corporately it has been identified that there is no overall reporting of programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level. Management actions have been agreed corporately and also at a directorate level to address this. Four management actions specific to CEF were agreed, 3 have been reported as implemented. The remaining action, due to have been implemented by 31 March 2014, is still outstanding. Internal Audit will continue to monitor implementation status of this action via the 4action system.

**Governance & Financial Management OFRS Main Directorate Report 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 15 April 2014 | |
| Total: 2 | Priority 1 = 1 | Priority 2 = 1 |
| Current Status: | | |
| Implemented | 2 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

All actions have been fully implemented.

Authority & Governance

There was 1 management action raised as part of the 2012/13 SCS Governance & Financial Management Internal Audit report relating specifically to Authority & Governance within OFRS. This has been reported as fully implemented, and

effective implementation has been confirmed as part of testing undertaken in relation to Authority & Governance within the directorate for 2013/14.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level. It should be noted that specific testing was not undertaken in OFRS.

The Information Governance Group was re-launched following the 2012/13 audit but this body, whilst making some progress, has not been fully effective in addressing previously identified weaknesses in this area. This group included representation from OFRS.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target date having been moved to 31/03/14 from 31/03/13. Across each directorate specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including client data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who are the priority users for such software or escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters, but this suite of documents needs to be reviewed. Given the number of documents

there is some overlap in content. There is confusion in relation to the naming conventions and it is therefore not always possible to tell what document reference is being made to

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

Business Continuity

Not tested for 2013/14

Risk & Performance Management

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two areas was split. The Chief Internal Auditor and the Head of Policy are now the corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

They author a quarterly Business Management Monitoring Report versions of which go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate, but this does not include OFRS performance. We did not include any detailed review of OFRS performance in 2013/14.

The Audit Working Group usually meets monthly and at each meeting one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. The FRS Integrated Risk Manager presented at the February 2014 AWG.

The corporate risk lead has undertaken a quality review of the risk registers including the strategic FRS risk register and for 2014/15 corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged.

Our review of the risk management process within the OFRS was limited, but we noted that the service is very risk focused. There is a detailed Integrated Risk Management Plan (2013-18) and a strategy document that describes the risk management that will be undertaken for all the service's activities and details the relationship between their risk management activities and the government requirements to produce an Integrated Risk Management Plan (IRMP) - (Community Risk Management Plan). In addition to the strategic risk register there is also a lower level operational risk register.

We noted some minor issues with the FRS "strategic" risk register which were in line with the findings of the corporate risk lead in his initial review.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. It was noted that there is no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process in place for non-compliance. Corporate management actions were agreed to address this.

A separate corporate report on Fees and Charges has also been issued and finalised (22 August 2013). The overall conclusion was Issues. The audit identified that the Charging Policy, set out in Annex 3a of the 18th December 2012 Cabinet papers, did not contain any documented information on the roles and responsibilities of relevant officers involved in the fees and charges process. Regarding the setting of fees, there were varying levels of evidence across the directorates from fully documented cost models to detailed methodology explained by service heads to support fees set.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Financial Compliance:

Detailed testing was focused in the main directorates across a sample of establishments and services. This was not tested in OFRS for 2013/14.

Procurement:

This was tested during the audit of Fire and Rescue Stores. From review of a sample of purchases made by the Workshop store, a high volume of retrospective purchase orders were found. Instances were also identified where items had been purchased through R3 when they should have been purchased through SRM.

A separate report with agreed management actions to address the weaknesses identified at Fire and Rescue Stores has been issued and finalised (18 November 2013). 15 management actions were agreed, 10 have been reported as implemented, 3 have been reported as partially implemented and 2 have not yet been implemented (1 of these is not due to be implemented until the end of June). Actions not yet reported as implemented will continue to be monitored by Internal Audit via the 4action system.

Control of Assets:

This was tested during the audit of Fire and Rescue Stores which identified that there was a lack of documented local procedures in relation to the Workshops store. Supplies store local procedure documentation was noted as being comprehensive, but contained omissions in some areas, for example disposals and write offs. It was also noted that there was no clear guidance for Fire Service staff in relation to the process to be followed for obtaining stock from the supplies store. One of the key

areas of weakness noted was the lack of guidance in relation to the out of hours process.

Some non-compliance was identified in relation to authorisations for requests for stock from the Supplies store. There were also found to be control weaknesses in the out of hours process.

Stock checks were found to be being undertaken once a year in the Workshop, there was also a lack of accountability in relation to who had undertaken the check and who had reviewed it. In the Supplies store, it was found that in year stock checks should take place, but it was reported that none had been undertaken during the 2013/14 financial year at the time of the audit. It was reported in year stock checks were not documented and, as with the Workshop store, there was a lack of accountability in relation to who had undertaken the checks and who had reviewed them.

The Workshop did not submit their 2012/13 year-end stock check by the date required of 31st March 2013, it was submitted on 10th April 2013. Working papers provided in support of the year-end stock check did not enable independent verification of the final figures presented.

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

Detailed testing was focused in the main directorates across a sample of establishments and services. This was not tested in OFRS for 2013/14.

Programme Governance

Programme / Project Management arrangements for OFRS have not been considered for 2013/14. A corporate management letter has been issued instead. Corporately it has been identified that there is no overall reporting of programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level.

The Fire and Rescue Service are currently managing a number of projects including Joint Fire Control and others in relation to the Community Risk Management Plan. OFRS have reported that Project Managers have all undertaken OCC project management training and project sponsors are either Deputy Chief Fire Officer or Assistant Chief Fire Officer level. Project risk registers are maintained and included within the quarterly updates on the projects made to the Senior Leadership Team.

**Governance & Financial Management Public Health 2013/14**

| | | |
|---|---|---|
| Opinion: n/a | 23 April 2014 | |
| Total: 1 | Priority 1 = 0 | Priority 2 = 1 |
| Current Status: | | |
| Implemented | 1 | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

All actions have been fully implemented

Authority & Governance

Audit testing identified that the published version of the PH Scheme of Financial Delegation has not been updated since April 2013. Corporate guidance requires that the Scheme is reviewed, updated and republished at a minimum of every 6 months.

Following the restructure of corporate finance, there have been changes to the process for amending profit and cost centres on SAP, this includes closing cost centres and making changes to authorisation limits of SAP approvers. As part of this audit, the process for closing cost centres and removing live approvers and the documentation and retention of approval of changes to authorisation limits on SAP have been clarified along with responsibility for ensuring that directorate leads, responsible for updating of the directorate scheme of financial delegation, are also informed of these changes to ensure the Scheme remains consistent with SAP Approvers.

Information Governance

A separate corporate report has been issued and finalised (30 January 2014). The overall conclusion was Unacceptable. The audit identified a number of risk areas with Information Governance that need to be addressed at both a corporate and local level.

The Information Governance Group was re-launched following the 2012/13 audit but this body, whilst making some progress, has not been fully effective in addressing previously identified weaknesses in this area. This group includes representation from Public Health.

The Information Asset Registers / External Data Transfer Registers in the directorates still have not been brought up to date and fully populated. This was raised in the previous audit but is still an outstanding corporate action with the target date having been moved to 31/03/14 from 31/03/13. Across each directorate, specific actions in respect of this are also outstanding or have been reported as implemented. Testing, however, has identified they are not complete. It is therefore not possible to give assurance that all sensitive and personal data transferred outside the organisation is done in a secure manner. Corporate management actions have been agreed to address this. Specific testing was not undertaken in Public Health however at the time of the audit it was reported that Public Health was still developing their Information Asset register.

The Council now has an email encryption product, Egress Switch, but testing has highlighted that not all employees who are sending sensitive data, including client data, outside the organisation have this or an alternative secure method of transfer. There are also reported issues, which have not been addressed, of external organisations refusing to use Egress. Within the Directorates there has been no identification of who the priority users for such software are or escalation when there is a gap in secure handling of data.

Work has been done in establishing roles and responsibility for information governance, but improvements are still required to ensure clarity and communication between key stakeholders. A Work Programme, identifying key risks to information governance was created in February 2013 but this did not include specific target dates nor has progress been monitored on an on-going basis.

There are many policies and procedures covering information governance matters but this suite of documents needs to be reviewed. Given the number of documents there is some overlap in content. There is confusion in relation to naming conventions and it is therefore not always possible to tell what document reference is being made to.

There is a further outstanding corporate action where the target date has been moved to 31/03/14 from 31/03/13. This concerns the lack of assurance that there is a data transfer agreement when transfer of data to an external source is not covered by a contract. This is dependent on all Information Asset Registers (IARs) being brought up to date.

Business Continuity

Not tested in 2013/14.

Risk & Performance Management

Public Health is smaller compared to the other main directorates. Most expenditure is on contracts and this is reflected in that there are just five risks in the risk register. Additionally, given size of the directorate, there are no issues regarding the reporting and communicating of risk. We noted that risk management is informing the allocation of resources into areas which need to be prioritised. We also noted that there were target dates by which the target risk score was to be achieved and that the risk mitigation / contingency section of the register had been completed.

Corporately there was a significant change in the areas of Risk Management and Performance Management at the end of 2013 when responsibility for these two areas was split. The Chief Internal Auditor and the Head of Policy are now the corporate leads for risk management and performance respectively. They work closely together. A corporate management letter has been issued to them with corporate management actions agreed.

They author a quarterly Business Management Monitoring Report versions of which go to CCMT, Informal Cabinet, Performance Scrutiny Committee, the Audit Working Group and Cabinet as appropriate, but this does not include Public Health

performance. We did not include any detailed review of Public Health performance in 2013/14.

The Audit Working Group usually meets monthly and at each meeting one of the Directorate Risk Leads takes questions from this group following presentation of their latest risk register. To date Public Health have not presented to this group,

The corporate risk lead has undertaken a quality review of the risk registers including Public Health and, for 2014/15, corporate quality monitoring is to be introduced. The risk registers will be reviewed quarterly for accuracy of completion and risk assessments will be challenged.

No further detailed testing was undertaken in the areas of risk and performance for Public Health in 2013/14.

Financial Management

Budget Setting/Budgetary Control:

A separate corporate report on Budget Setting has been issued and finalised (22 August 2013). The overall conclusion was Acceptable. However, it was noted that there was no mechanism to monitor the delivery of savings targets outside of Directorates to enable effective scrutiny and challenge at CCMT level. Issues were also noted with compliance of the deadline for the budget sign off process and no escalation process in place for non-compliance. Corporate management actions were agreed to address this. No specific testing was undertaken in Public Health in this area.

A corporate audit is being undertaken of Budgetary Control, which is looking at the implementation of the new BPC software which assists managers with their monthly budget monitoring and forecasting. A report is due to be issued.

Financial Compliance:

Detailed testing was focused in the main directorates across a sample of establishments and services. This was not tested in Public Health for 2013/14, however it is planned that testing will be undertaken in the Directorate in 2014/15.

Procurement:

Public Health's move from the Primary Care Trust to the County Council has meant that a number of contracts and arrangements were retendered during 2013/14. Internal Audit undertook a high level review of the procurement processes in operation. Internal Audit's overall conclusion in this area was Issues and a separate management letter has been issued and finalised (20 March 2014). The main audit finding was around risk recording being high level and not specific to an individual procurement project risk that feeds into the higher level risk register for the department or procurement process. It was also noted that although the County Council have acknowledged Clinical Governance as an area that needs to be more clearly developed, this does not appear as a clear risk area with an outlined mitigation strategy.

Control of Assets:

Detailed testing was focused in the main directorates across a sample of establishments and services. This was not tested in Public Health for 2013/14, however it is planned that testing will be undertaken in the Directorate in 2014/15.

Legislation - Health & Safety

Not tested in 2013/14.

Human Resources

Detailed testing was focused in the main directorates across a sample of establishments and services. This was not tested in Public Health for 2013/14, however it is planned that testing will be undertaken in the Directorate in 2014/15.

Programme Governance

Programme / Project Management arrangements for Public Health have not been considered for 2013/14. A corporate management letter has been issued instead. Corporately, it has been identified that there is no overall reporting of programmes / projects at CCMT level. Project risk registers are maintained separately from main directorate risk registers and therefore there is no formal process for escalation of major programme / project delivery risk to CCMT level.

**Local Enterprise Partnership 2013/14**

| | | |
|---|---|---|
| Opinion: Issues | 6 June 2014 2014 | |
| Total: 0 | Priority 1 = | Priority 2 = |
| Current Status: | Management actions not yet agreed | |
| Implemented | | |
| Due not yet actioned | | |
| Partially complete | | |
| Not yet Due | | |

The audit opinion is based on the fact that there is a need to clarify the working relationship between OCC and the OLEP with a more detailed Service Level Agreement (SLA). It is difficult to track running costs in the accounts and decision making regarding the awarding of the GPF is poorly documented. The agreed lighter touch due diligence arrangements have not been documented and the Memorandum of Understanding (MoU) between OCC, the OLEP and Vale District Council with

regard to collection of the business rate uplift in the Enterprise Zone (EZ) and repayment of GPF loans has yet to be put in place.

It is important to acknowledge that this area of work provides new challenges to OCC and that the introduction of an appropriate system of control is naturally very much a work in progress.

12 findings were raised as part of the audit, although a management response to the issues raised is yet to be received. An action plan is currently being worked on and this will be followed up outside the audit reporting process.