Division(s): N/A

AUDIT & GOVERNANCE COMMITTEE – 13 JANUARY 2016

INTERNAL AUDIT 2015/16 PROGRESS REPORT

Report by the Chief Finance Officer

INTRODUCTION

1. This report provides an update on the Internal Audit Service, including resources, completed and planned audits. For the first time this report also includes the planned activity for the Business Assurance Team, in relation to compliance reviews and assurance mapping of critical services. The activity of all three functions will inform the annual opinion of the Chief Internal Auditor on the System of Internal Control.

2. The report includes the following appendices:
   - Appendix 1 - Current Internal Audit Plan and progress status
   - Appendix 2 - Executive Summaries of Completed Audits
   - Appendix 3 - Counter-Fraud Plan
   - Appendix 4 - Compliance Plan 15/16
   - Appendix 5 - Assurance Mapping methodology and plan.
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3. We have successfully recruited to three new posts within the Internal Audit and Business Assurance structure. A Compliance Officer was appointed in November and was able to immediately take up the position. We have also recently appointed two Trainee Auditors, who are due to start in the middle of January 2016. They will be working across both the Internal Audit and Compliance functions.

4. The vacancies resulting from the restructuring had generated an underspend within the Internal Audit budget that was to be used in Q4 for buying in external resource to support the delivery of the audit plan; however in light of the Council's current financial position I have reviewed whether this spend is essential. I believe that the current revised work plans being presented with this report, will provide me with sufficient "evidence" that I can provide the Committee with an informed opinion on the system of internal control.

5. The impact has inevitably resulted in reducing the number of audits in the plan for 15/16, but I am prioritising the material financial systems and processes; however I am anticipating the complexity and degree of testing will result in the planned activity continuing into Q1 of 2016/17. Given the scope of change within the financial systems following the transition to Hampshire IBC, the audit methodology is being reviewed and will be dependent on the outcome of the ongoing

assessment of the design of controls including management oversight. It was expected that work would have been concluded by now, but there has been some slippage. The Internal Audit Plan is attached as Appendix 1 to this report. This reports on the progress of the first 3 quarters and also includes the proposed quarter 4 plan.

6. The resources for compliance activity to properly commence in Q4 have been confirmed following the recent appointments. A plan has been developed, for this year based on the available days, however the priority for the areas subject to compliance reviews have been developed in consultation with the Finance Leadership Team. The plan is attached as Appendix 4.

7. A report on the methodology and plan for developing assurance maps in relation to critical services and for combined assurance reporting as part of the Business Management reporting process was agreed by the Delivery Board on 9 December 2015. The report and plan is attached as Appendix 5

8. The agreement with Oxford City to provide counter-fraud support has been signed and is now operational with the team providing support for both reactive fraud work and also the pro-active fraud work. The Counter Fraud Plan is attached as Appendix 3 to this report.

9. For the remainder of 15/16 the strategy is to develop the individual functions within the Business Assurance Team and the Internal Audit Team. From 2016/17 there will be an integrated approach to the planning of each activity linked to the key risks. The intention is that future updates and progress reports to the Committee will extend across the assurance functions under the direction of the Chief Internal Auditor, and therefore will include summaries from counter-fraud and compliance reviews in addition to the usual internal audit updates.

2015/16 AUDIT PLAN PROGRESS

10. There have been 6 audits concluded since the last update (provided to the September 2015 meeting of the Audit and Governance Committee); summaries of findings and current status of management actions are detailed in Appendix 2. The completed audits are as follows:

Directorate	**2015/16 Audits**	**Opinion**
CEF	Troubled Families	n/a
CEF	Foster Care Payments - Internal & External	Amber
CEF	MASH (Multi Agency Safeguarding Hub) 2015/16	Amber

SCS	Direct Payments (Part 1) 2015/16. *	Red
SCS	Adult Social Care IT System Implementation Follow-Up Review 2105/16.	Amber
EE	Broadband Project Review 2015/16	Green

* The Direct Payments Report was presented to the Audit Working Group on 5 November, attended by the Deputy Director and the Finance Business Partner. This was reported back to the 18 November Audit Committee.

PERFORMANCE

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

Performance Measure	Target	% Performance Achieved	Comments
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	91%	
Elapsed Time between issue of Draft report and issue of Final Report.	15 days	50%	For the audits that did not meet this PI, there were known delays in finalisation due to key staff being on holidays or there were complex issues that required additional time to determine and agree the appropriate management actions.

12. The other four performance indicators are:

- % of 2014/15 planned audit activity completed by 30 April 2016 - reported at year end.
- % of management actions implemented as at December 2015 (measured from 13/14 to date) = 87%. (At the last update this was 77%) Of the remaining 13% - there are 35 actions that are overdue, and 57 actions not yet due.

- Effectiveness of Internal Audit - reported at year end.
- Extended Management Team satisfaction with internal audit work - reported at year end.

COUNTER-FRAUD

13. The two external potential SCS frauds have now concluded. For the first case, this had been referred to the Police who after some initial investigations are not pursuing the case any further. Additional internal monitoring of this provider is now in place, whilst waiting for a de-brief, from the Police. For the second case internal monitoring has increased and improvements have been made by the provider which has enabled the Director to sign off that the case can be closed with no further action to pursue.

14. The investigations into the potential misuse of four direct payment cases are ongoing. The audit of Direct Payments concluded with a number of control gaps which the directorate have agreed actions to resolve. A further direct payment case has arisen, the procedures were not clear on what happens if the recipient goes into hospital, subsequently a carer continued to claim for hospital visits to the service user. The procedures have been updated and a repayment plan now agreed with the individual. As part of the Counter Fraud plan, Internal Audit are planning to undertake proactive testing of direct payments made whilst service users are in hospital.

15. A school has reported a potential theft. They were advised to contact the Police and an update will be sought once the Police have been engaged and it is known whether they will take up the case or not. The control arrangements surrounding cash handling and safe storage have been discussed with the school and new processes are currently being embedded.

BLUE BADGE PROACTIVE EXERCISE

16. Using the Oxford City Fraud Resource a pro-active anti-fraud exercise against blue badge misuse and abuse has recently been completed. The government has been concerned about the increase in the abuse of the blue badge scheme by some individuals and many Local Authorities that administer the scheme are now clamping down on it. This was run as a pilot scheme, with Internal Audit and the City Council Investigation Team working with E&E to assess and highlight the potential problems within the County.

17. The pilot scheme was carried out over 3 days in Bicester, Banbury and Oxford City. During the exercise over 200 badges were checked by the officers. During the exercise a total of 10 blue badges were seized by the officers for blatant mis-use. This included cases where the badge holder was not present and the badge was being used by persons not entitled to use it, using out of date badges and even using the badges

of a deceased person. Each of these cases is now being considered for possible legal action against the offender. The Enforcement Officers, during the exercise also moved on a number of cars where the drivers pulled into a disabled parking space without any badge.

18. The effect of misuse not only impacts on legitimate blue badge holders, who may be unable to find parking spaces which they are entitled to use, but also on the finances of the relevant local authorities as offenders are avoiding their responsibilities to pay for parking. During the exercise, officers involved were regularly approached by members of the public with comments of thanks and support for tackling this type of crime.

NATIONAL FRAUD INITIATIVE (NFI)

19. The matches from the 2014/15 exercise have been released. In total OCC have had 15,266 matches returned, of which 6,850 are recommended to be looked at. Key officer and Councillor checks have been completed and no issues have been identified. Data matches are now being reviewed by individual teams across the Council and Internal Audit.

20. Four potential matches have been identified for pensions payments made to deceased persons. These are currently being investigated further and recovery processes have commenced.

21. One potential match has been identified so far in comparing payments made to residential providers for deceased residents. This case is being investigated further and the overpayment has already been recovered.

RECOMMENDATION

22. **The Committee is RECOMMENDED to note the report.**

LORNA BAXTER
Chief Internal Auditor

Background papers: None.
Contact Officer: Ian Dyson, Chief Internal Officer, 01865 323875

APPENDIX 1 - Internal Audit Plan 2015/16

Progress against Q1, Q2 & Q3 plan, plus proposed Q4 audits - listed by directorate.

Directorate	Qtr Start	Audit	Status
CEF	1	**CEF Safeguarding (Children's Social Care Management Controls) - Missing Children**	Fieldwork
CEF	1	**CEF Thriving Families - Summer Claim**	Complete - Final Report
CEF	1	**CEF Thriving Families - Winter Claim**	Fieldwork
CEF	2	**CEF MASH (Multi Agency Safeguarding Hub)**	Complete - Final Report
CEF	2	**CEF Social Care Payments**	Fieldwork
CEF	2	**CEF Foster Payments (Internal & External)**	Complete - Final Report
CEF	1-4	**Schools Assurance**	For 15/16 Internal Audit will map the S151 assurance framework and design of controls post implementation of the IBC.
SCS	1	**SCS Personal Budgets / Direct Payments**	Complete - Final Report
SCS	1-4	**LEAN / Responsible Localities**	This has been removed from the proposed plan. A specific review of care management processes in 16/17 will be undertaken once LEAN review is complete and the new Adult Social Care ICT system is embedded
SCS	1-4	**SCS Implementation of the Care Bill**	This has been removed from the proposed plan. Full funding reform changes have not happened. The care bill implementation was

Directorate	Qtr Start	Audit	Status
			achieved by April 15. One area that will be reviewed is the collection of deferred payments, this will be covered under client charging audit.
SCS	3	**Adult Social Care Information System - follow up audit**	Complete - Final Report
SCS	4	**Adult Social Care Information System - post implementation I.T. application review of LAS and Controcc**	Planned for March / April 2016.
SCS	4	**SCS Client Charging, including ASC debt management and also management of deferred debt**	Planned for Feb 2016.
SCS	4	**Residential and External Home Support Payment systems.**	Planned for March 2016.
SCS	4	**SCS Pooled Budgets**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and the need to prioritise audit resources on key financial systems. This was planned for Jan / Feb - and was merged with SCS contract management audit, as the scope intended to look at significant contracts commissioned by the pool and review contract management arrangements. Also planned to cover arrangements re Better Care Fund. It is proposed that this will be

Directorate	Qtr Start	Audit	Status
			undertaken early within the 2016/17 Internal Audit Plan.
SCS	4	**SCS Safeguarding (Adult Social Care Management Controls) - follow up.**	Planned for March 2016.
OFRS	4	**OFRS - Payroll (Garton Processes)**	Exit Meeting
CEO	3	**Treasury Management**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and will be audited in 2016/17.
CEO	4	**Pensions Fund**	Planned for Feb
CEO	4	**Pensions Administration**	Planned for Feb
CEO	4	**Accounts Receivable**	Planned for Feb/March/April
CEO	4	**P2P / Accounts Payable**	Planned for Feb/March/April
CEO	4	**Main Accounting / General Ledger**	Planned for Feb/March/April
CEO	4	**Payroll**	Planned for Feb/March/April
CEO	4	**Banking / Cash Receipting**	Planned for Feb/March/April
CEO	4	**Imprest / Petty Cash**	Planned for Feb/March/April
Cross Cutting	1-4	**Grant Certification** A number of grant conditions, for grants claimed across the Council, require that the Chief Internal Auditor verifies and certifies the grant claim being made.	On-going

Directorate	Qtr Start	Audit	Status
EE	3	**Capital Programme Governance & Delivery**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and will be audited in 2016/17.
EE	2	**Highways Contract**	Draft report
EE	2	**Energy Recovery Facility**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and the need to prioritise audit resources on key financial systems. It will be considered for the 2016/17 audit plan.
EE	2	**Planning**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and the need to prioritise audit resources on key financial systems. It will be considered for the 2016/17 audit plan.
EE	4	**Supported Transport Programme - Hub Development / Follow up of CEF safeguarding transport audit**	Planned for April 2016
EE	3	**City Deal**	This has been removed from the 2015/16 plan due to a reduction in audit resources available and the need to prioritise audit resources on key financial systems. It will be considered for the 2016/17 audit plan. A high level review of the control framework will be undertaken for

Directorate	Qtr Start	Audit	Status
			15/16.
Corporate	3	**OLEP Governance Framework**	This has been removed from the 2015/16 plan due to a reduction in audit resources available.
EE	1	**Externalisation Programme**	In progress
EE (ICT)	1	**Cyber Security**	Complete - Final Report
EE (ICT)	2	**ICT Disposal of Equipment**	Complete - Final Report
EE (ICT)	2	**ICT Change Management**	Complete - Final Report
EE (ICT)	2	**Broadband Project**	Complete - Final Report
EE (ICT)	3	**Commissioning of ICT Services**	Draft Report

NB. There is no specific audit of Budget Setting and Budgetary Control for 2015/16, however the key controls around these processes are being reviewed through other audits within the audit plan and compliance testing is also planned.

Appendix 2

Summary of Completed Audits (since last update to Audit Committee, September 2015)

(Status of Management Actions as at 21 December 2015)

Troubled Families Management Letter 2015/16.

Opinion: N/A	30 September 2015	
Total: 01	Priority 1 = 0	Priority 2 = 01
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	01	

Oxfordshire was an early adopter of Phase 2 of the Troubled Families Programme, which began in September 2014. Attachment fees for 434 families were processed at the outset, and so far approximately 1,200 eligible families have been identified. A first 'Payments by Results' claim of 12 families is due to be submitted. The audit so far has reviewed the process followed for identifying eligible families, monitoring their outcomes and submitting PBR claims.

Overall, there is a robust process in place and the audit did not find any significant areas of weakness. The Outcomes Plan is documented; and clear and measurable indicators have been identified. Where possible, data is being gathered on-going (for example schools attendance), although the majority of the on-going monitoring process and spread sheets are still being fully developed. The team is confident these will be ready well before the next claim in January 2016, and audit will continue to monitor this. Despite the absence of a database for processing the large volume of data, the team are working well with multiple spread sheets.

Further to testing a sample of 20 families to assess they meet the eligibility criteria and a further sample of 4 out of the 13 in the current PBR claim, Internal Audit agrees to sign-off the current claim. The audit testing identified that one of the 13 did not meet the outcome of moving off JSA for 26 weeks and has therefore been removed from the claim.

Foster Care Payments 2015/16.

Opinion: Amber	14 December 2015	
Total: 29	Priority 1 = 05	Priority 2 = 24
Current Status:		
Implemented	03	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	26	

Overall Conclusion is Amber

This audit was a review of foster care payments. This included both internal foster care placements, where foster carers are in-house, employed by the Council and paid through the Trojan system and external foster care placements, where foster carers are external and employed through an Independent Foster Agency (IFA), payment is made to external providers through the accounts payable system.

The overall conclusion is amber, the key issues in relation to Internal Foster Care placements were lack of clarity regarding delegated authority to approve foster care payments within the CEF Scheme of Financial Delegation, incomplete audit trail relating to electronic approval of foster care payments and the timeliness of completion of movement forms by social care teams. There was also found to be a lack of system enforced segregation of duties and reconciliation processes in relation to the Business Data Upload (BDU) payment system. The key issues identified in relation to IFA placements were a lack of accurate and up to date contract documentation on individual placements, a lack of supporting documentation showing agreement of changes in fee rates or for one off payments and inconsistencies between key sources of information on IFA placements. Duplicate and incorrect payments were identified within the sample tested.

Internal Foster Care Placements

It was identified that the coverage of who has the delegated authority to approve payments to internal foster carers was not clear from the CEF Scheme of Financial Delegation. There was therefore found to be a risk that inappropriate authorisations could be made for these payments. It was found that the supporting documentation held in relation to one off payments did not clearly demonstrate authorisation. Email and electronic signature authorisations were common, but the emails were not retained and often not sent from the authoriser. Thus, it was not possible to fully evidence appropriate authorisation for these payments resulting in a risk of unauthorised payments being made.

Information across key systems and documentation for new placements was reviewed for consistency. Inconsistencies were identified in 2/20 new placements reviewed. Both had resulted in overpayments (the value of the first was £59.28, the value of the second was £1,058.86). There was also found to be some inconsistency in the way in which reduced holiday allowance payments had been made, this appears to be due to a lack of formally documented process and methodology for reducing payments. Currently there is a risk that carers will not be treated consistently and fairly with regard to these payments which could have reputational implications for the Council.

Issues were identified with the timeliness of completion of movement forms. These forms are completed by social care teams on frameworki for each new placement and should be completed, authorised and sent through to the Payments Team within 24 hours of a new placement / movement. 13/20 (65%) had not been completed within the required timescale. Most movement forms had been completed within a week of the placement starting, but there were instances where time taken to complete and approve the form ranged from 7 to 41 days from the start of the placement. This was an area of weakness highlighted during the last Internal Audit in 2011/12. Where there is a delay in completion and authorisation of movement forms, there is a risk that payments to carers will be delayed. There is no management information produced which monitors this.

It is noted that performance of the Payments Team in relation to prompt processing of payments has been good. Despite staff shortages and holidays, it was found that all payments sampled had been processed promptly once all required information had been received from the children's social teams or carers.

Internal foster care payments are made through an upload from the Trojan system into SAP via the BDU (Business Data Upload). Control issues were identified in the BDU process. Although segregation of duties is enforced within the team so that different staff members enter data on to Trojan, prepare uploads on Trojan and process the upload through the BDU, there are no system controls in place to ensure that these tasks are undertaken by different staff members. There is nothing to stop the same member of staff adding a new payment / vendor to the Trojan system, preparing the payment file and then uploading this file for payment. Where there is a lack of system enforced segregation of duties, there is an increased risk that incorrect payments will be made due to error or fraud.

It was also noted that the current process being followed in relation to uploads through the BDU did not include confirmation that the upload process had been successful or any reconciliation processes to confirm that payments expected matched payments made. There is therefore a risk that errors will not be identified and resolved promptly.

Internal Audit testing included follow up on 3 management actions agreed during the 2011/12 Payments to Foster Carers - Trojan audit. It was found that one action had been fully implemented (movement forms are now completed within frameworki), 1 had been superseded (due to the development and implementation of movement forms within frameworki) and the other had been partially implemented. The action found to be partially implemented concerned completion and authorisation of movement forms within 24 hours of a placement starting. As detailed above, testing has identified that timeliness of completion of movement forms is still an issue, with 65% of the sample not having been completed within the required timeframe. A re-worded management action has been agreed as a result of this audit.

IFA Placements

For 15/20 (75%) of the external foster placements sampled, it was found that there is no accurate, signed Individual Placement Agreement (IPA) in place. This was for a number of different reasons, including lack of information provided to Placement Duty Admin and providers not having returned signed agreements. It was found that there was a lack of a clear and effective process in following up and escalating

issues with missing information which has resulted in IPA's not having been produced. There are systems in place to track IPA progress but these are incomplete and hard to link to individual placements. Where there is no signed IPA in place, there is no documented agreement over the placement of the child in terms of the provider and rate agreed. This is higher risk for spot placements outside of the two main frameworks as the IPA is the only contractual document relating to the placement. Where there is no document in existence, the Council has no recourse in the event of poor performance of the provider, and there also maybe issues in relation to ending placements.

It was found that there was a lack of documentation retained in relation to changes to fee rates for external placements and for the agreement and approval of one off payments. The audit trail was therefore incomplete.

Testing of one off payments identified that POs (purchase orders) have been raised retrospectively, resulting in the Council having committed to expenditure before it was approved and in the circumvention of procurement controls.

A duplicate payment was also identified during testing on one off payments. An invoice for an annual bus ticket for a child costing £232.80 had been paid for in June against an old PO reference and then the same amount was paid again at the end of September against a new PO reference.

Internal Audit testing has identified an instance where the previous provider for a placement was paid for two invoices sent from the new provider (totalling just under £10K), additionally the new provider has also been paid for at least one of these invoices. Due to it not currently being possible to view invoices on IBC and there not being any meaningful comments on invoice transactions in relation to time periods individual payments cover, it has not been possible to confirm whether the July invoice has also been paid twice.

Some issues were identified which relate to the implementation of IBC. As a result of the move to the new system, it was necessary to create two separate POs (value orders) for each placement. The first covered the start of the financial year to the end of July and the second from August 15 to March 16. Testing undertaken at the beginning of October identified that some of the new POs had not yet been created. As a result, payment of providers for invoices received since August had been delayed. It has been reported that the delay in creating these new POs is due to volume of work required as a result of the implementation of IBC and that creation of new POs has been prioritised accordingly to value of the placement (higher cost placements dealt with first).

Additionally, it was noted that there is a lack of clarity over how some parts of the external foster payment process will work post IBC. Because of this, invoices are not yet being sent directly to Hampshire County Council for payment and reconciliations confirming payments expected to payments made have not been undertaken since the beginning of July. There are queries outstanding with Hampshire in relation to it not being possible to view invoice images and relating to lack of facility to add comments or text when approving invoices for payment (required as part of the reconciliation process).

Numerous inconsistencies were identified from testing undertaken comparing key information recorded on the external placements spreadsheet, frameworki and IPA contract documentation. Inconsistencies mainly related to fee rates. Agreement of

changes in fee rate were found not to have been formerly documented. There were also inconsistencies relating to placement start dates, carer information, frameworks in use, and frameworki recording. Where key sources of information on IFA placements are inconsistent, there is a risk that payments made could be inaccurate or could be made to the wrong provider. This could affect Council budgets, the accuracy of budget monitoring and forecasting as well as adversely affecting the relationship between the Council and IFA providers.

There is a great deal of reliance on the external placements spreadsheet. This spreadsheet records all external placements, fee rates being paid etc. and is feeds into the budget monitoring and forecasting process. Spreadsheets are open to human error either in accidental amendment or deletion of formulas or input errors. There is a risk that information produced from this spreadsheet could be inaccurate.

It was not possible to locate one of the signed framework agreements in place for the sourcing of external foster care placements. There is a risk that contract terms may not be fully understood, maybe misinterpreted or not complied with. This could result in the Council being in breach of contract or in providers not being required to fulfil their obligations. Furthermore, it was reported that improvements were required in relation to contract monitoring arrangements for the external IFA placements. CEF are currently discussing with Joint Commissioning, how contract monitoring could be improved for these agreements.

A further issue was identified regarding access to placement detail information.

MASH (Multi Agency Safeguarding Hub) 2015/16.

Opinion: Amber	11 November 2015	
Total: 07	Priority 1 = 02	Priority 2 = 05
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	07	

Overall Conclusion is Amber

The Oxfordshire MASH was established and has been operational since September 2014. The governance arrangements and project management appear to have been good during the start-up phase, and the multi-agency Steering Group has maintained oversight and provided support throughout. There have been challenges and teething problems during the first year of operations, however there have also been

examples of good practice, e.g. around multiple agency working. There are two key areas of operational weakness, which are closely interlinked with one another. The first is performance, as the MASH has faced serious issues in meeting operational timescales for acting upon enquiries and making referrals - although performance has been improving. Performance figures are also not reported to DLT or CCMT. The second has been resources, as the Hub started with insufficient staff and although the situation has improved, this has been a continuing theme ever since - as a result of a reported under-allocation of posts required from the outset and difficulty in recruiting permanent staff. However, there have recently been some innovative ideas for addressing resourcing gaps such as rotating locality staff into the MASH, although these are yet to be implemented.

A Governance:

The governance structure has been effective in ensuring oversight of the MASH project. OCC's representation on the Steering Group and Operational Managers group has ensured senior management have participated and been informed throughout. The role of the MASH Operations Manager has helped to maintain a link between the two Groups and ensure escalation of issues and risks.

B Ways of working:

The key processes detailing how enquiries can come into the MASH and are then passed through have been established and documented. ICT policies regarding information sharing, confidentiality and use of systems have been agreed also. This audit did not undertake any compliance testing of adherence to the procedures nor the effectiveness of the processes; a LEAN review is shortly to be undertaken which will address this.

A newly established case audit process is providing useful information on the quality of information sharing and decision-making. In future, this will need to be formally reported to the Steering Group in order to provide assurance on the effectiveness of the MASH.

C Risk management:

Risk management was used effectively during the project management phase, with risks effectively escalated from the operational managers group to the Steering Group and documented in a continually updated risk register. However, there is currently no formal risk management process in place, although there is an intention to establish an Operational Managers Group risk register.

The risks regarding resourcing and not achieving timescales were included in the Risk register; however they were scored as low probability of materialising, despite these being the two biggest risks which have materialised. Insufficient human resources has been one of the major weaknesses since the MASH became operational, and is the main reason for the poor performance indicators and the large backlog of enquiries. There is no documented resourcing strategy to address this major risk.

D Performance:

There are a number of performance indicators to track the timeliness of responses to enquiries, information requests and decision-making. These figures are overseen by

the Steering Group; however they are not reported up to DLT or CCMT. Following analysis of the performance figures it has been identified that some of these have been erroneous. At the time of the audit an exercise was underway to seek to address this.

Performance has been weak, but all performance figures have been steadily improving. In August 2015, 47.6% of the third of enquiries sent for information share were processed to timescale (for all MASH enquiries this was 77%) and the repeat enquiry rate was 51% (although this may have been 32% according to subsequent, more accurate figures). There had been a serious backlog of cases and difficulties in getting cases through the process; however these have now reduced, so the MASH is now working in real time. The performance issues have been raised through the Operational Managers group to the Steering Group throughout and remedial action taken where possible, such as recruiting more agency staff and addressing the problem of obtaining consent.

Although the timescale targets have been set for each stage of the process, based upon the RAG rating of each case; there are no performance targets in order to guide the MASH on the level of performance they are expected to achieve overall.

Direct Payments (Part 1) 2015/16.

Opinion: Red	09 November 2015	
Total: 22	Priority 1 = 12	Priority 2 = 10
Current Status:		
Implemented	02	
Due not yet actioned	01	
Partially complete	0	
Not yet Due	19	

Overall Conclusion is Red

OCC spent £25m in 2014/15 on Direct Payments across adult service user groups for approximately 1,770 service users. This audit of Direct Payments identified insufficient controls in place to provide SCS management with assurance that all personal budgets are spent as intended, in accordance with service users assessed care needs, and that any misused funds are identified and recovered. At the time of the audit, a number of these weaknesses were already known to SCS management (who had requested this audit during audit planning) and some management actions were already in progress.

The purpose of DPs is to allow Service Users and/or their representatives, more choice and flexibility in how they manage their care to meet their assessed needs. However if boundaries of expenditure are not clear and communicated, there are risks of misuse, inequality amongst service users and value for money not being achieved. Management are currently developing a new DP policy that will provide

clarity over permitted expenditure, value for money and equity considerations, whilst still applying the fundamental DP principles of Service User choice and control.
Direct Payments present a risk of fraud or error due to the high value of some of the DP packages and the potential opportunity for recipients to misuse them. Detective controls therefore need to be strong but proportionate in order to identify and follow up on any potential misuse. There are potential safeguarding risks where a Service Users' assessed eligible care needs are not met due to misuse of a DP. The audit sample testing of DPs identified:

- Cases where DPs were used to fund high mobile phone bills, utility bills, carers food, household repairs and expensive Apple computer equipment, as well as two cases where parents paid themselves high salaries. Some of this expenditure had been approved by Social Care and some had not (but was not stopped nor recovered). The Deputy Director has confirmed these example items may not be relevant to meet assessed eligible need and will require further scrutiny, as currently being applied to new cases via the current Panel Process.
- The current internal guidance for practitioners does not adequately clarify what is or isn't acceptable DP expenditure and is therefore open to interpretation and inconsistencies in application (this guidance is currently being re-drafted). The lack of explicit guidance has led to unclear expectations of what the DP team should check during financial reviews. More recently, the LD and OP/PD Panels have provided greater scrutiny over DP packages and set the tone for what senior management expect DPs to be used for (the cases in the audit sample where issues were identified were long-standing DP packages and would therefore not have been subject to the current Panel's scrutiny applied to new cases).
- The DP Team check the bi-annual finance returns for self-managed accounts. From sample testing, Internal Audit identified examples of questionable expenditure that had been queried, as well as examples where they had not been identified and challenged, and a lack of follow through on queries to a satisfactory completion. All DP accounts are reviewed in the same manner, irrespective of the DP materiality. The current process does not require evidence to support payments such as timesheets, invoices and receipts to be submitted and cheque payments are not queried to identify the payee.
- The annual reviews of care needs do not include a detailed review of DP expenditure and rely upon verbal feedback from the Service User or their representative. It is reported that some Social Care Team members will contact the DP team in advance of arranging the annual review for feedback on their observations, however this is not a formalised process and the DP team only have access to the submitted bank account statements and not any supporting documentation. 12 out of the 15 self-managed cases tested had a social care review in the last year or were ongoing, with the remaining 3 having had one in the last 3 years (therefore not having recently reviewed whether care needs were being met and the DP being used as intended). Overall, SCS performance figures report that 73% of annual reviews have been completed in the last year (this is 71% for DP).
- The audit identified examples from sample testing where communication between the finance DP Team and Social Care teams was not always

effective or joined up, as the audit found cases where finance queries had gone un-answered and also questionable expenditure not challenged.

- There is a lack of management information to provide assurance on DP expenditure and usage, at both individual Service User level and higher level overview.

Adult Social Care IT System Implementation Follow-Up Review 2105/16.

Opinion: Amber	08 September 2015	
Total: 0	Priority 1 = 0	Priority 2 = 0
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	0	

There were no new actions raised in this follow up audit.
Overall Conclusion is Amber

The original audit undertaken in January 2015 identified a number of significant risk areas, especially around system testing. The overall conclusion to the audit was Red, based on there being 12 management actions, 6 of which were categorised as being priority 1.

Since that review, the delivery timescale for the new system has changed and it is now scheduled to go-live in November 2015. This has given the project team more time to implement the system as well as address the risk areas identified in our report.

A follow-up of the 12 management actions has found that a number are still in the process of being addressed, with only four having been fully implemented. The implemented actions include confirming the scope of Cycle 1 testing, ensuring there is a process for re-testing and agreeing a retention period for test scripts. The account lockout policy on LAS has also been confirmed with the supplier.

The remaining management actions are all still being addressed by the project team, with some being closer to full implementation than others. The action where least progress has been made is agreeing responsibilities for data ownership and management within LAS. The project team are engaging with ICT Information

Governance colleagues to help address this, although it is important to note that whilst ICT may provide support in an advisory capacity, data within LAS should be owned by business areas and not ICT.

The following is a brief summary of the outstanding management actions, all of which are logged and monitored on 4Action. The action number from the original report is provided for ease of reference:

- User access rights have yet to be formally agreed and approved. This is now planned to be undertaken given business processes have recently been agreed and will be used as a basis to map user access requirements.

- Spending limits have been tested using a sample of data and further more refined testing is planned, including specific testing of high limit authorisers and the structure of the scheme of delegation.

- A Testing Strategy has been drafted but requires some further work before it can be submitted for approval. Given that the purpose of the strategy is to agree the overall approach to testing, it should be finalised and approved as quickly as possible.

- UAT (User Acceptance Testing) Cycle 6 is nearly complete. All testing is supported by test scripts and these will be reviewed by "operational champions" to ensure they cover all relevant business processes. However, test reports have not been produced for each cycle of testing e.g. cycles 3, 4 and 5. At the end of each testing phase, a test report should be produced confirming the scope, limitations and results of testing, before moving on to the next phase.

- We understand that LAS and Controcc test scripts are reviewed at the end of each test to ensure they have been completed successfully. However, this review is not evidenced and hence there is a lack of assurance that it takes place.

- There is greater visibility of the SharePoint project than before and some interface testing has been completed. However, the SharePoint site still needs to be formally signed-off as meeting the requirements of the ASC project.

Broadband Project 2015/16.

Opinion: Green	19 October 2015	
Total: 0	Priority 1 = 0	Priority 2 = 0
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	0	

Overall Conclusion is Green

The structure of the project was found to be well defined with the relevant roles and responsibilities clearly laid out and all key tasks being owned. There is a high level of governance and transparency in place with sufficient information available which is reported to the strategic and other boards on a regular basis. Meetings are tabled ensuring that participants are aware of their commitments and the expectations from them with decision making minuted. There is also a communications plan in place to ensure that stakeholders and other personnel are kept aware of project developments.

Key documentation was found to be in good order with key risks and issues recorded, prioritised, and owned by specific individuals to ensure that they are completed in a timely manner. Highlight reports and end of stage reports are presented in an easy to follow PowerPoint format allowing further dialogue of key points as required by the attendees.

There is a comprehensive project plan in place which is supported by a number of spreadsheets which monitors progress against the plan to ensure that there are no undue surprises emerging and to facilitate the tracking of progress against the overall plan. The plan is in accordance with the national template issued by BDUK and forms the core monitoring documents for the delivery of the programme. BDUK recently audited the governance of the programme and commented within their report with regard to the high level of confidence that the required level of contract management is in place and this is to be commended.

Project costs are recorded in full and reported to the strategic board through the monthly board meetings at a strategically high level. However, whilst the majority of the costs are capital funded it is felt that including the revenue costs would provide a total cost of ownership concept and a more fuller financial reporting structure.

Supplier management deliverables concentrated around the agreed contact with the preferred supplier, BT, and again there was found to be a good level of information available with key deliverables clearly detailed and any deeds of variation required were found to be clearly documented and authorised at an appropriate level.

Appendix 3

Counter Fraud Plan 2015/16

Activity	Qtr	Status
Development of SCS Fraud procedures	2	Complete
Fraud awareness / identification of fraud risk areas	all	Ongoing
Fraud awareness training inc DPs to SCS	4	Planned
Review and update of fraud intranet pages & procedures	4	Planned
Review and update of Fraud Risk Register	all	Ongoing
Procurement Cards Review	3	Testing
Travel and Expenses Review	4	Planned
Blue Badge Review	3 / 4	Planned
Reactive fraud work - DP cases	3/4	Ongoing
Reactive fraud work - pre October 2015	3/4	Ongoing
Reactive fraud work - post October 2015	3/4	Ongoing
NFI 2015	all	Ongoing
Development of Counter Fraud arrangements with City Council to include SPD (Single Person Discount - Council Tax) processes.	4 / &Q1 16/17	Ongoing
Duplicate Payments - data matching	4 / &Q1 16/17	Provisional
Direct Payments - data matching	4 / &Q1 16/17	Provisional

Future work plan to include:
Public Health Payments

Appendix 4

Compliance Plan 2015-16

1. Detailed below is the Compliance Plan for the remainder of 2015/16. The plan has been presented to and endorsed by Finance Leadership Team. The Business Assurance team has recently recruited a permanent Compliance Officer, with two Auditors hopefully joining the wider Internal Audit team during early 2016.

Area	Scope	Current Status
Budget Monitoring and Forecasting	The review will determine the level of organisation compliance with the stated budget monitoring and forecasting processes. Sample testing will be conducted on a range of cost centres and cost centre groups from across each Council Directorate.	Scoping
Outstanding Income and Debt Management	The review will determine the level of organisation compliance with the stated outstanding income and debt management processes. Sample testing will be conducted on a range of services from across each Council Directorate who have outstanding income.	To start
Local Cash Receipting and Banking	The review will determine the level of organisation compliance with the stated cash receipting and banking processes. Sample testing will be conducted on a range of services from across each Council Directorate who collect and bank income.	Scoping
Business Data Upload	The review will determine the level of organisation compliance with the stated Business Data Upload (BDU) process. Sample testing will be conducted on a range of file types uploaded via the BDU system.	To start
Journals	The review will determine the level of organisation compliance with the stated journal processes. Sample testing will be conducted on a range of services from across each Council Directorate who have processed journals.	To start

New Vendor Creation	The review will determine the level of organisation compliance with the stated new vendor creation process. Sample testing will be conducted on a range of services from across each Council Directorate who have raised new vendors.	To start
Invoicing Plans	The review will determine the level of organisation compliance with the stated invoicing plan creation process. Sample testing will be conducted on a range of services from across each Council Directorate who have created invoicing plans.	To start
One Time Vendor Payments	The review will determine the level of organisation compliance with the stated one time vendor payments process. Sample testing will be conducted on a range of services from across each Council Directorate that have requested one time vendor payments.	To start
Employee Changes	The review will determine the level of organisation compliance with the stated employee change process (i.e. honorariums, increments, acting up arrangements, one-off or recurring employee payments, deductions, change in hours, etc.) Sample testing will be conducted on a range of services from across each Council Directorate that have processed an employee change request.	To start