# Oxfordshire County Council
# Internal Audit Services
# Annual Report of the Chief Internal Auditor

# 2015/16

**Date Issued:  June 2016**

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# 1 INTRODUCTION

## 1.1 BACKGROUND

1.1.1 The Accounts and Audit Regulations 2015 require the Council to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The Public Sector Internal Audit Standards 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.

1.1.2 The Accounts and Audit Regulations 2015 require the Annual Governance Statement (AGS) to be published at the same time as the Statement of Accounts are submitted for audit and public inspection. The internal timetable for submitting the accounts and publishing a draft AGS has been bought forward to mid-June 2016 In order for the Annual Governance Statement to be informed by the CIA's annual report on the system of internal control, this interim CIA annual report has been produced for the May 2016 Audit Working Group meeting. This is the full and final CIA annual report.

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

**1.4    THE AUDIT METHODOLOGY**

- The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAS). The annual self-assessment against the standards has recently been completed (May 2016). This has identified the following areas of non-conformance in 2015/16:

- The previous Chief Internal Auditor had operational management responsibility for the Risk Management and Strategic Insurance functions, so was not wholly independent. The risk of conflict of interest was managed where audit activity undertaken in areas where the CIA has operational responsibility was managed by the Audit Manager who reported on these directly to the Chief Finance Officer (S151 Officer). From 1 April 2016 this conflict is no longer applicable due to the change in roles within Internal Audit, with the appointment of Sarah Cox as Interim Chief Internal Auditor who has no operational management responsibility for Risk Management or Strategic Insurance;

- The PSIAS requires that an Internal Audit Charter is in place for each local authority. Oxfordshire County Council Internal Audit Charter is included within Appendix 3 of this report. The Charter sets out the purpose, authority and responsibility of the Council's Internal Audit function. The Internal Audit Charter has been drawn up in line with the PSIAS requirements and replaces all previous Internal Audit Terms of Reference. The Internal Audit Charter is subject to approval by the Audit & Governance Committee of Oxfordshire County Council on an annual basis, in line with PSIAS requirements.

- It is a requirement of the PSIAS for Internal Audit to have a Quality Assurance and Improvement Programme. This is included in Appendix 4.

- It is a requirement of the PSIAS for an external assessment of internal audit to be completed at least every five years. This must be completed by 31 March 2018 but will be considered later this year. The results will be reported back to the Audit & Governance Committee.

- The annual self-assessment against the PSIAS identified that the Internal Audit Procedures manual needs review and updating. This will be completed by the end of September 2016.

1.4.1 The Monitoring Officer has conducted a survey of Senior Management on the effectiveness of Internal Audit. The results from this survey were presented to the April 2016 Audit & Governance Committee meeting and it concluded that the results were very positive and the Internal Audit Service overall continues to be effective.

1.4.2 The Internal Audit Strategy and Quarterly Plans for 2015/16 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.

1.4.3 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.

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

GREEN   There is a strong system of internal control in place and risks are being effectively managed.

AMBER   There is generally a good system of internal control in place and the majority of risks are being effectively managed. However some action is required to improve controls.

RED   The system of internal control is weak and risks are not being effectively managed. The system is open to the risk of significant error or abuse. Significant action is required to improve controls.

1.4.5 In appendix 1 to this report there is a list of all completed audits for the year showing the overall conclusion at the time audit report was issued,

and the current status of management actions against each audit, (based on information provided by the responsible officers).

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 2015/16 the Internal Audit Service was delivered by an in house team, supported with the successful recruitment of two Junior Auditors who started in January 2016. The specialist area of IT audit was outsourced. In addition to the Internal Audit Team, the work undertaken by Business Assurance Team, comprising of an Audit Manager, Compliance Officer and the corporate risk management undertook has been taken into account when considering the annual report on the system of internal control.

1.5.2    The Chief Internal Auditor was shared with Buckinghamshire County Council in 2015/16. This arrangement ended on 31 May 2016. In addition the Chief Internal Auditor managed the internal audit service of Thames Valley Police/Office of the Police and Crime Commissioner. The TVP activity was mainly outsourced, with a small number of days provided by the Audit Manager. This activity will also cease in 2016/17.

1.5.3    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.

1.5.4    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. (Please note from 1 April 2016 these conflicts are no longer applicable due to the change in roles within Internal Audit, with the appointment of Sarah Cox as Interim Chief Internal Auditor).

- 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.

- 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 2015/16 Internal Audit Plan has been completed.

2.1.2 The plan was revised during the year, and twelve audits originally planned have been cancelled or deferred (these were reported to the 13 January and 20 April 2016 Audit Committee meetings):

- SCS - LEAN / Responsible Localities
- SCS - Implementation of the Care Bill
- SCS - Pooled Budgets
- CS - Treasury Management
- CS / EE - Capital Programme Governance & Delivery
- EE - Energy Recovery Facility
- EE - Planning
- EE - City Deal
- EE - OxLEP Governance Framework
- CEF - S151 Schools Assurance - mapping of design of controls.
- SCS - Safeguarding (Adult Social Care Management Controls) - follow up.
- EE / CEF - Supported Transport Programme - Hub Development / Follow up of CEF safeguarding transport audit

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

2.1.4 In addition to the internal audit reviews, the internal audit team has also reviewed the results of the assurance mapping undertaking with the directorates so far, which aims to identify the level of assurance those managers have over their critical services. This work is on-going and has identified some areas where actions are required, but these are not material to the overall level of assurance for 2015/16.

2.1.5 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.

2.1.6　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.

2.1.7　There have been 30 audits undertaken in 2015/16. There have been seven audits which have been graded as RED during 2015/16; Key Financial Systems - Design of OCC controls, SCS Direct Payments, Procurement Cards, ICT disposal of equipment, Payroll, Accounts Payable and Accounts Receivable.

2.1.8　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 takes into account the implementation of management actions.

2.1.9　In addition to the internal audit reviews, the Compliance Function has undertaken specific reviews in the following areas, the results of which have been considered when undertaking the key financial systems audits. Implementation status of the agreed management actions, from these reviews, is included within the table in Appendix 1. Key findings from these reviews are included in Appendix 6.

- Budget Monitoring
- Journals
- Cancelled and Re-issued Invoices
- Invoicing plans, vendor creation & one time vendors
- Employee changes
- Business Data Upload (On-going)
- Local Cash Receipting and Banking

2.1.10　As part of governance arrangements developed when Oxfordshire County Council joined the Hampshire Integrated Business Centre (IBC) Partnership in July 2015 it was agreed that the Southern Internal Audit Partnership would provide annual assurance to Oxfordshire County Council on the adequacy and effectiveness of the framework of governance, risk management and control from the work carried out by the IBC. The statement of assurance report has been received and is included in Appendix 5 of this report. The overall opinion given is that the framework of governance, risk management and management control is 'Adequate' and audit testing has demonstrated controls to be working in practice. Individual audit reports produced on the IBC key financial systems by Southern Internal Audit Partnership are due to be shared with Oxfordshire County Council.

2.1.11    The Anti-fraud and corruption strategy remains current and relevant. During 2015/16 there has been an increase in the amount of reported fraud, or attempted fraud, including external fraud

2.1.12    The National Fraud Initiative data matching reports have been reviewed and key matches are being investigated.

2.1.13    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.

2.1.14    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.

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

   ▪ The results of all audits undertaken as part of the 2015/16 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;

   ▪ Whether or not any limitations have been placed on the scope of Internal Audit – of which there have been none.

   ▪ Assurance provided by Southern Internal Audit Partnership on the effectiveness of the framework of governance, risk management and control from the work carried out by the IBC on behalf of Oxfordshire County Council.

   ▪ Compliance reviews completed by the Business Assurance Team

   ▪ Corporate Lead Assurance Statements on the key control processes, that are co-ordinated by the Corporate Governance Assurance Group (of which the CIA is a member of the group), in preparation of the Annual Governance Statement.


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

In my opinion there is **qualified** assurance over Oxfordshire County Council's system of internal control. Whilst the opinion is based on the whole system of internal control and there are a relatively small number of limited assurance reports issued by Internal Audit, the underlying issue has been weaknesses in the system of financial control. This includes the outcome of the review of the design of controls

including corporate oversight in relation to the key financial systems, following the fundamental changes to the OCC control environment resulting from the transfer of transactional processing to the Hampshire IBC. The review was commissioned by the Chief Finance Officer following the stabilisation period of the implementation of the new service. There are a number of areas identified that require improvement, so a financial management improvement plan is being devised to ensure that all issues are addressed, and crucially that any cultural and learning points are included to ensure that improvements are sustainable, and enable continuous improvement for both the system for control and the performance and efficiency of those systems.

2.2.1    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 (20 April 2016) are attached as appendix 2;

- IT Application Audit of LAS (Adult Social Care I.T system)
- IT Application Audit of Controcc (Adult Social Care Finance I.T system)
- Main Accounting.
- Specific review of individual direct payment case.
- Pensions Administration
- Pensions Fund
- SCS Client Charging
- SCS Payments to Residential and Home Support Providers
- Accounts Receivable
- Accounts Payable
- Payroll
- Banking / Cash Receipting


**2.3    INTERNAL AUDIT PERFORMANCE**

2.3.1    The following table shows the performance targets agreed by the Audit Committee and the actual 2015/16 performance.

| Measure | Target | Actual Performance 2015/16 |
|---|---|---|
| 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 | 58% of the audits met this target. (2014/15 this was 52%, 2013/14 this was 70%) |
| Elapsed time for completion of the audit work (exit meeting) to issue of draft report | 15 Days | 96% of the audits met this target. (2014/15 this was 83%, 2013/14 this was 82%) |

| Measure | Target | Actual Performance 2015/16 |
|---|---|---|
| Elapsed time between issue of draft report and the issue of the final report | 15 Days | 48% of the audits met this target. (2014/15 this was 69%, 2013/14 this was 65%) |
| % of Internal Audit planned activity delivered | 100% of the audit plan by end of April 2014. | 66% of the plan was completed by the end of April 2015. (2014/15 this was 64%, 2013/14 this was 86%). |
| % of agreed management actions implemented within the agreed timescales | 90% of agreed management actions implemented | As at 23 June 2016:<br><br>412 Management Actions agreed in 2015/16: 34% implemented, 53% not yet due, 6% partially implemented and 7% overdue.<br><br>243 Management Actions agreed in 2014/15: 93% implemented, 3% not yet due, 3% due or partially implemented. |
| Customer satisfaction questionnaire (Audit Assignments) | Average score < 2 | Based on 8 questionnaires returned the average score was 1.07<br><br>(14/15 was 1.02, 13/14 was 1.24, 12/13 and 11/12 were both 1.32). |
| Directors satisfaction with internal audit work | Satisfactory or above | Achieved – Evidenced via Monitoring Officer's survey |

**RECOMMENDATION**

**The committee is RECOMMENDED to:**

a) **Consider and endorse this annual report**

b) **Approve the Internal Audit Charter included within Appendix 3 of this report**

c) **Note the Quality Assurance and Improvement Programme included within Appendix 4 of this report.**

Ian Dyson - Assistant Head of Finance (Assurance), Chief Internal Auditor until 1 April 2016.

Sarah Cox, Audit Manager, Interim Chief Internal Auditor from 1 April 2016.

July 2016.

**APPENDIX 1  - Implementation status of 2015/16 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 23 June 2016 |
|---|---|---|---|---|
| CEF | CEF Safeguarding (Children's Social Care Management Controls) - Missing Children | Amber | 24 | 5 implemented, 8 not due, 2 partially implemented and 9 overdue. |
| CEF | Thriving Families - Summer Claim | N/A | 1 | 1 implemented. |
| CEF | Thriving Families - Winter Claim | N/A | 4 | 2 not due, and 2 overdue. |
| CEF | MASH (Multi Agency Safeguarding Hub) | Amber | 7 | 6 implemented, and 1 partially implemented. |
| CEF | CEF Social Care Payments | Amber | 18 | 7 implemented, 5 not due, 5 partially implemented, and 1 not implemented. |
| CEF | Foster Payments (Internal & External) | Amber | 29 | 13 implemented, 2 not due, 9 ongoing, and 5 overdue. |
| SCS | SCS Personal Budgets / Direct Payments | Red | 22 | 20 implemented, and 2 not due. |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 23 June 2016 |
|---|---|---|---|---|
| SCS | Adult Social Care Information System - follow up audit | Amber | N/A | Management confirmed actions implemented prior to go live. |
| SCS | Adult Social Care Information System - I.T. application review of LAS | Green | 3 | 2 implemented and 1 not due. |
| SCS | Adult Social Care Information System - I.T. application review of Controcc | Green | 1 | 1 not due. |
| SCS | Client Charging, including ASC debt management and also management of deferred debt | Amber | 44 | 40 not due, and 4 implemented |
| SCS | Residential and External Home Support Payment systems. | Amber | 9 | 9 not due |
| SCS | Review of specific DP case (addition to plan) | N/A | 9 | 5 not due, 1 implemented and 3 overdue. |
| OFRS | Retained Fire Fighters - Payroll (Garton Processes) | Green | 3 | 3 implemented. |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 23 June 2016 |
|---|---|---|---|---|
| EE | Highways Contract | Amber | 13 | 8 implemented, and 5 not due. |
| EE (ICT) | Cyber Security | Amber | 11 | 11 implemented. |
| EE (ICT) | ICT Disposal of Equipment | Red | 10 | 10 implemented. |
| EE (ICT) | ICT Change Management | Amber | 7 | 7 implemented. |
| EE (ICT) | Broadband Project | Green | 0 | n/a |
| EE (ICT) | Commissioning of ICT Services | Green | 4 | 2 implemented, and 2 partially implemented. |
| Key Financial System | Key Financial Processes (Design of Controls) | Overall – Red | 73 | 7 implemented 59 not due, 3 partially implemented and 4 overdue. |
| Key Financial System | Pensions Fund | Pension Fund | 0 | n/a |
| Key Financial System | Pensions Administration | Green | 2 | 2 not yet due |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 23 June 2016 |
|---|---|---|---|---|
| Key Financial System | Accounts Receivable | Red | 19 | 18 not due and 1 implemented. |
| Key Financial System | P2P / Accounts Payable | Red | 8 | 8 not due. |
| Key Financial System | Main Accounting / General Ledger | Amber | 2 | 2 implemented. |
| Key Financial System | Payroll | Red | 14 | 13 not due and 1 implemented. |
| Key Financial System | Banking / Cash Receipting | Amber | 4 | 4 not due. |
| Key Financial System | Procurement Cards (addition to plan) | Red | 15 | 1 implemented, 12 not due, and 2 overdue. |

| Directorate | Audit | Overall Conclusion at Final Report Stage | Number of Management Actions agreed | Reported implementation status as at 23 June 2016 |
|---|---|---|---|---|
| All directorates | 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. | N/A | N/A | N/A |
| Compliance Review | Budget Monitoring | N/A | 7 | 6 not yet due and 1 implemented. |
| Compliance Review | Journals | N/A | 4 | 3 not yet due and 1 implemented. |
| Compliance Review | Cancelled and Re-Issued invoices | N/A | 5 | 5 not yet due |
| Compliance Review | Invoicing plans, vendor creation & one time vendors | N/A | 4 | 1 not yet due and 3 overdue |
| Compliance Review | Employee Changes | N/A | 1 | 1 not yet due |
| Compliance Review | Cash Receipting - locally agreed actions | N/A | 5 | 5 implemented |

## APPENDIX 2

## Summary of Completed 2015/16 Audits since last reported to the Audit & Governance Committee on 23 June 2016.

### LAS IT Application Review 2015/16

| Opinion: Green | 25 April 2016 | |
|---|---|---|
| Total: 03 | Priority 1 = 01 | Priority 2 = 02 |
| Current Status: | | |
| Implemented | 02 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 01 | |

Overall Conclusion is Green

Users require a valid username and password to access the LAS application. All LAS user accounts are linked to Windows Active Directory and use the same credentials i.e. users re-enter their Windows username and password when they login to the application. Logical security for the application is therefore taken from Windows Active Directory, which we have confirmed provides an adequate level of password control.

Security roles are used to define the level of access that users have within the application. They were created and tested as part of the implementation project, however, there is no evidence of them being formally approved in accordance with a previously agreed management action. The ICT Applications and Systems team are responsible for the administration of the application and adopt corporate ICT procedures for managing users i.e. starters and leavers. The users with administrator level access were reviewed and found to be adequate.

LAS has an audit trail facility which is enabled by default and does not require any local configuration. The information held in the audit logs cannot be amended or deleted and can be extracted via the reporting functionality.

Configuration workshops were held early in the implementation project to determine requirements for mandatory data fields. There are certain fields that the application determines as being mandatory and these cannot be switched off. We reviewed a sample of LAS screens and forms and found they contained adequate mandatory fields and other options, such as drop-down lists and calendars, to ensure the completeness and accuracy of data input.

Users are required to raise all support calls with the ICT service desk, where they are logged and managed through to resolution. Nearly 2500 support calls relating to LAS and Controcc were logged by the ICT service desk between the 9th November 2015, when the system went live, and 29th February 2016. Whilst the majority of these have been resolved and closed, it was noted that they had all been categorised as low urgency and priority. This suggests that the impact and severity of calls is not being formally assessed and could lead to critical issues not

being prioritised over those that are less critical. We also found that there is no formal process for reporting back to service areas any details on the types of issues and problems being raised by users with the ICT service desk. As such, they may not be aware of any common themes which need to be addressed via further training or support.

Whilst the ICT service desk deal with day-to-day user issues, an update on the ASC IT system implementation was reported to ASC DLT on the 17th February 2016. It highlights some of the more critical issues which have arisen following system implementation and how they are impacting on the delivery of ASC services. A key area that has been identified is the need to review business processes and workflows. The report recommends that a project team is reformed to lead the business process improvements that are required. ETMS upload issue and manual adjustments are being reviewed as part of the Payments to Residential and Home Support Audit.

A backup of LAS is undertaken on a daily basis. The SQL database is subject to a full weekly and a daily differential backup and there is a daily incremental backup of the application. A backup of SQL log files is also taken every hour to facilitate recovery and minimise the loss of data. Disaster recovery documentation has been updated with details of LAS and a recovery of the system was performed following an incident in September 2015. Whilst the system had not gone live at this stage, the exercise confirmed the reliability of backups and processes.

Internal Audit are currently undertaking audits of both Client Charging and also Payments to Residential and Home Support Providers, and therefore testing processes on both LAS and Controcc.

## Controcc IT Application Review 2105/16

| Opinion: Green | 25 April 2016 | |
|---|---|---|
| Total: 01 | Priority 1 = 01 | Priority 2 = 0 |
| Current Status: | | |
| Implemented | 0 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 01 | |

Overall Conclusion is Green

The logical security of the application is based on single sign-on, utilising Windows Active Directory network logins. As such, users are not required to enter a secondary username and password when accessing the system. A review of Windows Active Directory has confirmed that it provides an adequate level of password control.

Security roles are used to define the level of access that users have within the application. They were created and tested as part of the implementation project, however, there is no evidence of them being formally approved in accordance with a previously agreed management action. To avoid duplication, we have reported this risk in the LAS IT Application report and it is included here for information only.

The ICT Applications and Systems team are responsible for the administration of the application and adopt corporate ICT procedures for managing users i.e. starters and leavers. The users with administrator level access were reviewed and found to be adequate.

Controcc comes with an audit trail facility which is enabled by default and does not require any local configuration. Audit data is available at screen level and it is also possible to generate specific audit reports via the reporting functionality.

We reviewed a sample of Controcc screens for setting up a new contract, adding services to a contract and setting up the payment method and found that they contain adequate mandatory data fields and drop-down lists to ensure the completeness and accuracy of data input. However, there is a key risk issue relating to the ETMS data upload into Controcc. There are problems with the upload which means the payments team has to carry out a manual reconciliation of the figures.

Users are required to raise all support calls with the ICT service desk, where they are logged and managed through to resolution. Nearly 2500 support calls relating to LAS and Controcc were logged by the ICT service desk between the 9th November 2015, when the system went live, and 29th February 2016. Whilst the majority of these have been resolved and closed, it was noted that they had all been categorised as low urgency and priority. This suggests that the impact and severity of calls is not being formally assessed and could lead to critical issues not being prioritised over those that are less critical. We also found that there is no formal process for reporting back to service areas any details on the types of issues and problems being raised by users with the ICT service desk. As such, they may not be aware of any common themes which need to be addressed via further training or support. To avoid duplication, we have reported these issues in the LAS IT Application report and they are included here for information only.

Whilst the ICT service desk deal with day-to-day user issues, an update on the ASC IT system implementation was reported to ASC DLT on the 17th February 2016. It highlights some of the more critical issues which have arisen following system implementation and how they are impacting on the delivery of ASC services. A key area that has been identified is the need to review business processes and workflows. The report recommends that a project team is reformed to lead the business process improvements that are required. ETMS upload issue and manual adjustments are being reviewed as part of the Payments to Residential and Home Support Audit.

A backup of the Controcc system is undertaken on a daily basis. The SQL database is subject to a full weekly and a daily differential backup and there is a daily incremental backup of the Controcc application server. A backup of the SQL log files is also taken every hour to facilitate recovery and minimise the loss of data. Disaster recovery documentation has been updated with details of Controcc and a recovery of the system was performed following an incident in September 2015. Whilst the system had not gone live at this stage, the exercise confirmed the reliability of backups and processes.

Internal Audit are currently undertaking audits of both Client Charging and also Payments to Residential and Home Support Providers, and therefore testing processes on both LAS and Controcc

**Main Accounting 2015/16**

| Opinion: Amber | 27 April 2016 | |
| --- | --- | --- |
| Total: 02 | Priority 1 = 01 | Priority 2 = 01 |
| Current Status: | | |
| Implemented | 02 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 0 | |

Overall Conclusion is Amber

Design of controls - reported in separate letter dated 8 April (included in 20 April Audit & Governance Committee report).

Effectiveness of Controls

Many of the main accounting functions have moved to IBC, including the management of the majority of suspense and holding accounts and undertaking bank reconciliations. Other processes, such as internal recharges and journals have moved to self-service, so there is a reduced role for OCC finance teams in monitoring these. For the functions that remain, the changes to ways of working are bedding in, however there are some areas of weakness, including:

- Bulk data upload checks are robust however they do not cover all uploads.
- There is no segregation of duties for internal recharges and the audit identified one case in a sample of 10 where the same person requested and accepted the internal recharge. There are also numerous coding errors with internal recharges, resulting in inaccurate budget figures and time taken to review and correct these errors.
- The audit identified up to 100 cost centres (exact figure to be confirmed by the Assurance and Reporting team) without a person responsible for monitoring the budget.

**Review of individual direct payment case 2015/16**

| Opinion: n/a | 04 May 2016 | |
| --- | --- | --- |
| Total: 09 | Priority 1 = 04 | Priority 2 = 05 |
| Current Status: | | |
| Implemented | 01 | |
| Due not yet actioned | 03 | |
| Partially complete | 0 | |
| Not yet Due | 05 | |

A specific direct payment case was referred to Internal Audit for review in February 2016 following a request from the Locality Manager to make a large backdated payment for unpaid invoices to the care agency. This had occurred because a couple were receiving a joint care package, however when the wife

went into residential care and then sadly passed away shortly afterwards there was no re-assessment of the husband's package and whilst the direct payment was reduced the care provision continued at the same level.

The audit has established a series of failings in process, decision-making and communications by the Social Care team and the Direct Payments team, in relation to the case, including:

The significant delay in completing the social care assessments and Support Plan, resulted in the unresolved backlog of unpaid invoices. There were continuous attempts at adjusting the personal budget which were never processed, as they did not meet the higher unresolved ongoing care costs. Whilst the DP team continually alerted and chased the Social Worker regarding the unpaid invoices, they did not escalate the issue, and there is no evidence that they challenged the premises upon which the backdated calculations were made. A contribution was agreed by the family that did not follow the correct process.

Actions have been agreed with management to address the specific weaknesses relating to this individual case and also to ensure that process weaknesses are addressed. Since this review, multiple Direct Payment training sessions have been delivered to staff across social care.


## Pensions Administration 2015/16

| Opinion: Green | 11 May 2016 | |
| --- | --- | --- |
| Total: 02 | Priority 1 = 01 | Priority 2 = 01 |
| Current Status: | | |
| Implemented | 0 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 02 | |

Overall Conclusion is Green

The Pensions Team administer the Local Government Pension Scheme in Oxfordshire for over 200 employers, the largest employer being Oxfordshire County Council. Various members of the team sit on a number of national groups, which discuss and interpret updates to the pension regulations; this ensures the day-to-day guidance used by the team is kept continually up to date.

Comprehensive procedures have been established, and subject to update when necessary, for all starter, leaver and amendment processes. Appropriate segregations and checks are in place to ensure that all updates to records, and payments made to individuals are accurate (such as death grant payments). Throughout testing all individuals had second checks undertaken by a senior officer and the relevant checklist/calculation signed off.  A wider segregation of duties issue was noted however. Only two senior members of the team have access to perform both administrative tasks and run the payroll function, this was reportedly necessary to correct minor payroll reconciliation errors, to ensure the payroll runs on time. The issue is that one of these individuals undertakes the

payroll reconciliation, runs a report from Altair to show what transactions she and the other member of staff have performed, and uploads the Pensions payroll information to SAP via the Business Data Upload (BDU) facility. Both of the reports run from Altair, the one to show the transactions performed, and the one raised to upload to SAP are produced in a format that can be easily amended. Essentially one individual could set up a ghost pensioner, or divert funds to a different bank account when the payroll is run, with it going unnoticed indefinitely. It should be noted however that there were no signs of any financial irregularity in the documentation reviewed during the audit.

The Pension Services Manager and team have been proactively working with all employers within the scheme to obtain monthly data returns (MARS), detailing the changes to employees records, such as starters, leavers and change of hours etc. There have been significant issues with getting this information from Oxfordshire County Council. This has resulted in delays in various processes, including the issuing of annual benefit statements. Regulations require all individuals to receive a statement, however the Pension Services Manager has had to report a breach in regulations as not all statements could be issued on time. A considerable delay was also noted in the issuing of Previous Pension Forms for new starters, should they wish to transfer previous pensions into the LGPS scheme, some were up to 11 months late. The team have been using test data to challenge OCC's submissions and a former member of OCC HR staff has also been re-employed to work on getting the MARS data accurate. However there are still reported issues with data accuracy.

Another issue was noted around the TUPE transfer of OCC to staff to other organisations. If the Pensions Admin Team are not advised of the transfer in a timely manner, the new employer may not be admitted to the LGPS in time which could cause a gap in pension for any transferred employees. If there is insufficient provision to ensure the employee's pension is protected during the transfer action could be taken against OCC as they become liable for any gaps in service. It was reported that there are still issues with both schools and OCC teams not informing Pensions in a timely manner when tendering services.

Effective and timely management reporting takes place, highlighting issues and performance statistics at the Pension Fund Committee meetings, ensuring they are kept fully up to date.

## Pensions Fund 2015/16

| Opinion: Green | 18 May 2016 | |
|---|---|---|
| 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

Performance of the assets and investments are kept under continual scrutiny. Markets are also continually reviewed to highlight any potential issues or investment opportunities.

Prior to the start of the financial year a reporting schedule had been agreed, detailing when the Fund Managers would present a report at the Pension Fund Committee and when the Independent Financial Advisor would provide a verbal update. All reports and verbal updates were presented in line with the schedule, ensuring the committee were kept up to date with performance of the investments.

The cash balance is also monitored regularly to ensure there are sufficient funds to meet the liabilities. Costs such as hidden costs (early retirements) and fees are reviewed and charged back to the employers or absorbed by the fund.

Fund Managers, the Custodian and the Independent Financial Adviser are regularly reviewed to ensure performance is in line with the respective contracts. The Fund Manager and Custodian's records are also cross checked against each other to ensure the Fund Managers are not misstating the value of the assets. The performance of the assets dictates the level of pay the Fund Managers receive, in all cases tested the invoices had been scrutinised against the asset records to ensure the correct charge has been applied.

There were no significant control weaknesses identified in the audit that required any management actions needing to be agreed.

## SCS Client Charging 2015/16

| Opinion: Amber | 21 June 2016 | |
|---|---|---|
| Total:44 | Priority 1 = 03 | Priority 2 = 41 |
| Current Status: | | |
| Implemented | 04 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 40 | |

Overall Conclusion is Amber

It is acknowledged that the both the Financial Assessments Team and the ASC Income Team have been subject to significant changes in terms of staffing, processes and systems during 2015/16. The introduction of IBC at the beginning of July resulted in changes to financial processes and changes to staffing structures. In November 2015, LAS and ContrOCC were implemented, resulting in further change to processes.

The client charging process has changed significantly following the introduction of LAS and ContrOCC in November 2015. Whilst high-level training was provided to

social care and support teams, there is still work to be done to formalise and document detailed financial procedures and confirm management information and reporting requirements. When used correctly, the new systems should facilitate a smoother process, however it is recognised that this is not yet happening. The new system is highlighting long-standing issues which previously were hidden, such as delays in completing and authorising Support Plans and personal budgets. The knock-on effect on charging has resulted in delayed assessments / commencement of charging and the use of work-arounds, manual adjustments and corrections to resolve inaccurate and missed charges.

Senior management are aware of the issues and a project team is established to lead the business process improvements that are now required.

Key findings identified during the audit are summarised below:

- There are processes within Financial Assessments Team and the ASC Income Team which have not yet been fully thought through and confirmed in relation to the new systems. Management information and reporting requirements have not been defined. Although some reports are being run from ContrOCC, and reporting processes are being developed where a need is identified, this is ad hoc and reactionary, rather than agreed and planned development of reports as part of the new systems implementation.

- Due to issues with the accuracy and format of customer payment and account information currently available through the IBC portal, the Financial Assessments Team are currently reliant on the ASC Income Team for obtaining information on customer accounts / balances, adding to the workload for both teams.

- Sample testing of residential financial assessments noted delays in completion of assessments, with current targets often being missed. Some issues were also noted in relation to the accuracy of financial assessment information recorded on ContrOCC in relation to financial assessments, although they did not affect the outcome of the assessment.

- Review of system parameters on ContrOCC identified that minimum income guarantee allowances for some non-residential service users were found to be inconsistent with guidance from the Department of Health, resulting in some client contributions being slightly higher (10p or less per week) than they should have been. A discrepancy with the savings disregard for non-residential couples for 2016/17 was also noted.

- Issues with the saving of supporting documentation to Sharepoint and with saving documentation to the wrong service users Sharepoint record / LAS record were identified in relation to the Financial Assessments Team and the ASC Income Team.

- Examples were identified where service users moving from non-residential to residential care were charged incorrectly due to delays in deactivating non-residential services. Delays were also identified in relation to the start of charges due to delays in approval (and therefore activation) of new services on ContrOCC. None of the sample tested had services approved / activated prior to the start date of care. Although this does not necessarily mean that the service hadn't been authorised promptly (Annex 2 may have been completed promptly)

outside of ContrOCC, delays in approval on ContrOCC had resulted in delays in being able to raise charges.

- Issues were identified in relation to the assessment reduction process. There was found to be a lack of visibility of reductions of under £1000. For reductions of over £1000, although these are checked by Team Leaders or the Financial Assessments Manager, an error was noted within the sample, where the reduction applied was for £2K more than it should have been due to the contribution rate used being incorrect. Therefore checking processes do not appear to be fully effective. On the non-residential side, issues were identified with the retention of documentation. For one service user in the sample, where a reduction of just under £5K had been processed, it has not been possible to confirm the accuracy of the calculation.

- Processes around third party top ups were found to be unclear, which could have resulted in the Financial Assessments Team not having been made aware of instances where third party's need to be invoiced. Revised processes and guidance have been agreed and already implemented as a result of this audit which should ensure that new third party top up arrangements can be invoiced promptly going forward.

- Although processes within LAS include prompts to ASC teams to refer service users for a financial assessment, there are no system controls in place which ensure that this happens. Reporting processes have been developed within the Financial Assessments Team in order to identify service users with a provision which has not been authorised or where there a provision has been approved but no charges raised (indicating a financial assessment may not have been completed). However, there is currently a gap in process in relation to identifying and resolving cases where a service user is identified as being in receipt of a chargeable service from ETMS exception reporting, but has not had a financial assessment.

- Testing on the non-residential assessment process identified that there were no targets in place over the non-residential financial assessment process. An instance was noted where it appears that care recorded on ETMS has not transferred to ContrOCC or been invoiced, this is in the process of being investigated.

- It was noted that service users who have home support from providers who do not use ETMS (estimated to be 20-25%) are currently being charged based on the hours care in their support plan rather than on actual care received. This is contrary to the Contributions Policy approved by Cabinet in February 2015 and could mean that service users are not being charged consistently.

- Noted that for some service users who initially receive non-planned care (e.g. crisis response or reablement), but then go on to have an ongoing service, some have not being charged when they should have been, due to delays in loading care package line items (CPLIs) on to ContrOCC.

- It was noted that the upload of billing run information from ContrOCC to SAP / IBC is currently done through the BDU. There is currently a significant amount of manual manipulation required to get the data in the correct format to be uploaded, increasing the risk of errors. It is planned that an automated interface between ContrOCC and IBC will be developed to address this.

- Arrangement, administration and interest charges agreed by Cabinet are not currently being charged as processes are still to be fully determined.

- Not all migrated debts are currently being actively monitored and chased by the ASC Income Team.  There were also examples identified from testing where there was a lack of evidence that appropriate recovery action was being taken in relation to some debts (this includes action by Hampshire County Council as well as the ASC Income Team).  This was acknowledged by the team who are trying to ensure that all migrated debts they are not aware of are identified and that recovery action is prioritised appropriately.

- It was noted that the process / parameters for when ASC teams should be informed of unpaid debts required clarification.

- There is currently no ASC aged debt reporting.  This is a corporate issue and is being addressed as part of the 2015/16 Accounts Receivable audit.

- From review of deferred payment agreements, it was noted that there had been a lack of review or follow up on equity remaining in properties during 2015/16.

Although it was reported that all management actions agreed as part of the 2014/15 Client Charging audit had been fully implemented, follow up testing has identified that this is not the case.  Of the 10 management actions agreed, it was found that 5 had been fully implemented, 2 had been superseded, but 1 action had been partially implemented and 2 had not been implemented.

It was found that reconciliations had not been completed with the required frequency in relation to some service users with personal budgets.  It was also noted that there are refunds due from a reconciliation undertaken for the period October 14 to March 15 have not been processed.  It was found that no process has been agreed for what action should be taken in the event that it is identified, from this reconciliation process, that the service user has underpaid.

It was also found that there was still a lack of clarity over the process for how changes to charges are agreed and communicated to ensure that service users are charged correctly and consistently.

## SCS Payments to Residential and Home Support Providers 2015/16

| Opinion: Amber | 14 June 2016 | |
| --- | --- | --- |
| Total: 09 | Priority 1 = 0 | Priority 2 = 0 |
| Current Status: | | |
| Implemented | 0 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 09 | |

<u>Overall Conclusion is Amber</u>

The provider payments process has changed significantly in the last few months following the introduction of LAS and ContrOCC in December 2015. Whilst high-level training was provided to social care and support teams, detailed financial procedures were not documented and training provided for all finance processes until after go-live. When used correctly, the new systems should facilitate a smoother process, however it is recognised that this is not yet happening. The new system is highlighting long-standing issues which previously were hidden, such as delays in completing and authorising Support Plans and personal budgets. The knock-on effect on payments has resulted in delayed payments and the use of work-arounds, manual adjustments and corrections to resolve inaccurate and missed payments.

Senior management are aware of the issues and a project team has been established to lead the business process improvements that are now required. However funding for the 'Phase 2' project has not yet been agreed by CCMT, and if the improvements are not implemented then the risk of ongoing payments inaccuracies and delays is higher.

<u>Payments Accuracy</u>

Incorrect use of LAS and a significant backlog of services to be uploaded have resulted in hundreds of cases of care packages not being authorised prior to care commencing and payments made. As a result, manual payments have been processed where home support care has been delivered but without an authorised care package.

A limited number of inaccuracies in the work-around manual payments were identified during the audit, where some provider payments had been omitted or were incorrect. There is a lack of transparency for providers on the nature and calculation of these payments on their remittances.

From a sample of 20 home support payments, 9 did not have a Support Plan in place when care began and payments made, however all of these were 'non-planned' services from Oxfordshire Reablement Service (ORS), Discharge to Assess (D2A) or Crisis. In 4 out of these 9 cases there was still no Support Plan within 6 months of care starting - in one case the Support Plan had been overdue for more than a year.

From a sample of 20 residential payments, in 11 cases the Annex 2's had been authorised after the placement began and payments made (one of which was signed off 5 months after the placement had commenced).

The bi-annual remittance quality control process has successfully identified at least one over-payment to a residential provider by comparing OCC residential service user records against actual residents. However there are weaknesses in the process (almost half of providers have not responded) and there are currently discussions underway over its future direction.

From a sample check of 5 death reconciliations, in one case the home support care package had not been terminated, resulting in a risk of over-payments if the provider continued to log visits after death (in this case no further visits were logged).

<u>Blocks and Capacity</u>

The Placements Team's process is to place service users with block providers before purchasing from spots. However there is significant wastage, particularly in respite placements. In the last reported quarter (Quarter 3, 2015) the total cost of vacant beds was £33.6k for the third quarter and a 78% occupancy rate (16% cancelled and 6% empty). This is a worsened picture compared to the same quarter in 2014. There are no similar figures available for long-term placements.

<u>Follow Up</u>

The previous audit in 2014/15 was graded Red, and highlighted significant issues in particular with regards oversight of the Electronic Time Monitoring System (ETMS) used by home support providers. The monitoring of ETMS usage has improved, with a full time Quality Contracts Officer appointed to undertake this. Overall, ETMS direct login has improved since the last audit, from 83% in August 2014 to 86% in March 2016. There are fewer providers in the Red category (the lowest score is 77% where previously it was 45%). Overlapping, double handed and missed visits are being scrutinised by the ETMS QCO on an ongoing basis, and overpayments refunded to OCC as a result.

The last audit report contained 35 actions, of which 32 have been reported as implemented, 2 superseded and 1 being implemented. From this audit review, 27 are fully implemented, 2 superseded, 5 partially implemented/implemented but not working effectively and one still open.

**Accounts Receivable 2015/16**

| Opinion: Red | 22 June 2016 | |
|---|---|---|
| Total: 19 | Priority 1 = 03 | Priority 2 = 16 |
| Current Status: | | |
| Implemented | 01 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 18 | |

<u>Overall Conclusion is Red</u>

The audit was split into two parts, the first being a review of the design of controls (completed by Neil Shovell, Audit Manager) and the second being the audit of the effectiveness of the implementation of controls. However, limited testing has been undertaken this year, due to the known issues, and management actions already in progress to resolve some of the problems identified since go live.

Design of controls - reported in separate letter dated 8 April (included in 20 April Audit & Governance Committee report).

Some compliance work has also been undertaken in relation to Accounts Receivable.  This found that compliance with the stated requirements was generally sufficient, but issues were identified with the Intranet guidance and the fact that, as discussed in the Design and Controls report, invoices can be cancelled twice on the system. There is also no prompt on the system for the user to raise a replacement invoice, and approval requests go to the user's line manager rather than the Cost Centre Manager. An emphasis is therefore placed on effective budget monitoring, as the Cost Centre Manager is not required to give separate approval for the transaction.

Effectiveness of Controls

Many accounts receivable processes have moved from OCC Shared Services to Hampshire / IBC, who are now responsible for the raising of invoices, receipt and allocation of payments and the initial stage of debt recovery (dunning).  OCC has retained small number of staff in relation to income, this includes a Corporate Income Manager and a team who deal with Adult Social Care Debt Recovery.  The following has been identified as part of the Internal Audit work undertaken on the effectiveness of controls:

- 3/30 instances where there was a delay of a number of months in raising of the invoice.  Reported as due to work backlogs.

- Issues were reported in relation to the sent from email addresses and subject fields in invoice and dunning emails sent by Hampshire.  As these were not clearly identifiable as invoices and dunning letters from OCC, they were either going to debtors spam folders or were being ignored as thought to be spam.

- Lack of guidance noted over supporting documentation to be retained for invoices raised.  There was lack of supporting documentation for 3/30 sampled.

- Lack of clarity over roles, responsibilities, policies and procedures noted in relation to the debt monitoring and recovery process.  This relate to corporate debt as well as ASC debt.  Testing undertaken indicates staff in services are unclear on their responsibilities in this area.

- Management information including aged debt reporting is still in the process of being formalised.  There are also known issues in relation to the accuracy of the information on debtors available for managers through the IBC portal.

- Debt monitoring and recovery process in relation to invoices raised by Pensions Services reported as being considered prior to IBC go live, were not implemented. No recovery action was being undertaken by IBC (now resolved), but the Pensions Services Manager did not have access to information to be able to monitor these debts.  Interim measure is now in place, with a permanent solution being developed.

- There was a lack of clarity over what action should be / is being undertaken by Hampshire in the event that invoice or dunning emails bounce back.  It is understood that there is no reporting available on the level of bounce-backs.

- Instances were noted where invoices had been reported by the debtor to have been paid, but were still showing as overdue on SAP.  An example has been identified where income had been received, but was sitting in the unallocated

income account. It is noted that there was (as at 3 June 2016) £1.1M of unallocated income which will include some debtor payments. Clearing of this unallocated income could have a significant impact on debt recovery action required. Management actions are to be agreed in relation to this as part of the 2015/16 Cash & Banking audit.

- Issues were noted with delays in the process of chasing of debts, particularly after the dunning stage.

- There are still a number of migrated debts which are still outstanding. It has been reported that these have now been identified by the Corporate Income Team and are being reviewed to ensure appropriate recovery action is being undertaken.

- Write off procedures and approval levels require updating as they no longer reflect the way in which write offs are processed. Once revised procedures have been clarified, all directorate schemes will need to be updated.

- Errors have been noted in relation to miscoding and misallocation of income.

## Accounts Payable 2015/16

| Opinion: Red | 21 June 2016 | |
|---|---|---|
| Total: 08 | Priority 1 = 04 | Priority 2 = 04 |
| Current Status: | | |
| Implemented | 0 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 08 | |

Overall Conclusion is Red
The audit was split into two parts, the first being a review of the design of controls (completed by Neil Shovell, Audit Manager) and the second being the audit of the effectiveness of the implementation of controls.

Design of controls - reported in separate letter dated 8 April (included in 20 April Audit & Governance Committee report).

Some compliance work has also been undertaken in relation to Accounts Payable. The majority of the issues identified from the compliance reviews are included in the Final Management Letter on the Key Financial Processes (Design of Controls) issued on 8 April 2016. Additionally, the following was reported in the compliance review management letter, in relation to One Time Vendor Payments:

Inconsistencies were noted with the way in which some one time vendor payments had been processed by the Corporate Procurement Team;

There was found to be a lack of clarity over whether the "authorising manager" of a one-time vendor payment should be the cost centre manager or the requesters line manager; and

Internet guidance in relation to when one time vendor payments should be used was found to be unclear.

Effectiveness of Controls

Many accounts payable processes have moved from OCC Shared Services to Hampshire / IBC, who are now responsible for vendor creation and maintenance, PO and invoice processing / supplier payments etc. A small OCC Corporate Procurement Team has been retained by OCC. The following has been identified as part of the Internal Audit work undertaken on the effectiveness of controls:

- There is a lack of corporate guidance from OCC on the urgent and emergency payments process and on the set up and use of invoicing plans. Additionally, the link to the list of non-PO categories within the "Non-Purchase Order Payments Policy" was found to be broken.

- Issues were identified with the accuracy and completeness of reports provided by Hampshire for the identification of potential duplicate payments. Additionally, it was noted that there was a lack of clarity over how duplicate payments identified should be dealt with and by whom, particularly where they are not identified by the Corporate Procurement Team from reports provided by Hampshire.

- There are significant issues in relation to late payments. Testing undertaken as part of this audit has highlighted that 13% / 14,672 invoice report covering IBC go-live in July 15 to 24th March 16, were not been paid within 30 days of the date of the invoice. Delays ranged up to 819 days. There is no detailed management information available to the Corporate Procurement Team showing date invoices are received by Hampshire versus date invoice is paid. The Corporate Procurement Team does not currently have any strategic oversight of procurement activity

- It was identified that invoices are getting lost. These invoices, which cannot be processed by the HCC system due to PO number being in the wrong place for example, disappear before the stage at which they become blocked. There is no reporting or management information coming back to OCC on how quickly these invoices are reviewed and processed by Hampshire.

- OCC do not have any visibility of blocked invoices which makes it difficult to establish whether there are performance / process issues at OCC which need to be addressed.

- From detailed testing undertaken as part of this audit, a high volume of Purchase Orders which were dated after the date of the invoice were identified (42% of the sample reviewed).

- Testing also highlighted that published Schemes of Financial Delegation are out of date in the majority of directorates. Some examples were identified where IBC approvers were not named on the published Scheme of Financial Delegation. There were also 2 instances where POs had not been approved at the correct level. Further work will be undertaken on this as part of the 2016/17 audit of Schemes of Delegation.

**Payroll 2015/16**

| Opinion: Red | 21 June 2016 | |
|---|---|---|
| Total: 13 | Priority 1 = 04 | Priority 2 = 09 |
| Current Status: | | |
| Implemented | 01 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 12 | |

Overall Conclusion is Red

Following the recent move to IBC there have been significant problems with compliance leading to payroll inaccuracy and this audit identifies substantial weaknesses in the overall system of control. The Council has not ensured that for key financial systems that adequate change management was put in place prior to the IBC transition to ensure all staff are trained and informed in and complying with the new processes; that payment inaccuracies are identified; and key documentation is retained on staff HR records. Whilst the responsibility and resources for producing and reviewing management information to provide assurance over the accuracy of payroll transactions are the responsibility of the IBC, there has been no oversight of this by OCC and no process to review and obtain assurance over payroll control and accuracy. Management are aware of many of the issues following the move to IBC and where possible, improvement action has been taken. The weaknesses identified are not a result of the failure of HR or Finance staff to fulfil their allocated roles and responsibilities correctly; the audit observed a considerable and continuing effort by them to work with IBC to manage the changes within the new model and to resolve many of the continuing identified issues. The IBC have also made a number of improvements following feedback from OCC. A shift in approach is yet to take place in order to successfully embed the self-service model and ensure adequate assurance over its operation. An improved 'self-help' framework is required in order to support this, as well as a re-definition of the corporate oversight role.

Design of controls - reported in separate letter dated 8 April (included in 20 April Audit & Governance Committee report).

A. Control environment: Policies, Procedures, Training and Strategy

Policies and procedures were generally accessible and up to date, but notable errors and omissions were found with regards to retaining supporting documentation, gaining approval for hiring casual workers, emergency and unpaid leave, and managing dismissals. There is a risk therefore that staff are not clear on the correct processes to follow.

There has been a lack of understanding amongst staff in the new systems and processes and (unintentional) misuse of the system, leading to over and under payments to staff. Key processes were not sufficiently tested before the switch to IBC, such as the electronic flexi timesheet system, usage of which has recently been suspended due to consistent technical issues with time recording. This would indicate that the change management and business readiness strategy has not been fully effective.

B. Starters and Leavers

Council policy does not usually permit 'Pay in lieu of leave' payments, except in cases where high work load prevents leavers from taking their remaining leave entitlement. However, between July 2015 to March 2016, 125 payments were made totalling £100k, the majority of which related to leavers, however some were for existing staff. Two significant over-payments were identified from a sample of six reviewed during the audit, totalling £8,514. These had not been identified prior to the audit and were due to a lack of awareness regarding the new system. In another case, an overpayment had been identified, but the invoice to the leaver was not raised until seven months after he had left, reportedly due to a processing backlog at IBC.

From the unpaid leave testing, a case was identified where unpaid leave was not taken into account prior to conversion to Academy and the amounts were therefore not deducted from the employee's pay or reclaimed by OCC.

One employee was found to have multiple employee numbers for different roles and was receiving three separate payslips for different roles at the same time. This was an error in their date of birth for two of these roles, which were therefore not linked together by the system as a result, resulting in an overpayment. This was reclaimed through salary payments prior to the audit, after the mistake was identified and employee records corrected.

C. Variations and Overtime

There have been multiple overpayments to staff due to errors when completing timesheets. 10 of these payments were reviewed during the audit, 2 of which were found to be overpayments which had not yet been repaid. There has been no review at OCC of these payments prior to the audit and no indication of the possible total value of overpayments to staff.

Five cases of triple overtime were identified in the audit (£870), from a report of all overtime payments made between July 2015 and February 2016, which had been paid in error but not identified or repaid prior to the audit (triple overtime is not usually permitted).

The audit testing identified two cases of incorrect unpaid leave payments. This was due to full time employees being deducted pay for unpaid leave based on part time hours, and has been confirmed as an IBC error (a bug in the system had previously been identified and corrected). In both cases, the employees have repaid the amounts by cheque.

In the separate compliance tests undertaken in February 2016, 30 changes to employee pay were reviewed, including honorariums, merit increments, secondments, acting up, changes to hours and contract types and extensions of temporary contracts. The main issue found was a lack of awareness amongst staff regarding the approval process, and the need to submit the HR approval E-form before processing a change. This was rarely used and, where it had been submitted, in most cases this was done retrospectively. Where approval had been gained through other means, in a number of cases this was not provided by the relevant Deputy Director. Supporting evidence for changes was often unclear in regards to dates or context, or had not been retained at all, and for some changes the Intranet guidance needed updating to ensure continuity of advice.

D. Management Information

This area was covered in detail in the Design of Controls Management Letter, and so actions were not repeated in this audit, however there are some additional data reports which are not produced which will be added. The findings in this audit support the need for this oversight, as issues with triple overtime claims, timesheet errors and pay in lieu of leave overpayments and unpaid leave discrepancies were only discovered as a result of the audit. These payments were not being reviewed at any point in the payroll process, demonstrating that there are insufficient controls in place to effectively monitor changes to pay.

A review of the oversight of IBC issues was undertaken during the audit. An issues log specific to HR has been maintained and action has been taken where possible to rectify the issues.

It is the responsibility of managers to upload key documentation into personnel HR records on the portal, however from the audit testing undertaken this is not happening sufficiently. There is very little transparency of the information available from the OCC end, for example we cannot view who has authorised transactions (e.g. starters, leavers, variations to pay, overtime etc.) and there are limited documentation trails of emails retained in personnel files.

## Banking / Cash Receipting 2015/16

| Opinion: Amber | 22 June 2016 | |
|---|---|---|
| Total: 04 | Priority 1 = 03 | Priority 2 = 01 |
| Current Status: | | |
| Implemented | 0 | |
| Due not yet actioned | 0 | |
| Partially complete | 0 | |
| Not yet Due | 04 | |

Overall Conclusion is Amber

The audit was split into three parts, the first being a review of the design of controls (completed by Neil Shovell, Audit Manager), the second being a cash receipting compliance review and the third being the audit of the effectiveness of the implementation of controls.

Design of controls - reported in separate letter dated 8 April (included in 20 April Audit & Governance Committee report).

Cash Receipting Compliance Review

Six establishments were visited for the Compliance review. The main findings include:

- In 3 establishments, there was inadequate segregation of duties in the cash receipting process, as the same person received cash, completed the cashing up process and the banking, without any checks by a second person. In two of these cases, there was also no independent banking reconciliation to check expected against actual income.

- In 3 establishments, the Cost Centre manager did not check actual income received against income expected and actually banked. There was no sample checking undertaken of cash received and banked.

- There are some inconsistencies, gaps and lack of clarity in the OCC cash income and banking procedures.

- In one establishment, cheques received by post were not recorded before being distributed round the office for identification and coding, resulting in a risk of loss. In another establishment, cheques were not rung through the till.

Effectiveness of Controls

The main findings relating to the effectiveness of cash and banking controls include:

- A sample of 5 cost centres that receive significant and regular cash income were reviewed between November 2015-April 2016. All 5 had appropriate procedures in place for tracking the cash/cheque income (usually using a spreadsheet) and all had processes in place for ensuring it had been banked. However in only two of the 5 cost centres, the manager had completed budget monitoring and forecasting in all 6 months reviewed (the others had done it 5 times, one 4 times and one twice).

- There have been significant values of unallocated income sitting in the holding account - as at the beginning of June 2016 this was £1.13m, with un-cleared items dating back to June 2015.

- The process for managing bank account signatories, openings and closures was found to be satisfactory.

# Oxfordshire County Council Internal Audit Charter

# Introduction

The Public Sector Internal Audit Standards (PSIAS) came into force on 1 April 2013. These are the first Internal Audit standards to apply across the whole public sector.

The PSIAS requires that an Internal Audit Charter is in place for each local authority. The Charter must be consistent with the Definition of Internal Auditing, the Code of Ethics and the Standards contained in the PSIAS.

This Charter sets out the purpose, authority and responsibility of the Council's Internal Audit function, in accordance with the PSIAS.

This Internal Audit Charter has been drawn up in line with the PSIAS requirements and replaces all previous Internal Audit Terms of Reference.

This Internal Audit Charter is subject to approval by the Audit & Governance Committee of Oxfordshire County Council on an annual basis, in line with PSIAS requirements.

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# Definition of Internal Audit

Oxfordshire County Council has adopted the PSIAS definition of internal auditing as follows:

*"Internal auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of Oxfordshire County Council. It assists Oxfordshire County Council in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the organisation's risk management, control, and governance processes."*

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# Statutory Requirement

Section 151 of the Local Government Act 1972 requires that authorities "make arrangements for the proper administration of their financial affairs and shall ensure that one of their officers has responsibility for the administration of those affairs." In Oxfordshire County Council, that officer is the Chief Finance Officer.

Specific requirements are detailed in the Accounts and Audit Regulations 2015, in that a relevant body must undertake an adequate and effective internal audit of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control. Any officer or member of a relevant body must, if the body requires:

> a. make available such documents and records as appear to that body to be necessary for the purposes of the audit; and

> b. supply the body with such information and explanation as that body considers necessary for that purpose.

In accordance with these regulations, internal audit staff should have access to any financial or non-financial records maintained by the council, or its partners in delivering council services, that are relevant to the audit activity being performed.

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# Definition of the Chief Audit Executive (CAE)

Chief Audit Executive describes a person in a senior position responsible for effectively managing the internal audit activity in accordance with the internal audit charter and the PSIAS *Definition of Internal Auditing*, the *Code of Ethics* and the *Standards.* Within Oxfordshire County Council the Chief Internal Auditor is the designated 'Chief Audit Executive'

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# Definition of the Board

The PSIAS lays out the role of a Board in relation to specific standards. In a local authority the role of the Board may be satisfied by an Audit Committee. In Oxfordshire Council the Audit & Governance Committee, for the purposes of the key duties laid out in the PSIAS, is the Board.

The key duties of the Board (Audit & Governance Committee) as laid out in the PSIAS are as follows:
- Approve the Internal Audit charter
- Approve the risk based Internal Audit plan including the approval of the Internal Audit budget and resource plan
- Receive communications from the Chief Internal Auditor on internal audit's performance relative to its plan and other matters
- Receive an annual confirmation from the Chief Internal Auditor with regard to the organisational independence of the internal audit activity
- Receive the results of the Quality Assurance and Improvement Programme from the Chief Internal Auditor.

- Make appropriate enquiries of the management and the Chief Internal Auditor to determine whether there are inappropriate scope or resource limitations.

# Definition of Senior Management

The PSIAS anticipates the role of Senior Management includes the following:

- Input to the risk based Internal Audit plan
- Receive periodic reports from the Chief Internal Auditor on internal audit activity, that includes follow up reports
- Receive the results of the Quality Assurance and Improvement Programme from the Chief Internal Auditor

Within Oxfordshire Council 'Senior Management' is defined as the Section 151 Officer (Chief Finance Officer)

# Professionalism

Oxfordshire County Council Internal Audit will govern itself by adherence to The Institute of Internal Auditors' mandatory guidance including the Definition of Internal Auditing, the Code of Ethics, and the International Standards for the Professional Practice of Internal Auditing (Standards). This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the internal audit activity's performance.

# Authority

Oxfordshire County Council Internal Audit, with strict accountability for confidentiality and safeguarding records and information, is authorised full, free, and unrestricted access to any and all of the organisation's records, physical properties, and personnel pertinent to carrying out any engagement. All employees are requested to assist the internal audit activity in fulfilling its roles and responsibilities. The internal audit activity will also have free and unrestricted access to the Audit & Governance Committee.

# Organisation

The Chief Internal Auditor will report functionally to the Audit & Governance Committee and administratively to the Chief Finance Officer & Assistant Chief Finance Officer (Assurance).

The Chief Internal Auditor will communicate and interact directly with the Audit & Governance Committee, including in executive sessions and between meetings as appropriate.

# Independence and objectivity

The internal audit activity within Oxfordshire County Council will remain free from interference by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of a necessary independent and objective mental attitude.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited within Oxfordshire County Council. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair internal auditor's judgment.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments.

The Chief Internal Auditor will confirm to the Audit & Governance Committee, at least annually, the organisational independence of the internal audit activity.

# Responsibility- Scope & Objectives

Internal audit is an assurance service that provides an independent and objective opinion to the council on the control environment comprising risk management, performance, control and governance by evaluating the effectiveness in achieving the organisation's objectives. Internal Audit objectively examine, evaluate and report on the adequacy of the control environment as a contribution to the proper, economic, efficient and effective use of resources.

Internal Audit Services is accountable to the Chief Finance Officer (Section 151 Officer) for the terms of reference, scope and coverage of its audit activities. In addition there is a responsibility to those changed with corporate governance being the council (through the Audit & Governance Committee and Audit Working Group) and the Head of Paid Service to give an annual opinion on the whole system of internal control and to support the Monitoring Officer in respect of matters of standards/ legality.

The council's external auditor relies on Internal Audit to undertake a continuous programme of audits of key corporate controls. Also, due priority needs to be given to the key strategic risks of the council including the requirements of the Section 151 Officer. Audit work is included to ensure an opinion can be given on the whole of the

control environment. These priorities constitute most of the Annual Plan the balance being risks identified by Internal Audit. The Chief Internal Auditor collates an annual report on the effectiveness of the council's internal control environment.

Internal audit may perform consulting and advisory services related to governance, risk management and control as appropriate for the organisation. It may also evaluate specific operations at the request of the Audit & Governance Committee or management, as appropriate.

Based on its activity, Internal audit is responsible for reporting significant risk exposures and control issues identified to the Audit & Governance Committee and to Senior Management, including fraud risks, governance issues, and other matters needed or requested.

## Internal audit plan

At least annually, the Chief Internal Auditor will submit to the Audit and Governance Committee an internal audit plan for review and approval. The Chief Internal Auditor will communicate the impact of resource limitations and significant interim changes to senior management and the Board.

The internal audit plan will be developed based on a prioritisation of the audit universe using a risk-based methodology, including input of senior management, including the Chief Finance Officer, Directors, Deputy Directors and Finance Business Partners. Prior to submission to the Audit & Governance Committee for approval, the plan may be discussed with appropriate senior management. Any significant deviation from the approved internal audit plan will be communicated through the periodic activity reporting process.

The audit plan is dynamic in nature and will be reviewed and realigned on a regular basis to take account of new, emerging and changing risks and priorities. It will be based on a risk assessment that covers financial materiality and business risks as well as any suspected or detected fraud, corruption or impropriety that has come to the attention of the Chief Internal Auditor.

Internal Audit will consult with the Council's external auditor and with other relevant inspection and review bodies, as required, in order to co-ordinate effort and avoid duplication.

As part of the planning process, the Chief Internal Auditor will identify other potential sources of assurance and will include in the risk based plan the approach to using other sources of assurance and any work required to place reliance upon those other sources.

For each audit assignment, Internal Auditors will develop and document a plan including the objectives of the review, the scope, and timing and resource allocations. In planning the assignment, auditors will consider, in conjunction with the

auditees, the objectives of the activity being reviewed, significant risks to the activity and the adequacy and effectiveness of the activity's governance, risk management and control processes.

# Reporting and monitoring

A written report will be prepared and issued by the Chief Internal Auditor or designee following the conclusion of each internal audit engagement and will be distributed as appropriate. Internal audit results will also be communicated to the Audit & Governance Committee. The internal audit report will include an opinion on the adequacy of controls in the area that has been audited.

The draft report will be discussed with the auditees and management actions agreed for the weaknesses identified, along with timescales for implementation. The final report will be issued to the relevant Director, Chief Finance Officer and other officers in line with directorate protocols.

The internal audit activity will be responsible for appropriate follow-up on engagement findings and monitoring and reporting on the implementation of management actions.

# Arrangements for appropriate resourcing

Internal Audit must be appropriately staffed in terms of numbers, grades, qualification levels and experience, having regard to its objectives and to the standards. All Internal Auditors will hold a professional qualification or be training towards a professional qualification.

In the event that the risk assessment, carried out to prepare the annual plan, identifies a need for more audit work than there are resources available, the Chief Internal Auditor will identify the shortfall and advise the Chief Finance Officer followed by the Audit & Governance Committee as required to assess the associated risks or to recommend additional resources are identified.

The audit plan will remain flexible to address unplanned work including responding to specific control issues highlighted by senior management during the year.

Internal audit work is prioritised according to risk, through the judgement of the Chief Internal Auditor, informed by the Council's risk registers and in consultation with senior management and External Audit.

All internal auditors have a personal responsibility to undertake a programme of continuing professional development (CPD) to maintain and develop their competence. This is fulfilled through the requirements set by professional bodies and through the Council's appraisal and development programme.

# Fraud and Corruption

The County Council is one of the largest business organisations in Oxfordshire. In administering its responsibilities; the Council has a duty to prevent fraud and corruption, whether it is attempted by someone outside or within the Council such as another organisation, a resident, an employee or Councillor. The Council is committed to an effective Anti-Fraud and Corruption culture, by promoting high ethical standards and encouraging the prevention and detection of fraudulent activities.

The Council's Anti-Fraud and Corruption Strategy, sets out responsibilities in this area.

Internal Audit within Oxfordshire County Council is responsible for developing and implementing the Anti-Fraud and Corruption Strategy and monitoring the investigation of any reported issues. To ensure that all suspected or reported irregularities are dealt with promptly and in accordance with this strategy and that action is identified to improve controls and reduce the risk of recurrence. Internal Audit maintains the fraud log for Oxfordshire County Council.

# Definition of Consulting Services

The PSIAS defines consulting services as follows: *"Advisory and client related service activities, the nature and scope of which are agreed with the client, are intended to add value and improve an organisation's governance, risk management and control processes without the internal auditor assuming management responsibility. Examples include counsel, advice, facilitation and training."*

The PSIAS requires that approval must be sought from the Audit & Governance Committee for any significant additional consulting services not already included in the audit plan, prior to accepting the engagement. Within Oxfordshire County Council significant is defined as any single assignment equivalent to 5% of annual planned days; these will be brought to the Audit & Governance Committee for approval.

# Periodic assessment

The Head of Internal Audit is responsible also for providing periodically a self-assessment on the internal audit activity as regards its consistency with the Audit Charter (purpose, authority, responsibility) and performance relative to its Plan.

In addition, the Head of Internal Audit will communicate to senior management and the Board on the internal audit activity's quality assurance and improvement program, including results of ongoing internal assessments and external assessments conducted at least every five years.

# Quality assurance and improvement programme

The internal audit activity will maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity. The programme also assesses the efficiency and effectiveness of the internal audit activity and identifies opportunities for improvement.

The Chief Internal Auditor will communicate to senior management and the Audit & Governance Committee on the internal audit activity's quality assurance and improvement programme, including results of ongoing internal assessments and external assessments conducted at least every five years.

**Signed by:**

Sarah Cox, Audit Manager - Interim Chief Internal Auditor

Lorna Baxter, Chief Finance Officer

Councilor David Wilmshurst, Chairman of the Audit & Governance Committee

Date approved: *To be presented for approval at July 2016 Audit & Governance Committee*
Date of next review: July 2017

# APPENDIX 4

**OXFORDSHIRE COUNTY COUNCIL**
**INTERNAL AUDIT SERVICES**

# Oxfordshire County Council Internal Audit - Quality Assurance and Improvement Programme

## Introduction

Internal Audit's Quality Assurance and Improvement Program (QAIP) is designed to provide reasonable assurance to the various stakeholders of Oxfordshire County Council Internal Audit Service that Internal Audit:

- Performs its work in accordance with its Charter, which is consistent with the Public Sector Internal Audit Standards, Definition of Internal Auditing and Code of Ethics;

- Operates in an efficient and effective manner;

- Is adding value and continually improving the service it provides.

- The Chief Internal Auditor is ultimately responsible for maintaining the QAIP, which covers all types of Internal Audit activities. The QAIP must include both internal and external assessments. Internal assessments are both ongoing and periodical and external assessments must be undertaken at least once every five years.

## Internal Assessments

Internal Assessment is made up of both ongoing reviews and periodic reviews.

Ongoing Reviews

Ongoing assessments are conducted through:
- Supervision of audit engagements
- Regular, documented review of work papers during engagements by appropriate Internal Audit staff
- Applying relevant audit policies and procedures, including those set out in the Oxfordshire County Council Internal Audit Manual, to ensure applicable audit planning, fieldwork and reporting quality standards are met
- Review of all audit reports and agreed management actions by the Chief Internal Auditor prior to formal circulation.

- Feedback from Customer Satisfaction Questionnaires (CSQs) on individual audit assignments
- Established key performance indicators (KPIs) designed to improve Internal Audit's effectiveness and efficiency. These are signed off each year by the Audit & Governance Committee.
- Corporate performance monitoring
- In assigning audit work to an individual auditor consideration is given to their level of skills, experience and competence and an appropriate level of supervision exercised
- Feedback from CSQs, performance against KPIs and reviews of working papers and audit reports will form part of the discussion during regular 1-2-1 meetings and will help inform formal appraisal discussions.

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<u>Periodic Reviews</u>

Periodic assessments are designed to assess conformance with Internal Audit's Charter, the Standards, Definition of Internal Auditing, the Code of Ethics, and the efficiency and effectiveness of internal audit in meeting the needs of its various stakeholders. Periodic assessments will be
conducted through:

- Quality audits undertaken to ensure performance in accordance with Internal Audit's Quality Procedures Manual.
- Review of internal audit Key Performance Indicators by the Chief Internal Auditor on a monthly basis, including elapsed time between start of audit and exit meeting, elapsed time between exit meeting and issue of draft report, elapsed time between issue of draft report and issue of final report, % of planned activity completed and % of management actions implemented.
- Quarterly activity and performance reporting to the Audit and Governance Committee and Section 151 officer.
- Annual self-review of conformance with the Public Sector Internal Audit Standards. Any resultant action plans will be monitored by the Chief Internal Auditor on a quarterly basis.

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# External Assessment

External assessments will appraise and express an opinion about Internal Audit's conformance with the Standards, Definition of Internal Auditing and Code of Ethics and include recommendations for improvement, as appropriate.

An external assessment will be conducted every 5 years by a qualified, independent assessor from outside the Council. The assessment will be in the form of a full external assessment, or a self-assessment with independent external validation. The format of the external assessment will be discussed with the Audit & Governance Committee.

# Reporting

Internal Assessments – reports of internal assessments will be reported to the Audit & Governance Committee on an annual basis.

External Assessments – results of external assessments will be reported to the Audit & Governance Committee and Section 151 officer at the earliest opportunity following receipt of the external assessors report. The external assessment report will be accompanied by a written action plan in response to significant findings and recommendations contained in the report.

Follow Up - the Chief Internal Auditor will implement appropriate follow-up actions to ensure that action plans developed are implemented in a reasonable timeframe.

## Signed by:

Sarah Cox, Audit Manager - Interim Chief Internal Auditor

Lorna Baxter, Chief Finance Officer

Date approved: May 2016
Date of next review: May 2017

## Appendix 5

**Statement of Assurance – Integrated Business Centre**

**2015 - 16**

**Southern Internal Audit Partnership**

Assurance through excellence
and innovation

# Contents

**1.  Role of Internal Audit**

The requirement for an internal audit function in local government is detailed within the Accounts and Audit (England) Regulations 2015, which states that a relevant body must:

*'Undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.'*

The standards for 'proper practices' in relation to internal audit are laid down in the Public Sector Internal Audit Standards 2013 [the Standards].

The role of internal audit is best summarised through its definition within the Standards, as an:

*'Independent, objective assurance and consulting activity designed to add value and improve an organisations operations.  It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'.*

Hampshire County Council is responsible for establishing and maintaining appropriate risk management processes, control systems, accounting records and governance arrangements. Internal audit plays a vital role in advising Hampshire County Council that these arrangements are in place and operating effectively.

Hampshire County Council's response to internal audit activity should lead to the strengthening of the control environment and, therefore, contribute to the achievement of the organisations objectives.

## 2. Internal Audit Approach

To enable effective outcomes, internal audit provide a combination of assurance and consulting activities. Assurance work involves assessing how well the systems and processes are designed and working, with consulting activities available to help to improve those systems and processes where necessary.

A full range of internal audit services is provided in forming the annual opinion.

The approach to each review is determined by the Head of the Southern Internal Audit Partnership and will depend on the:

- level of assurance required;

- significance of the objectives under review to the organisations success;
- risks inherent in the achievement of objectives; and
- level of confidence required that controls are well designed and operating as intended.

All formal internal audit assignments will result in a published report. The primary purpose of the audit report is to provide an independent and objective opinion on the framework of internal control, risk management and governance in operation and to stimulate improvement.



### 3. Internal Audit Opinion

Oxford County Council joined the Shared Services Partnership in July 2015, meaning that Oxfordshire's transactional HR, Finance and Procurement would be delivered through the IBC, supported by the online self service system. As part of governance arrangements it was agreed that the Southern Internal Audit Partnership would provide annual assurance to Oxford County Council on the adequacy and effectiveness of the framework of governance, risk management and control from the work carried out on the IBC.

In giving this opinion, assurance can never be absolute and therefore, only reasonable assurance can be provided that there are no major weaknesses in the processes reviewed. In assessing the level of assurance to be given, I have based my opinion on:

- written reports on all internal audit work completed during the course of the year (assurance & consultancy);
- results of any follow up exercises undertaken in respect of previous years' internal audit work;
- the results of work of other review bodies where appropriate;
- the extent of resources available to deliver the internal audit work;
- the quality and performance of the internal audit service and the extent of compliance with the Standards; and
- the proportion of audit need that has been covered within the period

**Audit Opinion**

**I am satisfied that sufficient assurance work has been carried out to allow me to form a reasonable conclusion on the adequacy and effectiveness of the internal control environment within the Integrated Business Centre.**

**In my opinion, the framework of governance, risk management and management control is 'Adequate' and audit testing has demonstrated controls to be working in practice.**

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

**4. Internal Audit Coverage and Output**

The 2015-16 internal audit plan, for reviews pertinent to the IBC were informed by internal audits own assessment of risk and materiality in addition to consultation with management to ensure it aligned to key risks facing the organisation. The plan has remained fluid throughout the year to maintain an effective focus.

| In delivering the internal audit opinion the Southern Internal Audit Partnership have undertaken 10 reviews contributing to my audit opinion: Review | Status | Assurance Opinion | |
|---|---|---|---|
| **Order to Cash** | Final | Substantial | |
| **P2P** | Draft | 2.3.1.1.1 | Adequate |
| **Payroll** | Draft | 2.3.1.1.2 | Adequate |
| **Issue Resolution** | Final | Adequate | |
| **ICT System Integration Testing** | Final | Adequate | |
| **OCC UAT / Regression Testing** | Final | Substantial | |
| **OCC Data Migration** | Final | Adequate | |
| **P-cards Strategy and Process** | Draft | 2.3.1.1.3 | Adequate |

Fieldwork remains in progress in respect of 2 reviews (Information Governance and Debt Collection, however I do not consider these exceptions to have an

**Substantial** - A sound framework of internal control is in place and operating effectively. No risks to the achievement of system objectives have been identified;

**Adequate** - Basically a sound framework of internal control with opportunities to improve controls and / or compliance with the control framework. No significant risks to the achievement of system objectives have been identified;

**Limited** - Significant weakness (es) identified in the framework of internal control and / or compliance with the control framework which could place the achievement of system objectives at risk; or

**No** - Fundamental weaknesses identified in the framework of internal control or the framework is ineffective or absent with significant risk to the achievement of system objectives

adverse impact on the delivery of my overall opinion for the period.

## 5. Disclosure of Non-Conformance

In accordance with Public Sector Internal Audit Standard 1312 [External Assessments] which requires 'an external quality assessment to be conducted at least once every five years by a qualified, independent assessor or assessment team from outside of the organisation' I can confirm endorsement from the Institute of Infernal Auditors (November 2015) that:

**'the Southern Internal Audit Partnership conforms to the, Definition of Internal Auditing; the Code of Ethics; and the Standards'**

There are no disclosures of Non-Conformance to report.

## 6. Quality control

Our aim is to provide a service that remains responsive and maintains consistently high standards.  This was achieved in 2015-16 through the following internal processes:

- On-going liaison with management to ascertain the risk management, control and governance arrangements, key to corporate success;
- On-going development of a constructive working relationship with the External Auditors to maintain a cooperative assurance approach;
- A tailored audit approach using a defined methodology and assignment control documentation;
- Registration under British Standard BS EN ISO 9001:2008, the international quality management standard complimented by a comprehensive set of audit and management procedures;
- Review and quality control of all internal audit work by professional qualified senior staff members; and

- Independent External Quality Assessment undertaken by the Institute of Internal Auditors (IIA) concluding 'the Southern Internal Audit Partnership conform to all Standards within the IPPF, PSIAS and LGAN.

## 7. Acknowledgement

I would like to take this opportunity to thank all those staff throughout Hampshire County Council (IBC) with whom we have made contact in the year. Our relationship has been positive and management were responsive to the comments we made both informally and through our formal reporting.

Neil Pitman
Head of Southern Internal Audit Partnership
May 2016

# APPENDIX 6 - 2015/16 Compliance Review Key Findings

**BUDGET MONITORING COMPLIANCE REVIEW: Overall Conclusion and Key Findings**

Overall compliance with regard to the budget monitoring process was generally good. The following issues were found during the review:

- The majority of Cost Centre Managers commented that they have either not used the intranet guidance or they did not find it useful.
- Not all Cost Centre Managers had attended the bite size training sessions or had received financial management training. All agreed that additional training would be beneficial to them.
- There was an inconsistent approach to Cost Centre Managers using BPC to manage their budgets. Issues identified included budgets not being monitored on a monthly basis, issues with some Cost Centre Managers being responsible for large numbers of cost centres and budgets not including comments on a monthly basis.
- Issues were also identified in relation to Cost Centre Managers reviewing the IBC Portal Finance Reports. Specifically, Cost Centre Managers not regularly checking their salary and expenditure position and the staffing report not being helpful as they could not drill into individual costings.
- There were also issues with the Performer, Reviewer and Approver role. For three budgets, the Performer, Reviewer and Approver roles were all completed by the same person and Reviewers and Approvers not completing their tasks on a monthly basis. The review was also unable to ascertain how Corporate Finance oversees that Approvers and Reviewers are completing their tasks on a monthly basis.
- Since the move to the IBC, a BPC "Audit Report" has not been available for Corporate Finance.

**JOURNALS COMPLIANCE REVIEW: Overall Conclusion and Key Findings**

In general, compliance with the stated requirements was identified, but the following issues were found:

- The majority of respondents provided some form of supporting documentation, but there were notable instances where this had either not been retained or did not provide sufficient evidence for the transaction.
- There was a lack of awareness of the need to send backing documentation to Assurance & Reporting for journals of over +/- £50,000, and as a result this requirement had not been fulfilled. This raises a risk due to the high value of these transactions.
- User information from the BDU is not transferred through to SAP, resulting in issues with locating the creator of a particular journal and consequently with monitoring the transactions made through the system.
- The processing of journals under £1,000 does not present a significant material risk, but it highlights the lack of clarity in the guidance with regards to these journals.
- The accompanying text generally contained acronyms, meaning that the reason for the journal was often unclear, and, where miscodings were being corrected, the document numbers of the original transactions were not included.

- The intranet guidance required updating for a number of the above issues to ensure a clear understanding of best practice when submitting journals.

## CANCELLED AND RE-ISSUED INVOICES COMPLIANCE REVIEW: Overall Conclusion and Key Findings

In general, compliance with the stated requirements was sufficient, but there were issues regarding duplicate cancellations and OCC intranet guidance available to staff.

The compliance review tested a sample of 30 invoices, taken from a report run from SAP by the IBC. This included 24 invoices cancelled on the IBC Portal and six invoices from Legacy SAP. The reasons for cancellations were all found to be justified, with appropriate documentary evidence retained.

## INVOICING PLANS, VENDOR MAINTENANCE & ONE TIME VENDOR COMPLIANCE REVIEW: Overall Conclusion and Key Findings

There were compliance issues with the standard Invoicing Plan and One Time Vendor process. Compliance with the Vendor Creation and Vendor Change was generally good. The issues identified within each area are:

*Invoicing Plans*:

- Three people contacted had not retained any evidence to support the creation of the Invoicing Plan vendor.
- One person contacted had not retained any evidence to support the creation of three Invoicing Plan vendors.
- One person, who is not on their Directorate's Scheme of Delegation, approved three Invoicing Plans. The total value of the commitment is £1,200.
- Three people approved Invoicing Plans that were in excess of their approval limit their Directorate's Scheme of Delegation. This related to five Invoicing Plans, totalling £410,000.
- As Invoicing Plans are created using a Hampshire e-form, any email address / individual can be entered into the Invoicing Plan e-form as approver.
- Six Invoicing Plans were approved by officers who were not the Cost Centre Manager or within the line manager structure of the cost centre.

*Vendor Creations and Vendor Changes:*

- Those contacted were unaware of what documentation should be retained, as there is currently no guidance on OCC's intranet site. From 40 vendor creations tested, one had not retained any supporting and two had originally submitted new vendor creations, but these were rejected as the vendor already existed.
- From the 21 vendor changes tested, three did not have any documentation, all of which were for bank account changes. One change was requested in a meeting

verbally, change in e-mail address. Two were originally submitted, but documentation was subsequently not needed. For one change evidence was not provided.

*One Time Vendor Payments*:

- In one sampled payment for £765, the Cost Centre Manager's approval was not sought from the Corporate Procurement Team. Instead, the spreadsheet was accepted from the user completing it and sent to the IBC for processing.
- For one payment (£11,730), the spreadsheet was not completed by the team member requesting the payment, as the Corporate Procurement Team arranged the payment.
- One of the sampled payments was from a team who submit one time vendor payment requests on a monthly basis. The team confirmed they copy in the Cost Centre Manager on payment requests, but the Corporate Procurement Team had advised approval for individual payments was not necessary.
- In one of the sampled cases, the person requesting the payment was also the person to approve it.
- Testing found that for four payments, the approver was not on their Directorate's Scheme of Delegation, including a payment of £77,000. The other three payments were for £145, £250 and £765.
- The term "authorising manager" on the spreadsheet is unclear as to whether this is the Line Manager or Cost Centre Manager.
- The Procurement Team are completing checks on One Time Vendor payments. However, these have not been documented and agreed.
- Guidance on one time vendor payments on OCC's intranet page is limited to a paragraph on the 'Making Payments' page, rather than a detailed description of the process.
- For one of the 30 payments sampled, the spreadsheet was sent to an individual team member's email address, instead of the team inbox.

**EMPLOYEE CHANGES COMPLIANCE REVIEW: Overall Conclusion and Key Findings**

Compliance is generally good with regards to processing employee changes, but there was significant evidence of non-compliance regarding the approval process beforehand. The following issues were found during the review:

- A general lack of awareness of the need to submit the HR Approval Eform before processing a change. As a result the majority of changes were made without having fulfilled this requirement.
- Approval was generally gained through other means, such as by email, but in some cases this provided insufficient information and had not been gained from the relevant Deputy Director.
- Supporting evidence was often unclear with regards to details such as the dates of the change or the context for it, particularly when further adjustments had been made to an initial change. In one case a piece of supporting documentation completed by the employee had not been retained.

- Very few errors were found regarding the process of making and amending employee changes.
- The process of ending temporary changes was found to be generally effective as the system requires an end date to be entered when the change is made in the IBC.
- Intranet guidance was at times unclear or inconsistent with regard to a number of the above points.

**CASH RECEIPTING**

Findings combined and reported in the Audit Report of Cash and Banking 15/16