Oxfordshire County Council

Internal Audit Services

Annual Report of the Chief Internal Auditor

2016/17

OXFORDSHIRE COUNTY COUNCIL
INTERNAL AUDIT SERVICES

Author: Sarah Cox, Chief Internal Auditor. April 2017

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 (PSIAS) updated in 2017, 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 is submitted for audit and public inspection. The internal timetable for submitting the accounts and publishing a draft AGS has been bought forward to end of June 2017. In order for the Annual Governance Statement to be informed by the CIA's annual report on the system of internal control, this CIA annual report was been produced for the April Audit and Governance Committee 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 Internal Audit 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 PSIAS require that the internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement.

1.3.2 The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organisation’s governance, operations and information systems regarding the:

- Achievement of the organisation’s strategic objectives;
- Reliability and integrity of financial and operational information;

- Effectiveness and efficiency of operations and programmes;
- Safeguarding of assets; and
- Compliance with laws, regulations, policies, procedures and contracts.

1.3.3 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

1.4.1 The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAS). The annual self-assessment against the standards is completed on an annual basis and was last completed in May 2016. The areas of non-conformance highlighted for 2015/16 have now been addressed; the Internal Audit Charter is now in place and subject to annual review and approval by the Audit & Governance Committee, there is now a Quality Assurance and Improvement Programme in place and the Internal Audit Procedures Manual has now been reviewed and updated.

1.4.2 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 and therefore will need to be commissioned during 2017/18. The results will be reported back to the Audit & Governance Committee.

1.4.3 The Monitoring Officer has conducted a survey of Senior Management on the effectiveness of Internal Audit. The results from this survey will be presented to the July 2017 Audit & Governance Committee meeting

1.4.4 The Internal Audit Strategy and Annual Plan for 2016/17 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.

1.4.5 The Internal Audit Plan, which is subject to continuous review, identified the individual audit assignments. The activity was undertaken using a systematic risk-based approach. Terms of reference were prepared that outlined the objectives and scope for each audit. The work was planned and performed so as to obtain all the information and explanations considered necessary to provide sufficient evidence in forming an overall

opinion on the adequacy and effectiveness of the internal control framework.

1.4.6 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.

1.4.7 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).

1.4.8 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 Principal Auditor or Chief Internal Auditor to perform quality reviews at four stages of the audit assignment: the terms of reference, file review, draft report and final report stages.

1.5 THE AUDIT TEAM

1.5.1 During 2016/17 the Internal Audit Service was delivered by an in house team, supported with the specialist area of IT audit which is outsourced. The team also work in collaboration with the Oxford City Council Investigation Team who provides counter-fraud resource.

1.5.2 Throughout the year the Audit and Governance Committee and the Audit Working Group were kept informed of staffing issues and the impact on the delivery of the Plan.

1.5.3 It is a requirement to notify the Audit and Governance Committee of any conflicts of interest that may exist in discharging the internal audit activity. There are none to report for 2016/17.

2 OPINION ON SYSTEM OF INTERNAL CONTROL

2.1 BASIS OF THE AUDIT OPINION

2.1.1 The 2016/17 Internal Audit Plan has been completed, with all reports finalised.

2.1.2 The plan is intended to be dynamic and flexible to change. It was revised during the year, and nine audits originally planned have been cancelled or

deferred. There were also three audits added to the plan. (these amendments were reported to the July 2016 and January 2017 Audit and Governance Committee meetings):

Cancelled or deferred:

- EE ICT Management Operations
- Governance Compliance Review
- Main Accounting
- Payments to Residential and Home Support Providers (deferred and started in April 2017 as part of 17/18 plan)
- Property
- Cloud Computing - back up
- Mobile Computing (deferred and will be started in Q1 of 17/18)
- PCI DSS Compliance
- S106 (deferred and started in April 2017 as part of the 17/18 plan)*

Additions to plan:

- Website Management
- Windows 10
- Thriving Families Spring Claim*

*Changes to the plan made following the January 2017 Audit and Governance Committee is the addition of the Thriving Families Spring Claim and deferring the S106 audit for 6 weeks to commence at the beginning of April. This audit was deferred to the 17/18 audit plan due to the additional time spent on the audit of the Capital Programme alongside some unexpected absences due to health issues with a member of staff. The scope of the audit has already been agreed and fieldwork now has commenced.

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.

2.1.4 In addition to the internal audit reviews, the internal audit team has also reviewed the results of the assurance mapping undertaken with the directorates earlier in 2016, which aims to identifying 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 2016/17.

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 33 audits undertaken in 2016/17. There have been two audits which have been graded as RED during 2016/17; Mental Health and Capital Programme - governance and delivery.

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 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 3 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 have been shared with Oxfordshire County Council.

2.1.10 The Anti-fraud and corruption strategy remains current and relevant. In 2016/17 there have been several instances of potential minor fraud reported.

2.1.11 The National Fraud Initiative data matching reports for the 2016 data match exercise have now been received. These are now being reviewed and key matches are being investigated.

2.1.12 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 and Governance Committee.

2.1.13 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.

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

- The results of all audits undertaken as part of the 2016/17 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.
- 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, for the 12 months ended 31 March 2017, there is **reasonable** assurance regarding Oxfordshire County Council's overall control environment, to enable the achievement of the Council's outcomes and objectives.

This is a positive assurance as the organisation continues to operate under significant financial pressure and is undertaking continuous transformational change.

This demonstrates improvement from last year when the overall Chief Internal Auditor's opinion was qualified assurance over Oxfordshire County Council's system of internal control. This was due to a small number of limited assurance reports issued by Internal Audit in relation to key financial systems. Follow up work completed during 2016/17 has evidenced sufficient improvements in the financial control environment to enable the overall opinion to be reflected as such.

This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

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 (January 2017) are attached as appendix 2;

- Schools - Mapping of S151 Assurance
- Childrens Social Care Management Controls
- Capital Programme - governance and delivery
- Pooled Budgets - contract management
- Adults Social Care Management Controls
- Budget Setting
- Unaccompanied Asylum Seeking Children
- Windows 10
- Money Management
- Pension Fund
- Thriving Familes Spring Claim
- Cloud Computing - Office 365 - part 3
- LEP
- Pensions Admin
- Accounts Payable
- Thematic Review - Schools HR contracts, combined with proactive fraud review.
- Accounts Receivable
- Personal Budgets including Direct Payments
- Highways - payments
- Payroll
- Client Charging

Since the last report to the Audit and Governance Committee, the report of the proactive fraud review of Travel and Expenses has been finalised. The executive summary is also included in Appendix 2.

2.3 INTERNAL AUDIT PERFORMANCE

2.3.1 The following table shows the performance targets agreed by the Audit Committee and the actual 2016/17 performance.

Measure	Target	Actual Performance 2016/17
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	60% of the audits met this target. (2015/16 this was 58%, 2014/15 this was 52%)

Measure	Target	Actual Performance 2016/17
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	94% of the audits met this target. (2015/16 this was 96%, 2014/15 this was 83%)
Elapsed time between issue of draft report and the issue of the final report	15 Days	75% of the audits met this target. (2015/16 this was 48%, 2014/15 this was 69%)
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2017.	100% of the plan has been completed by the end of April 2017. (2015/16 this was 66%, 2014/15 this was 64%)
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at 30 March 2017: 643 actions being monitored on the system (from 15/16). • 72% implemented • 21% not yet due • 4% partially implemented • 3% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2	Based on 9 questionnaires returned the average score was 1.1. (15/16 was 1.07, 14/15 was 1.02)
Directors satisfaction with internal audit work	Satisfactory or above	The results of this will be reported to the July Audit & Governance Committee

RECOMMENDATION

The committee is RECOMMENDED to consider and endorse this annual report.

SARAH COX,

Chief Internal Auditor, April 2017

APPENDIX 1 - Implementation status of 2016/17 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 29 March 2017
SCS	Mental Health	Red	24	17 not yet due, 4 implemented and 3 ongoing
SCS	Money Management	Green	2	1 not yet due and 1 implemented
SCS	Pooled Budgets - Contract Management	Amber	13	13 not yet due
SCS	Adults Safeguarding	Amber	4	4 not yet due
SCS	Personal Budgets inc Direct Payments	Amber	13	13 not yet due
SCS	Client Charging (including ASC debt)	Amber	13	13 not yet due
CEF	Unaccompanied Asylum Seeking Children	Amber	10	8 not yet due and 2 implemented
CEF	Thriving Families - Summer Claim	n/a	6	1 not yet due and 5 implemented
CEF	Thriving Families - Winter Claim	n/a	2	2 implemented
CEF	Thriving Families - Spring Claim	n/a	4	4 not yet due

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 29 March 2017
CEF	Children's Direct Payments	Green	3	3 implemented
CEF	Early Years Payments - Follow up	Amber	6	6 implemented
CEF	Childrens Safeguarding	Amber	8	4 not yet due and 4 implemented
Schools	Mapping of S151 assurance	Amber	3	3 not yet due
Schools	Thematic Review - Schools HR contracts, combined with proactive fraud review.	Green	1	1 not yet due
Corp / EE	Capital Programme	Red	20	20 not yet due
Corp / EE	LEP	Amber	11	10 not yet due and 1 implemented
EE	Highways Follow up	Amber	16	16 not yet due
ICT	Cloud Computing - Office 365 - part 1	Amber	7	6 implemented and 1 ongoing
ICT	Cloud Computing - Office 365 - part 2	Amber	8	2 implemented, 2 ongoing and 4 overdue
ICT	Cloud Computing - Office 365 - part 3	Amber	5	5 not yet due

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 29 March 2017
ICT	Website Management & Security	Amber	10	1 not yet due, 8 implemented and 1 ongoing
ICT	Windows 10 implementation	Green	4	1 implemented and 3 overdue
ICT	ICT application audit - Altair (Pensions Admin System)	Amber	7	5 implemented, 1 ongoing and 1 overdue
Corp	Budget Setting / Delivery of Savings	Amber	2	2 not yet due
Corp	Accounts Payable	Amber	3	3 not yet due
Corp	Accounts Receivable	Amber	11	10 not yet due and 1 implemented.
Corp	Treasury Management	Green	4	1 not yet due and 5 overdue
Corp	Payroll	Amber	11	11 not yet due.
Corp	Pensions Fund	Green	0	n/a
Corp	Pensions Admin	Green	0	n/a
Corp	Scheme of Delegation Application	Amber	3	1 not yet due, 1 implemented and 1 ongoing
Corp	BDU - monthly compliance checks on files uploaded to BDU	n/a	n/a	n/a

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 29 March 2017
Corp	BDU - compliance review, visiting officers and testing upload processes	Amber	7	7 implemented
Corp	Grant Certification (requests throughout year for CIA sign off)	n/a	n/a	n/a

APPENDIX 2
Summary of Completed 2016/17 Audits since last reported to the Audit & Governance Committee - January 2017.

Schools Assurance 2016/17

Opinion: Amber	04 January 2017	
Total: 03	Priority 1 = 0	Priority 2 = 3
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	3	

Overall Conclusion is Amber

Schools assurance has changed significantly over the past few years as a result of a reduction in resource in Corporate Services teams that used to undertake schools assurance activities, the decrease in the number of maintained versus academy schools and the move to IBC. Some of the main changes include the cessation of on-site school external assessments of the Schools Financial Value Standard (SFVS) managed by Corporate Finance, the Schools Finance team (EFS) moving from OCC to Hampshire County Council as part of the move to IBC and a shift from census figures informing the DSG being submitted directly to the Education Funding Agency (EFA) rather than via OCC. OCC still receive regular budget management information to review over and under spends and take action appropriately. For academy conversions, the financial management elements are undertaken by the CEF Finance Team within a dedicated OCC Academies team.

On-site financial external assessments of SFVS are no longer undertaken by OCC, since funding for this ceased in July 2016. The EFS Team do visit schools to provide financial support and advice, but not usually to audit unless this is specifically requested by the school. Their service is purchased by OCC. Internal Audit also do not carry out any regular programme of school audits. Internal Audit undertake schools audits on an ad hoc basis and one school audit has been undertaken in 2016/17. During the corporate Key Financial Systems audits, Internal Audit include school transactions within the sampling and there are a small number of days within the Internal Audit / Counter Fraud plans which are used to undertake directed thematic counter fraud work, such as most recently procurement cards and school HR contracts and payments.

An annual return has to be submitted by the Chief Finance Officer to the EFA to confirm the number of SFVS completed, and that a programme of audit is in place to provide assurance over their financial management and spend. OCC checks that all Self-assessments have been completed and signed by the Chair of Governors, but no longer audits or quality checks all returns. The Assurance form also confirms that all self-assessment forms were received for all maintained schools, however upon re-testing by Internal Audit, there were two forms which could not be located.

The EFS Team's role is to support and advise schools on financial matters. They provide OCC with the monthly budget management data. OCC place reliance on the EFS Team to provide assurance over the financial management within schools, however the arrangement has not been formalised and the written agreement between OCC and the EFS (EFS Accession Agreement for OCC) is still in draft and has therefore not been agreed. The draft version does not include any detail on accountability between OCC and the EFS Team for the delivery of accurate, prompt and insightful data, advice and assurance.

The Schools Financial manual of guidance is accessible to schools on the Intranet. However, it is not fully up to date, with many parts dated 2011 and some still blank. Internal Audit were informed that sections were only updated as and when necessary, however it does not appear that these have been updated following the move to IBC and the change in Contact details. The Corporate Finance team have an action underway to update this guidance.

From this year, the schools Repairs budget has been devolved to schools. There is currently a lack of assurance over expenditure of this budget to ensure the necessary repairs are being undertaken in order to remain compliant. However, the Health and Safety team are working with the relevant officers to set up the necessary assurance arrangements.

Children's Management Controls 2016/17

Opinion: Amber	17 January 2017	
Total: 08	Priority 1 = 0	Priority 2 = 08
Current Status:		
Implemented	01	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	07	

Overall Conclusion is Amber

There are approximately 430 school aged Looked After Children (LAC) and 450 post-16 LAC / Care Leavers in Oxfordshire, for whom OCC has a statutory responsibility as the Corporate Parent to ensure access to education and to provide support in achieving educational outcomes. This is achieved with the support of the Council's Virtual School which plans, supports and tracks their education, along with the child's school.

The audit mainly focused on the work of the Virtual School and found strong processes have been implemented for supporting and monitoring Looked After Children with their education.

A: Governance:

The Virtual School has clear policies, procedures, improvement and training plans in place to support their role in promoting LAC educational achievement. While reporting to the Children with SEN Manager, there is also regular communication with the Corporate Parenting Manager, and quarterly reporting to the Corporate Parenting Panel, who act as the Virtual School's School Governors. It was reported

to Internal Audit that a new sub-committee of the Panel is being established from January 2017 to provide a greater level of challenge and in-depth scrutiny of the Virtual School.

B: Systems and Processes:

PEPs

Testing during the audit found the PEPs reviewed were of sufficient quality and a good process is in place for agreeing and administering Pupil Premium funding. However, at the time of testing, three LAC in the sample of 20 did not have a PEP in place and a further two PEPs had been overdue at the time of the PEP meeting. A review of case notes on Frameworki found no evidence of Independent Reviewing Officers chasing for a PEP meeting in these cases.

From an internal audit review of LAC without a completed PEP, there were 22 without a PEP, of which 9 had not had a PEP meeting at all, and were an average of 30 days overdue (over and above the statutory guideline of 20 days), ranging from 8 to 59 days over. The other 13 LAC had had the PEP meeting but the record hadn't been completed by the Social Worker or Designated Teacher so had not been signed off by the Virtual School.

With regards incomplete PEPs, analysis by Internal Audit identified 89 where the PEP meeting had been held over 10 working days ago, which is the internal target for completing the PEP following the meeting (note that this figure includes the 13 reported above). The majority of these (89%) were due to delays in completion by the Social Worker and / or Designated Teacher. There was evidence to show the Virtual School chased Social Workers and Teachers to request completion of the PEPs.

A quarterly LAC scorecard is produced for the Corporate Parenting Manager, which includes data on educational attainment, absences and fixed term exclusions. However, there is no data reporting to senior management on the number of LAC without a completed Personal Education Plan (PEP) or the timeliness of completed PEPs. Following the audit, the Virtual School Manager intended to start reporting on this.

Attendance & Exclusions

A sound process is in place for monitoring LAC attendance, both on a daily basis as well as weekly attendance reviews.

Two out of the sample of 20 LAC reviewed by audit had particularly poor attendance (below 60%) at the time of testing, but a review of these confirmed the Virtual School are managing the cases well; one is now in a new placement with improved attendance and the Virtual School are continuing to work with various colleagues and organisations to improve the attendance for the other LAC.

Schools excluding LAC does remain an issue, however again there are processes in place to monitor this. While there were no permanent exclusions in 2015/16, there were 52 pupils with at least one fixed term exclusion (11.8%). These occurred mostly in Key Stage 3 and 4 so the Virtual School have been working closely with the secondary schools to identify alternative solutions, as evidenced for one school reviewed in the audit sample which has multiple LAC. Out of the sample of 20 LAC reviewed, four had at least one fixed term exclusion, all of which were well managed

by the Virtual School. At the time of testing 2 pupils were not on roll at a school, however there was evidence to show the Virtual School were working on these.

There are currently three pupils on reduced timetables, of which all were found to be appropriately overseen by the Virtual School. Reduced timetables are monitored and reported on, along with those not on roll, persistently absent, or refusing to attend, to senior management at monthly LAC attendance meetings.

Post-16's and EET Plans

The post-16 team provide support to those Leaving Care, completing PEPs for those in education and training, and EET Plans for those not in Education, Employment & Training. Only one of the three NEET reviewed had a formal EET plan in place, and this was dated 2015. This does not reflect the support provided to the young people though - there is evidence on FWi of multiple EET interventions by various teams, but they are not committed to using the EET form despite encouragement from the Virtual School.

Admission & escalation to EFA

The School Admission Code requires all schools, including academies to give the highest priority to LAC applications, and while most understand this, the Virtual School, Social Care staff and the Admissions Team have experienced difficulty in securing some places, particularly in academies out of county who challenge the application. However where schools do not comply, the escalation process to the EFA is followed. There were 6 cases escalated in 2015/16 (an increase from 2 in 13/14 and 3 in 14/15) and all were successfully resolved, albeit resulted in delays to the child accessing education. From the one case reviewed during the audit however (the most delayed case), there was evidence that alternative educational provision (home tutoring) was sourced in the meantime.

C: Out of County:

There are two Out of County Leads within the Virtual School to oversee all out of county placements, one for Primary (28) and one for Secondary (79). The audit found seven of the eight out of county LAC reviewed in the audit sample of 20 had an up to date PEP in place. One does not have a PEP despite coming into the Council's care in August, however there is evidence on Frameworki showing the Virtual School and Social Worker recognise the urgency and have been trying to set up a meeting with the school.

Out of the 22 LAC without a PEP reported under Section B, 4 are attending a school out of county, one of which has had the PEP meeting but it hasn't been completed on Welfare Call; and the remaining 3 have not yet had the meeting. This gives a 4.7% rate of PEP incompletion for out of county LAC, compared to 5% for all LAC.

Capital Programme Governance and Delivery 2016/17

Opinion: Amber	17 January 2017	
Total: 20	Priority 1 = 14	Priority 2 = 06
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	20	

Overall Conclusion is Red

The audit has identified that there is a lack of sound governance structure in place in relation to the delivery of schemes within the capital programme, with limited strategic oversight and a lack of clear roles and responsibilities between different levels of decision makers / management.

It is acknowledged that both the highways and property contracts were set up with a lean contract management resource on the OCC side, however arrangements for reporting, monitoring and escalation of significant issues on individual projects is unclear and is not working effectively.

Whilst there are gateway processes within the Communities Directorate which appear to provide additional support and challenge at the start and end of a project, there is a gap during the construction phase. Decisions by the Council, taken to devolve responsibility for project management to contractors without the appropriate assurance mechanisms and management information requirements being defined / in place, has resulted in the Council not having sufficient assurance over the delivery of its capital projects.

For property, there is acknowledgement that the current contractual arrangements are not working and so are in the process of being fundamentally reviewed.

At the time of finalising the report, Senior Management reported that, for Highways capital projects, there are a number of areas where positive changes have already been made to address some of the issues highlighted by the audit. This includes reported improvements with a procurement strategy for highways now in place, greater scrutiny and improved sign off of contract awards, clarity over roles and responsibilities, amended structure, strengthened project management disciplines, clear approvals of works and variations, improved progress reporting and strict discipline has been introduced over governance of contingency sums and budgetary provisions.

Whilst it was found that there was a clear process in place for identifying and including schemes in the capital programme, with frequent updates on the composition of the programme to members as part of the Financial Strategy & Monitoring reporting, the arrangements in place for monitoring and reporting on the progress of individual projects in terms of time, cost and quality was found to be weak. The key weaknesses are summarised as follows:

Governance Arrangements

There was a lack of strategic oversight on cost control / timescales / quality of individual major property projects by the CAPB (Capital Asset Programme Board) and no evidence that CAPB provide any scrutiny / challenge over outcome reviews / lessons learnt from major projects that have not delivered to time / cost /quality.

There was a lack of clarity over the process for escalation from the groups responsible for monitoring the individual projects to CAPB. Meetings were not minuted and decisions made were not formally recorded.

Weaknesses were identified with the level of challenge and strategic oversight provided by the Capital Finance Team.

Issues with the timeliness of reporting information to Cabinet was also noted.

Project Management / Contract Management

Weaknesses were identified at an individual project level, with a lack of regular, accurate and robust budget monitoring from the OCC side.

In terms of timescales, it was noted that project plans are in place with defined milestones and deadlines, however there was a lack of clarity over how the escalation process should work where time or cost overruns appear.

Whilst there is a process for consideration and management of risk on capital projects, there is a lack of clarity over what should be covered and how the process should be applied.

There is also a lack of detailed information on contingency spend which makes it difficult to see whether risks are being accurately and completely recorded and managed.

Whilst there is some information on contingency allocation / spend included in monthly project progress reports, contingency does not seem to be adequately controlled. Projects appear to always spend the contingency allocation.

Issues were identified with the timeliness of completion of documentation to support approval of changes to project scope and cost.

There is a conflict of interests between the property contractor and the company who undertakes the design and then Employers Agent role on behalf of the Council.

There is a known issue with the property contract with a lack of agreement over Key Performance Indicators (KPI's) and management information, combined with lean contract management on the OCC side to provide assurance that the Contractor is delivering projects on time, to budget and of the appropriate quality.

There is no routine review and reporting on whether the required outcomes and anticipated benefits from capital projects have been achieved.

Significant delays have been identified in the closedown process for both property and highways.

Pooled Budgets 2016/17

Opinion: Amber	10 February 2017	
Total: 13	Priority 1 = 08	Priority 2 = 05
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	13	

Overall Conclusion is Amber

The audit of Pooled Budgets 2016/17 focused on the contract and performance management arrangements operating within the Pooled Budgets.

Governance

At the start of the audit, the S75 and risk shares had not been agreed between OCC and the OCCG for 2016/17 despite being in Quarter 2 of the year. However, during the course of the audit, OCC and the OCCG agreed the risk share and signed it off in November.

Contracts

Overall, there is evidence that the contract and quality monitoring processes in place for the three contracts reviewed are designed and adhered to appropriately, with a clear programme of inspections, templates for visits, action plans, management review and follow up of actions. Where issues exist, the quality monitoring teams effectively identify these through the quality monitoring processes and follow up accordingly.

Individual weaknesses in relation to the three individual major contracts reviewed are as follows:

Contract 1:

There were limited contract indicators contained within the original contract (contract been in place for a long term) and there were weaknesses identified with the timeliness of management information received regarding the utilisation of the contract.

Contract 2:

Not all of the success criteria within the original business case were being measured and routinely monitored 6-7 months into the start of the contract, this was reported to be because these were not intended to be measured yet and that the complex methodology still needed to be developed. Some of the financial objectives of the business case are dependent on an approach which has not yet been implemented, although reported that this is not fundamental to delivery of the contract model and work was planned to progress this. Issues were noted with the escalation process to a corporate level, when the contract was significantly underperforming. Improvements are required in contract monitoring to provide the Council with assurance that workforce issues and associated risks are addressed. Safeguarding

alerts in relation to the contract, whilst being recorded and investigated, were not being strategically analysed and trends reviewed. The contract had originally not been correctly categorised and therefore was not subject to review by the Commercial Services Board.

Contract 3:

There is evidence of an effective commissioning process having taken place with the current provider and a robust system for quality monitoring and improvement is in place with OCC successfully delivering a budget reduction due to tighter controls around spend .

Adult Social Care Management Controls 2016/17

Opinion: Amber	23 March 2017	
Total: 04	Priority 1 = 0	Priority 2 = 04
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	04	

Overall Conclusion is Amber

A. Governance, Policies and Procedures

Appropriate governance arrangements, including oversight, escalation, policies and procedures are in place to manage adult safeguarding concerns and enquiries.

B. Compliance

Compliance to the governance arrangements was found to be mostly adequate, however some issues were identified from audit testing of Safeguarding Contacts and Enquiries:

- Timeliness: Customer Service Advisors did not upload the Contacts within the 2 hour timescale in half of the Contacts reviewed. Initial triage for Contacts took longer than the 24 hour timescale in 3/10 Contacts reviewed (up to 5 days) and 1/10 strategy meetings were not held within the 5 days' timescale - however these timescales are monitored daily and followed up by managers when they are overdue.
- Data Recording: This was mostly comprehensive, however in a minority of cases records were not fully complete, in particular in Enquiry Risk Assessments (2/10 had not been started and 5/10 were incomplete), absence of strategy review meeting records for longer investigations in 1/10 cases and incomplete or inaccurate recording of dates or action timescales in 3/10 Enquiries. Three cases reviewed were open to the Mental Health team who do not fully record in LAS, hence there was a lack of necessary safeguarding data recorded for these cases in LAS.

- Closure: For 1/10 Contacts and 4/10 Enquiries, these had not been closed down on the system despite the case being complete.

For providers subject to Serious Concerns or Standards of Care, a sound process was evidenced for identifying and jointly discussing safeguarding issues for care homes (however the process for home support was less formal). From a review of a sample of 5 providers currently subject to the 'Serious Concerns' process and 10 on Amber or Red 'Traffic Light' status:

- In 4/5 cases the Serious Concerns form was not completed (although in 3 of these cases there was evidence of robust discussion and the outcome was recorded despite the lack of a form - in the other case there was verbal confirmation of the discussion and it was decided the provider would not be subject to Serious Concerns despite it still being listed on the Serious Concerns list).
- In 1/5 serious concerns case the provider looks like it should have been placed upon Amber Traffic Light but was not on the Traffic Light list. In 1/10 providers on Amber Traffic Light for safeguarding issues, it appears that the provider was not considered as part of Serious Concerns.

In all the Contacts / Enquiries reviewed by audit relating to a provider, the Contracts team had been informed at either (or both) referral stage and closure stage.

The Safeguarding team complete self-audits to monitor compliance and quality & to identify learning points. Evidence was reviewed of some thorough audits being completed. However there had been a gap in this process following staff changes and it is yet to fully resume at the same rigour.

C. Management Information

Adequate management information was reviewed for overseeing the performance of Safeguarding Concerns and Enquiries - this is reviewed at the correct level and evidence was provided to demonstrate action is taken where performance is not achieved for example overdue Contacts and Enquiries. A strategic analysis of the reasons behind safeguarding Contact increases is being undertaken, as referred to in the recent Pooled Budgets audit.

Budget Setting and Delivery of Savings 2016/17

Opinion: Amber	21 February 2017	
Total: 02	Priority 1 = 0	Priority 2 = 02
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	02	

Overall Conclusion is Amber

The budget setting process commences in July and completes by February to start in the new financial year in April. The overall annual budget for the County Council is £796m for 2016/17. On top of the savings already achieved, the Council needs to make a further £114m in savings between 2016/17 to 2019/20. The Transformation Programme is tasked with achieving the so-far unidentified savings of £15m. In the current year 2016/17 all Directorates have savings identified, and these are being delivered to a varying degree.

There is recognition in the organisation that there needs to be a more strategic approach to identifying and making savings in order to prevent short term savings that result in longer term costs and to move from 'cuts' to services or operations to 'transformation'. In the past, Directorates have been allocated a savings target and savings plans were drawn up accordingly.

Savings are tracked and monitored monthly by Corporate Finance and risks of non-achievement reported upwards through Directorates to CCMT, the Delivery Board and Cabinet.

There is satisfactory high level oversight of budget and savings monitoring to understand where there are pressures, with a RAG process in place to highlight savings which are likely to be achieved or not. In February 2017, it was reported that of the £53m savings included in the budget for 2016/17, 89% have been achieved or are on track to be achieved by the end of the year. Within the Directorates, £6.9m are flagged as Amber or Red, so are less likely to be fully delivered in this financial year (however £1.1m will reportedly be partly delivered in 2016/17 and £2.7m next year, leaving £2.9m (6%) of the £53m saving that are not achievable.

The audit reviewed a sample of 10 different sized budgets and savings from CEF, SCS and E&E. There was evidence of some form of savings plan and calculations for each one. However, the viability of some of the savings and whether they could realistically be achieved given current conditions was variable, although these had later been flagged in the corporate RAG monitoring process where appropriate. Where there were issues with the savings calculations and assumptions, there was evidence of FBP involvement and these were being addressed going forward.

Unaccompanied Asylum Seeking Children 2016/17

Opinion: Amber	02 March 2017	
Total: 10	Priority 1 = 0	Priority 2 = 10
Current Status:		
Implemented	02	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	08	

Overall Conclusion is Amber

From review of process in place in relation to the management of the UASC budget and forecasting, it was found that there is regular monitoring and forecasting taking place. Although it was noted that the UASC budget is overspent, it is acknowledged that it is a difficult and volatile budget to manage as the number of UASCs requiring support is unpredictable.

It was noted that there is no formalised and documented checking process on UASC cases which provides assurance that the Council is claiming grant income for all the UASCs it is incurring expenditure for. Although it was reported that this is checked every couple of months, there is no evidence of this or of any queries having been raised.

There is a reliance on some key staff members for certain financial tasks, but no documented procedures or processes in place.

From review of the process for the payment of the supported housing provider placements, it was noted that payment is made and costs are journaled based on information provided from the provider. There is no verification of the types of placements invoiced to the placements actually made by the Placement Service.

Whilst is was found that there was appropriate consideration of a UASCs age when identifying where the UASC should be placed and evidence that decisions on placements were kept under review and changed where necessary, the process for documenting consideration of risks for new placements was found to be inconsistent. Guidance in relation to when suitable housing checklists need to be completed was found to be unclear. There also appears to be a lack of understanding from Social Care Staff over when these checklists should be completed. From review of a sample of 5 cases where a housing checklist should have been completed, only 1 was found. No checklists had been saved to Frameworki.

Non-compliance with Local Office Procedures was identified from review of transactions relating to rent or housing deposit payments from one area office. A small number of instances were identified where cash had been issued for a deposit, where payments were made direct to a young person rather than to the landlord and where repeat payments for rent had been made by cheque. Whilst it was found that these cases had been referred to the CEF Finance Business Partner for approval, the level of challenge was not always clear from the documentation retained. There does not appear to be a clear escalation process in place or being followed where requests which go against the Local Office Procedures are made. There was a lack of evidence that senior management within CEF were being made aware of requests for approval to go against the agreed Local Office Procedures.

When looking at the promptness of set up and closedown of placements, it was noted that there were delays in completion and submission of forms to finance which could result in incorrect payments being made or affect the accuracy of forecasting.

For placements where Purchase Orders needed to be raised, it was noted that this was happening after the placement had been made, therefore the approval of the expenditure was retrospective. An instance was noted where the raising of a PO was delayed by several months. It was also noted that there is currently no reconciliation undertaken to confirm that invoices from placement providers are received as expected for UASC placements.

Testing on a sample of new UASCs found no issues with the level of support provided, with key assessments, visits and reviews taking place with the required regularity. Management Information was found to be being produced regularly in relation to the number of UASCs, timeliness of assessments and LAC reviews.
It is acknowledged that there is a wider piece of work ongoing to consider the implementation of a new management information system for Children. Some of the management actions agreed as part of this report are therefore interim solutions to address the weaknesses identified until fully automated solutions can be developed.

Windows 10 Review 2016/17

Opinion: Green	06 March 2017	
Total: 04	Priority 1 = 0	Priority 2 = 04
Current Status:		
Implemented	01	
Due not yet actioned	03	
Partially complete	0	
Not yet Due	0	

Overall Conclusion is Green

The Windows 10 project forms part of the Connecting You programme and is managed and governed under that structure and framework. This structure was reviewed as part of the Office 365 internal audit review carried out during 2016/17. A Windows 10 project team has been established and a Communication and Engagement Plan is documented and awaiting approval from the Management Support Team (Programme Board). However, we have found that the Project Initiation Document has not been finalised and approved and hence there is a risk that the scope and objectives of the Windows 10 project are not formally defined and agreed.

There has been financial approval of the project by the Director of Finance and the Director for Environment & Economy. A programme level “RIDAL document is maintained that contains a risks and issues log, which has entries specific to Windows 10. However, we have found that both logs are missing some key information and thus should be reviewed and updated.

An overall Connecting You programme plan and a specific Windows 10 project plan are documented and maintained. The Windows 10 rollout was due to begin with ICT on the 20th February 2017 and then continue with the Fire Service from the 6th March. However, a decision has recently been made by the Management Support

Team to defer the start date by one month. There are a number of contributing factors behind this decision, including the instability of Skype for business which is a key product, outstanding information on applications and current devices, the availability of project team resources and the booking system for managing the rollout not being ready. The current project plan only includes rollout to ICT and the Fire Service and is based on issuing 30 devices per day. The ICT rollout will be used to test processes for issuing devices and the timeline for the remainder of the rollout will depend on whether the 30 per day target can be achieved.

A Windows 10 build has been developed, although decisions are still required on certain Microsoft products e.g. Skype for business, OneDrive and Direct Access, before it can be finalised. The security configuration of the current build was reviewed against CESG's guidelines for securing Windows 10 and it was noted that some of their recommendations around user account and system hardening have not been implemented. These should be reviewed to ensure that Windows 10 is suitably configured to minimise security and cyber risks.

There are adequate plans to identify the applications being used across OCC to ensure they are assessed for Windows 10 compatibility. A Service Lead will be identified for each Directorate and made responsible for completing a pro-forma listing all the applications used in their areas. When this information is returned to ICT, it will be verified against their records and used to confirm whether applications are Windows 10 compatible. Any that are not compatible will be upgraded, replaced or left on Windows 7. Local applications will need to be tested and each Directorate is responsible for identifying testers for this purpose. A test script has been documented and all testing will be managed and monitored on Supportworks, ICT's service management system.

Users will have the opportunity to attend "product familiarisation" sessions when they collect their new Windows 10 device and Champions will also be identified and trained to support them when they return to their workplace. There are two trainers already in post and a third is due to start at the beginning of March 2017. Formal plans and Windows 10 material/guides are in the process of being developed.

Money Management 2016/17

Opinion: Green	13 March 2017	
Total: 02	Priority 1 = 0	Priority 2 = 02
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	02	

Overall Conclusion is Green

With the exception of pre-paid card checking processes (as detailed below), it was found that there is appropriate guidance in place for Money Management staff, social care teams and the general public in relation to the Money Management Service. IT systems (specifically Lloyds Link and CASPAR) were found to be operating effectively and access / security arrangements appear reasonable.

With regard to referrals, examples were identified (8/20) where the case had been routed back to the Social Worker instead of the Money Management Team after approval by senior social care staff on LAS. This results in a delay in Money Management receiving the referral. The error is only identified if queried by the Social Worker at a later date. This issue had already been identified by the Money Management Team before the audit started, with reminders to social care staff that referrals via LAS should be sent to the Money Management work tray included in ASC Weekly Round-Up emails.

There are, on average, 40 clients on the waiting list each month waiting for their case to be allocated to a Money Management Officer. While referrals are recorded on a tracking spreadsheet, there is no formal process in place to document the prioritisation of the waiting list. Urgent cases where work has started by the management team before a Money Management Officer can be allocated are highlighted, however there is nothing further to indicate why the service users have been referred and who should be assigned to a Money Management Officer next. As part of the transformation agenda, all systems in use within Adult Social Care teams are being reviewed. It is planned that a feasibility exercise will be undertaken to review the systems in use within Money Management and consider whether the team could move to using LAS / ContrOCC. As part of this, waiting list recording will be considered.

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

All payments reviewed during the audit were found to have been authorised appropriately, with supporting documentation on Sharepoint in all cases, however it was found that checks on the Pre-Paid Card (PPCs) service (currently still at pilot stage), are not yet formalised and documented. Whilst management checks including checks on high balances and inactive cards have been established, not all checks were being formally documented at the time of testing. Checks on individual card accounts by Money Management Officers are not currently being documented.
Money Management was audited last in 2010/11. Of the 14 management actions agreed, it was found that five were no longer relevant as services had changed since the previous audit, and the remainder had been fully implemented with controls (or adequate controls if the process had changed) in place and operating effectively.

Pension Fund 2016/17

Opinion: Green	17 March 2017	
Total: 0	Priority 1 = 0	Priority 2 = 0
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	0	

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

Overall Conclusion is Green

Governance over the Pension Fund remains strong. Regular reporting takes place over the performance of the assets held by the fund managers, and any issues with asset performance are kept under scrutiny to see if any action needs to be taken. The policies and procedures governing the fund are subject to annual update to ensure they remain current and relevant.

Contributions from employers are monitored regularly to ensure the correct amounts are being received. Cashflow is also kept under regular scrutiny to ensure that there are sufficient funds available to meet liabilities.

The fund managers' and external advisors' performance has been reviewed as scheduled. Payment to the fund managers is variable based on the performance of the assets, for all invoices reviewed the pay had been checked against the asset records to ensure they were charging correctly.

The fund is currently participating in Project Brunel, aspects of this have not been reviewed as part of this audit, however it was noted that the Pension Fund Committee are being kept up to date of progress and presented with information ahead of gaining approval to join the pooled fund arrangement.

Thriving Families Spring Claim 2016/17

Opinion: n/a	23 January 2017	
Total: 04	Priority 1 = 0	Priority 2 = 04
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	04	

Overall Conclusion

Phase 2 of the Troubled Families Programme started in September 2014, and OCC has submitted claims twice a year from September 2015 to January 2017 (with the current claim being a third one for this year). The 2 management actions from the January 2017 Audit are not yet due, but it has been confirmed that the specified checks have been incorporated into the TF Data Team's processes. One action from the September 2016 audit is still outstanding, but is currently in the process of being implemented. This relates to making a repayment to the DCLG for 2 families incorrectly claimed for during the January 2016 claim.

The end of March claim consists of 150 families for Significant & Sustained Progress (SSP) and 21 families for Continuous Employment. No issues were found during testing of the Continuous Employment claim. Two families were removed from the claim following Internal Audit testing. These had not been identified prior to the submission of the claim to Internal Audit, and so additional quality checks in these areas will need to be completed by the Troubled Families team for future claims. No further issues were found, and checks were carried out to ensure the issues found did not apply to any other families in the claim. Internal Audit therefore signed off the claim.

Office 365 - Part 3 2016/17

Opinion: Amber	23 March 2017	
Total: 05	Priority 1 = 0	Priority 2 = 05
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	05	

Overall Conclusion is Amber

This audit of Office 365 was undertaken over three stages. The first stage review was completed in June 2016, stage two in November 2016 and stage three in March 2017. Management letters were issued and agreed following the first and second stage reviews and each identified a number of risks and both had an overall conclusion of Amber. This third stage review has culminated in this formal report and is the final planned audit of Office 365. The table above contains the total number of actions from this report together with those outstanding from the stage one and two reviews, which have not been repeated here.

Office 365 is OCC's first corporate level transition into cloud based services. It forms part of the Connecting You programme which also incorporates Windows 10, which was audited in January 2017. Office 365 will see the implementation of a number of Microsoft products and some of these are already live e.g. Exchange Online (email), In-Tune, SharePoint Online and Yammer.

A business case for moving to Microsoft Enterprise Cloud Suite (ECS), which incorporates Office 365 and Exchange Online, has been documented and approved. The strategic case includes how ECS supports wider corporate aims and objectives e.g. agile and flexible working. The financial case is based on how the cost of renewing the Microsoft Enterprise Agreement can be mitigated through the adoption of ECS through future cost avoidance.

The acceleration to cloud based services follows two serious data centre failures that have occurred in the past 18 months. Cabinet, Informal Cabinet and CCMT have been made aware of the move to cloud services, however, we believe that further work is required to ensure they fully understand and accept the risks involved. There was an agreed priority 1 action to address this in our stage one review but it remains outstanding. A Privacy Impact Assessment was undertaken following our stage one review although it has yet to be presented to the corporate Information Governance Group.

Data security is a key consideration when moving to cloud services. An Information Management Risk Assessment (IMRA) has been undertaken for the overall 0365 programme as well as for individual products. A review of the O365 programme IMRA revealed gaps for which a priority 1 action was agreed following our stage one review. This action is still outstanding. Further actions were agreed to review the CESG security guidance for O365 and the risk of users accessing O365 from non-corporate machines, these also remain outstanding despite being closed on 4Action. Our stage two audit found that an IMRA had not been undertaken for the In-Tune product and this also an outstanding action. This stage three review has confirmed that IMRA's have been undertaken for a number of smaller products that are currently being implemented.

Office 365 services are covered by the Microsoft Enterprise Agreement (MEA) which was signed in February 2016 and became effective on 1 March 2016. The MEA comprises of a number of documents, some of which are only available on the Microsoft website e.g. service level agreement, Online Services Terms – which includes privacy and security terms.

A programme structure has been established and roles and responsibilities have been documented and agreed. Since our stage one review, Office 365 and Windows 10 have come together under the same programme structure. A Management Support Team oversees the programme and they meet on a fortnightly basis. A Programme Initiation Document was produced following our stage one review to encapsulate all the projects within the programme and the order of implementation. There is a programme plan in place but it does not include the key milestones from each Project PID and we have also found that Highlight Reports are not being produced at the agreed frequency. A combined risks and issues log is maintained for Office 365 and Windows 10 but they need to be reviewed and updated.

A formal Test Plan has been developed and approved and there is clear evidence of products being tested before going live. However, some of the controls around testing need to be improved, such as signing off test scripts in advance and producing formal test reports at the end of each product test. A review of the recent

testing of Skype for Business found that it was only tested by 13 out of the 24 users selected for the task.

OxLEP 2016/17

An audit of OxLEP has been undertaken providing assurance to the OxLEP Chief Executive and Board around the governance and financial management policies and procedures. The audit has also provided assurance on the responsibilities of Oxfordshire County Council acting as Accountable Body.

The overall conclusion has been graded Amber. The audit has identified good governance and financial management arrangements operating within OxLEP and an effective working relationship between OxLEP and OCC as the Accountable Body. Where improvements to governance and financial management controls have been identified, these have been reported directly to OxLEP and management actions agreed for implementation.

In respect of OCC acting as an Accountable Body; a weakness was identified with retention of information to support payments made by OCC on behalf of OxLEP. Additional evidence has subsequently been produced to support the claims queried and a management action agreed to improve the process going forward.

Pensions Administration 2016/17

Overall Conclusion is Green

There were no new management actions agreed in the 16/17 report, however 1 action re-stated from the 15/16 audit which is partially implemented.

Issues noted in the previous audit around segregation of duties have still not been addressed. The same individual still runs the payroll, corrects administrative errors before it is released for payment, undertakes the reconciliation, uploads the payment files via the Business Data Upload (BDU) facility into SAP, and downloads the reports showing what functions have been performed by the two individuals with administrative and payroll access within Altair. This remains a significant control weakness in the system, however it is understood that an additional bolt on within the Altair system has been explored, to resolve this issue, and is due for implementation imminently. The management action raised in the previous audit has therefore been restated this year.

Governance and transparency over reporting issues continues to be good. With the increase in the number of employers and continual strive for full data accuracy, this has led to documented pressures on the team. These pressures have resulted in delays in administrative processing in some areas. In particular issues were noted with a number of deferred leavers, some of which are falling outside the regulatory limit of 3 months for processing. 40% of deferred leavers sampled exceeded the 3 month processing time, the majority of these were down to delays within the Pensions Admin Team as opposed to delays receiving information from the

employer. Additional to this, performance monitoring has shown a decrease in performance in all areas reported on, and a number of internal targets not met. To proactively try and resolve these issues and relieve pressures on the team a restructure has been proposed, along with an increase in staff, which has been agreed by the Pension Fund Committee.

Previously issues have been noted with the quality of monthly returns from employers (MARS data), and end of year returns (CARE data). Work is ongoing to improve data quality with employers, with some improvements noted. However the issues are still having a knock on effect on the ability to issue annual benefit statements to all employees on time. Not having all benefits statements issued on time is a breach of regulations, however this has been reported to the regulator and the Pension Fund Committee. Two management actions were agreed in the 2015/16 audit report, one of these has been implemented, the other is being restated in this audit.

Accounts Payable 2016/17

Opinion: Amber	28 March 2017	
Total: 03	Priority 1 = 0	Priority 2 = 03
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	03	

Overall Conclusion is Amber

The position since the last audit has improved considerably. Policies and procedures have been updated and brought more in line with help and guidance from Hampshire. Accessibility of the policies is still an issue as they are not always easily locatable; however positive work is underway to improve that across all financial policies and procedures.

Management information is now being received from Hampshire, which is helping to highlight where invoices are getting repeatedly blocked, or where delays are, for example. This enables OCC to pinpoint issues more accurately and resolve them quicker, ensuring suppliers are paid in a timelier manner. Control processes to resolve issues are embedding at the moment, internal management information is not yet in place to show how well these processes are working at reducing the issues.

Internal Audit undertook a high level analysis on the purchase orders raised from 01/04/2016 - 09/03/2017. This highlighted that there is further scope for encouraging better purchasing methods, to try and reduce the more resource intense usage of purchase orders for lower value procurement.

A process had been adopted to identify duplicate payments; however this has only resulted in a small number of refunds. The process has been reviewed and strengthened, which, going forward, should result in an increase in the recovery of duplicate payments. However, there is currently no management information

produced to be able to show the level of duplicate payments and monitor the success of recovery.

Where an overpayment has been identified, OCC's preferred option is to request a refund; however there is disparity between guidance on the Intranet and processes on the Hampshire help pages.

A review of purchase orders found all had been approved in accordance with the schemes of delegation, however raising purchase orders retrospectively is still an issue. 60% of those sampled (schools excluded) were found to have been raised retrospectively.

A process has been agreed with Hampshire that one time vendor payments will only be processed if sent through the Corporate Procurement Team. This process helps retain visibility of the process and the payments being made, however from a sample review of the data there were some payments that had been made to vendors that had already been set up. Equally, there were also instances noted whereby multiple one time payments were being made to the same vendor.

Follow up

There were 8 management actions agreed as part of the Accounts Payable Audit 2015/16. There are 7 management actions reported as implemented, 4 of these have been re-tested as part of the 16/17 audit and confirmed as working effectively, 2 were not tested during this audit and 1 which related to the policy/process for refunding duplicates has been implemented however a new action has been agreed this year as the refunds of duplicate payments have not been actioned. There is 1 action that has now been superseded.

There were 23 management actions agreed as part of the Design of Controls Audit 15/16 that relate to Accounts Payable controls. There are 14 management actions reported as implemented, 5 of these has been re-tested as part of the 16/17 audit and confirmed as working effectively (9 were not tested again as part of this audit). There are 7 actions that have now been superseded and a further 2 actions that are not yet implemented and are overdue. These relate to IBC approval levels and the 6 monthly review of the scheme of delegation (P1) which is partially complete and the requirement for a credit note policy (P2) (a credit note process is however now in place).

There were 4 management actions agreed as part of the One Time Vendor Compliance Review 2015/16. Two actions have been reported as implemented and re-tested as part of the 16/17 audit and confirmed working effectively, one action has been superseded and one action has not been implemented and is overdue (relating to guidance on the OTV spreadsheet to define who authorising manager is and that it should be in accordance with the scheme of delegation).

There were 15 management actions agreed as part of the Purchasing Cards Proactive Review 2015/16. There are 13 actions reported as implemented, these have been reviewed as part of ongoing work, and confirmed as implemented. One is not yet due for implementation, and one is overdue however partially implemented. A residual action was noted as part of the review of implementation; this will be covered and reviewed in more detail as part of the 2017/18 purchasing cards review.

The outstanding actions will remain on the 4action system and continue to be monitored for implementation.

Schools HR contracts, combined with proactive fraud review 2016/17

Opinion: Green	30 March 2017	
Total: 01	Priority 1 = 0	Priority 2 = 01
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	1	

Overall Conclusion is Green

Issues identified from recent counter-fraud/audit work within an individual school highlighted potential fraud risks in relation to HR contracts and payments. This was a combined audit to provide an opinion on the adequacy and effectiveness of internal controls within this area with also proactive fraud testing to highlight any potential fraudulent activity.

The audit covered the HR arrangements in place at a sample of 10 primary, secondary and special schools. Specifically, the following areas were tested; Employment contracts and annual leave records for support staff, Headteacher's pay, staff salary uplifts, additional allowances (excluding overtime & casual), staffing budgets and declarations of interest.

The testing undertaken at this sample of schools provides positive assurance that the weaknesses identified with the individual school earlier on in the year is not representative across other schools. For the specific HR processes reviewed it was identified that the schools sampled were applying good governance and could demonstrate effective management review and sign off.

One issue was identified. 7 schools (from whole school population) were found to be potentially applying the salary scale points for the Headteacher within their salary band incorrectly. These amounts are not materially high, but are now being reviewed by the CEF HR Business Partner.

Accounts Receivable 2016/17

Opinion: Amber	6 April 2017	
Total: 11	Priority 1 = 0	Priority 2 = 11
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	10	

Overall Conclusion is Amber

This audit provides assurance over the key control processes operated by OCC. Hampshire Internal Audit provide separate assurance over the IBC operated controls and processes. Their reports on Order to Cash (OTC) and IBC Master Data Team have been shared with Oxfordshire's Chief Internal Auditor and Director of Finance and the overall opinions contribute to the overall opinion on the system of internal control.

The situation since the previous audit of Accounts Receivable in 2015/16 has improved considerably. There is now clarity over key roles and responsibilities, policies and processes in relation to accounts receivable and corporate debt recovery. Processes, roles and responsibilities have been reviewed and agreed with the IBC (Integrated Business Centre).

Management information on aged debt and other key parts of the accounts receivable environment is now being produced and made available to senior management. OCC staff also now have access to customer account details and dashboard reports on accounts receivable and debt recovery through the IBC portal.

A conscious decision has been taken by senior management to delay work on review and updating of intranet policies, procedures and guidance to enable resources to be directed at ensuring appropriate controls are in place and that processes, roles and responsibilities are clearly understood and agreed first. Management action to produce and publish formal guidance has been agreed as part of this audit and it is expected that this will be in place before the end of the first quarter of 2017/18.

The key findings identified during the current audit are summarised below:

- It has been identified by the service that a debt management strategy is required. This will be produced and has been included as an improvement action within the Council's Annual Governance Statement.
- Schools do not currently have access to the OCC intranet, whilst this is wider than just Accounts Receivable, schools staff do not currently have access to any intranet information including self-help guidance on accounts receivable or debt recovery.
- Issues identified as part of the previous audit in relation to the make-up of dunning email addresses and subject titles have not yet been resolved, this may result in dunning emails not being received by debtors, and could impact on income recovery processes.
- Sample testing on invoices raised identified instances where issuing of invoices had been delayed. There were also a small number of issues noted in relation to the accuracy of charges raised and the documentation retained to support the charge. These issues are being followed up directly with the relevant service area.
- Whilst it was found that the process for instalment plans has been reviewed, updated and confirmed, a gap was identified in relation to review of legacy debt instalment plans. There are clear instructions for the agreement of new instalment plans and the repayment times allowed, however there was no process for periodic review of instalment plans already in place for legacy debts. An example

was identified from sample testing where the repayments agreed would mean that the debt would take 45 years to be paid off.

- It was identified that, due to staffing changes and responsibilities, monthly reports on outstanding pension's services debts had not been produced and circulated between December 16 and March 17.
- Responsibility for debt recovery of Adult Social Care charges raised off ContrOCC (for example day centre attendance, transport, adaptation loans) currently sits with Corporate Debtors rather than the Adult Social Care debtors' team. A management action was raised in relation to resolving this as part of the 2015/16 Accounts Receivable audit, however discussions are on still going.

Follow up

There were 18 management actions agreed as part of the 2015/16 Accounts Receivable audit. Testing undertaken during this audit has identified that 6 actions have been fully and effectively implemented, 2 actions have been reported as fully implemented but have not been tested during this audit and 10 management actions were found to have been partially implemented. These management actions have been superseded and revised management actions have been agreed to address the outstanding issues as part of this audit.

There were 17 management actions agreed as part of the 2015/16 Design of Controls audit relating to accounts receivable. Testing undertaken during this audit has identified that 6 actions have been fully and effectively implemented, 1 action has been reported as fully implemented but was not tested during this audit, 3 actions have been superseded as no longer relevant and 7 actions were found to have been partially implemented. These management actions have been superseded and revised management actions have been agreed to address the outstanding issues as part of this audit.

There were 5 management actions agreed as part of the Cancelled & Re-issued Invoices Compliance review 2015/16. Testing undertaken during this audit has identified that 1 action has been fully and effectively implemented, the other 4 actions have been superseded, 3 were found to be no longer relevant and the other 1 will be addressed by the management actions agreed within the current audit report.

Personal Budgets including Direct Payments 2016/17

Opinion: Amber	6 April 2017	
Total: 13	Priority 1 = 5	Priority 2 = 8
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	13	

Overall Conclusion is Amber

Introduction

An audit was undertaken in 2015/16 focussing on the Direct Payments process. This year, the audit has looked at both the Personal Budgets process (from assessment to review), and Direct Payments. Following the 2015/16 audit, a number of positive outcomes can be evidenced to improve Direct Payments processes, including updated policy and procedure documents, comprehensive staff training sessions and provision of management information on Direct Payments to the Adult Social Care Performance Board. There is evidence of increased scrutiny of issues identified with specific cases, as the Direct Payments team have escalated issues to the relevant ASC managers. The LD Community Connections team has also been reviewing high value LD DP cases where potential issues have been raised.

Management are planning to introduce pre-paid cards for direct payments during 2017/18. As part of the implementation of these there is a planned end-to-end review of processes which will have the opportunity to consider in detail and address the weaknesses still highlighted by this year's audit.

A: Policies and Procedures

Guidance exists for staff on the Personal Budgets process, including the use of LAS and the budget calculation process using the RAS. Some minor changes are required to the 'Assessment to Review' staff procedure document, which was last updated in 2015 and has not taken into account changes that have been made to processes on LAS since this time (such as the RAS calculation and Overview Assessment and Support Plan / Budget authorisation processes). However it is noted that up to date step by step guides on LAS usage is available to staff.

The Direct Payment policies and procedure for both staff and service users have been updated following the 2015/16 audit, and these are generally sound and accessible.

B: Personal Budget (RAS) Calculation & Authorisation

In the majority of cases reviewed during the audit, the Indicative Budget calculated by the RAS had little bearing upon the authorised budget amount and the actuals being paid - in most cases the RAS amount was lower. The RAS calculation does not take into account the increase in current care provider rates and in a number of cases in the sample did not appear to adequately reflect the needs of the service user.

Where Social Care staff are required to manually select the Support Plan and budget authoriser on LAS, there is a risk that the incorrect manager could be selected thereby not complying with the Adult Social Care Scheme of Delegation. In November 2016 the Budget Authorisation task was switched off - this included an in-built scheme of delegation via ContrOCC (although it is noted that this was not as sophisticated as it needed to be in order to route the authorisation to the correct person), however there is now no system requirement to authorise Personal Budgets at the correct level. Correct authorisation is reportedly checked during supervision

case audit checks so may be identified, however there is not currently a report being run to check all Support Plan authorisations against the Scheme of Delegation.

The current Scheme of Delegation has not been uploaded to the OCC Intranet, and is only available as part of the 'Assessment to Review' guidance documentation, so is therefore not easily accessible.

From the review of 15 Direct Payments, the audit noted that in 2 cases the Support Plans on LAS were either not sufficiently detailed or up to date in order to adequately inform appropriate DP expenditure, and in a further Mental Health case the Support Plan was not on LAS (recording on LAS by Mental Health is a known issue). In one case for a high value DP (£3.8k per week), there was a Care Plan dated 2006 and a Review from 2013, but nothing more recent and the LD Panel paperwork and authorisation could not be located.

In 5 of the 20 cases reviewed, there had not been a recent annual review of the Support Plan (and Direct Payment where applicable). However the issue of overdue annual reviews is known and reported on - as of February 2017, 47% of annual reviews had been completed (this has been increasing slightly by about 1% each month since the implementation of Responsible Localities).

C: Management Information & Oversight

A performance dashboard is reviewed monthly at the ASC Performance Board, with more detailed information on Personal Budgets and annual review figures sent to Team Managers, Service Managers and the Deputy Director ASC twice monthly for oversight (this breaks down the figures by team, as well as listing individual service users who are not on Self Directed Support or who are overdue an annual review). Information on the number of activities performed by each team and individual worker (assessments, support plans, reviews etc.) is also provided twice a month to the same people.

Management information on Direct Payments is now provided to the ASC Performance Board on a monthly basis, including current issues with DP accounts and the progress made regarding investigation and escalation of these. Clearly, numerous issues with DP accounts have been identified by the DP team, however many of these remain un-resolved with responses not having been received from the Social Care teams contacted (in the February review there are 32 DP cases with financial queries awaiting a response from Social Care, dating back over the past year). An overdue returns report is also provided to the Performance Board, the latest of which shows 35 overdue financial returns as at February 2017, most dating from 2016, however some go as far back as February 2015.

D: Direct Payments Audit Follow Up

This audit followed up on the management actions from the 3 relevant DP audits / investigations from 2015/16, as follows:

Direct Payments audit 2016/16

Out of 22 actions from the 2015/16 Direct Payments audit, 20 have been reported as fully implemented, with 2 still open and being implemented (cheque payments and pre-payment cards). Further to the current audit re-testing, only 14 can be evidenced

as fully implemented and working effectively, with 5 not yet fully implemented or working effectively (new DP Agreements signed at annual reviews, review of all high value DPs, review of DP packages at OP Panel, DP finance checklist reviewed and working & escalation and resolution of DP finance queries to Social Care). A further one could not be evidenced from testing (Social Worker review of DP expenditure).

Audit investigations into high value DPs:

12 of the 16 actions have been reported as implemented, with the remaining actions under implementation. However, following re-testing, 10 can be evidenced as fully implemented and the other 2 were not fully re-tested in this audit (review of current loans and process for reclaiming misused DP funds).

Mr & Mrs X audit investigation:

Out of 9 actions, all have been reported as implemented, and this can be confirmed although one action was not fully re-tested during this audit (one-off DP payments).

Where actions have been reported as implemented but were found not to have been fully and effectively implemented, they have been superseded by actions in the current report, further to the following key findings:

- The audit attempted to review the Social Worker reviews of Direct Payments, as per the process determined by management, following the 2015/16 audit. However any DP review they undertook with Service Users was not documented on LAS so it was not possible to evidence this. Furthermore, in only 3 out of 10 cases where a recent social care review or assessment had been completed was a new DP Agreement signed.
- The audit reviewed a sample of 5 high value DPs and of these two had not had a recent review.
- The audit found that in some cases, possible issues with Direct Payment expenditure had not been identified and challenged by the Direct Payments team, in accordance with agreed procedures. This included PAs not being listed on return forms, invoices and receipts not being provided for a DP of over £1,000 per week and potentially inappropriate expenditure not identified. Where issues are not identified or escalated internally, these are then not included in the referral / escalation process to Adult Social Care. As discussed under section C, following the successful implementation of these new escalation processes, it has identified the volume of DP finance queries referred that have not been resolved.
- The checklist completed by the DP team is not always being used effectively, as in the cases above the issues were not considered and boxes were ticked to confirm that the expenditure matched the support plan and there were no questionable transactions (in one case, there was no support plan and this had not been investigated further by the DP team). A prompt to check that PA's names have been listed is not included.
- From audit sample checking, issues were identified with one high value Direct Payment reviewed (£2.4k per week) that had not previously been detected or challenged. This case highlighted that there is a gap in policy approach towards DP recipients setting up care agencies, the cost in doing so, possible conflicts of

interest with such arrangements and the lack of transparency over the financial transactions incurred.

Highways - Payments 2016/17

Opinion: Amber	6 April 2017	
Total: 16	Priority 1 = 8	Priority 2 = 8
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	16	

Overall Conclusion is Amber

Introduction

The audit reviewed the implementation of all actions agreed during the 2015/16 Highways Payments audit. Many of the actions agreed in the last audit related to inaccurate and unreliable cost data in the Inform system in use at that time. Over the past year, a new work management and costing system has been introduced, SkanWorks, to improve the weaknesses with the previous system. This Follow Up audit therefore reviewed in some detail both the project governance for implementing the new system, to ensure the audit issues were satisfactorily factored in, as well as the system itself, to check it more accurately captures and reports on cost and payments data.

Conclusion

A: Follow Up on 2015/16 actions

Out of the 13 actions agreed in the 2015/16 audit, 11 have been reported as fully implemented with two outstanding. Following re-testing of audit actions, the current audit can confirm that only 4 have been fully implemented, with 3 partially implemented, 5 not implemented and 1not re-tested during this audit, as follows:

5 not implemented effectively: Two are still outstanding actions - the first being a retrospective check of all Closedowns to identify cases where costs have changed following closedown; the second being a review of the implementation of a new process for the 10% defect quality checks - this audit has also identified that No Cost Defects are not being logged on the system when they should be resulting in a lack of evidence to demonstrate failed defects have been re-repaired.

There are three actions reported as completed but where this could not be fully evidenced in this audit. The first is that the new system must have the functionality to close down a Task Order at the point of Skanska Closedown sign-off so no further costs can move in or out - this functionality is not yet in operation. The other is managers with Level 0 Authorisation will ensure that orders above their sole delegated authority are dual authorised - however this issue was found again in this audit. A process for recuperating costs for failed defects paid for twice was reported as implemented, however with the new system, issues have been found again with No Cost Defects, where their costs have been included in payments (less than £5k so far this year).

In terms of the accuracy of cost allocation, this appears to have improved however issues were identified again in the audit sample with costs being incorrectly allocated to Work Orders. Any incorrect costs cannot yet be corrected due to the system not yet facilitating the movement of costs between Work Orders.

3 partially implemented: The E&E (now Communities) Scheme of Delegation was updated following the previous audit, however the most recent 6 monthly check is now out of date. The £1 Task Orders for Disallowed or Disputed costs were set up; however these are not yet working as intended as they have very little in them and costs are not yet being moved out of them. Closedown analysis on pain/gain share has been partially done but not yet in full.

B: Governance & Control Framework

The audit found a high level of collaboration and transparency between the partnership to implement the new system and to share emerging risks and issues. As with any new system and changes to working practices, there have been problems, however these are being addressed and were openly shared with the auditors. From review of the project documentation, there was sufficient evidence that the audit issues raised previously were satisfactorily incorporated into the system development, albeit many of these functions are not yet working to a satisfactory level.

The Performance Indicator SPI 09 requires SkanWorks to be working effectively. The exact requirements to determine this are being defined and a decision is expected by July.

With the introduction of the new system from June 2016, staff were trained in its use, however there has not yet been a review of internal policies, processes and ways of working to fully exploit the potential of the new system, its reports and the data it can provide and the improved scrutiny it should offer. The audit sample testing demonstrated the varying degrees of system usage amongst Budget Holders and a lack of ownership of the system.

Performance and management information on productivity, accuracy and usage are not yet being produced or reviewed - this is important, for example, as the gang costing function in SkanWorks automatically allocates an 8 hour day across Work Orders, irrespective of how many hours a gang has actually worked or number of defects completed.

C: SkanWorks

In terms of transparency of cost data, the system is an improvement from the previous one. However, there are still a number of key functionalities that are not yet working as intended and thereby weaken this transparency and the reliability of cost data - all of these are being worked on by Skanska to rectify:

- The functionality to move incorrect costs between Works Orders is not yet in use
- The functionality to shut down a Work Order and Task Order is not yet in use.
- No Cost Defects are not removed automatically prior to payment.

- Sub-contractor costs are input manually and override the time records in the system.
- A number of system 'bugs' and manual workarounds are in place.
- Incorrect before/after defect photos have been uploaded.
- Out of the 5 budgets the audit reviewed, there was a variable level of usage of the available system functionalities.

Payroll 2016/17

Opinion: Amber	13 April 2017	
Total: 11	Priority 1 = 1	Priority 2 = 10
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	11	

Overall Conclusion is Amber

This audit provides assurance over the key control processes operated by OCC. Hampshire Internal Audit provide separate assurance over the IBC operated controls and processes. Their report on Payroll has been shared with Oxfordshire's Chief Internal Auditor and Director of Finance and the overall opinions contribute to the overall opinion on the system of internal control.

During the latter part of 2016/17 an additional piece of work was commissioned and undertaken to provide assurance in respect of the payroll configuration to calculate, action and report statutorily compliant payroll transactions; and also that future configuration changes are processed accurately and in a compliant manner to ensure changes are fully tested prior to release. This work was overseen by Hampshire Internal Audit and the report has now been received and will be reported separately to the Audit & Governance Committee in July 2017.

Overall, the payroll control environment and compliance has improved since the 2015/16 audit. HR policies and procedures have been updated (although further work is required in this area), detailed management information on HR processes is provided to HR Business Partners and there is generally an increased understanding of IBC processes and usage of the system amongst OCC managers and staff, resulting in fewer errors, as evidenced through Internal Audit sample testing. However, some issues remain regarding certain payroll processes, and in relation to the approval process for recruitment and changes that affect employee pay.

A: Policies and Procedures

Policies and guidance have been updated following the 2015/16 audit, however an issue was identified with the OCC Monitoring and Managing Sickness Absence Policy, which did not accurately reflect employee terms and conditions in the OCC Green Book in relation to payment of Statutory Sick Pay.

A lack of clarity on local overtime policies and the correct overtime codes to use was identified, resulting in incorrect time codes selected for overtime with the possibility of staff receiving incorrect overtime payments (this includes usage of the Regular Hours code which should only be used by Casual staff).

B: Starters and Leavers

HR approval forms are not completed for all new posts and starters (as covered under Section D).

The majority of overpayments due to manager error are the result of leavers being processed late, and one case where this had occurred was identified in the audit sample. The audit testing of leavers also identified a case where a member of school support staff had been underpaid due to non-compliant contractual arrangements.

C: Variations and Overtime

HR approval forms are not completed for all honoraria or employee record changes (as covered under Section D).

As referred to in Section A, usage of the Regular Hours code (intended for payments to Casual staff only) by temporary and permanent staff was an issue in a number of service areas, resulting in a risk of incorrect payments.

From audit testing of changes to employee records, one example was identified where a manager had incorrectly changed an employee from a temporary to permanent contract.

D: Management Information and IBC

HR Approval forms are not consistently completed by managers in all cases for recruiting staff, paying honoraria, employing new staff or making changes to employee records. There are currently no quality checks that the Forms are completed, nor any management information produced on this.

An overpayments report is produced monthly by the IBC, listing all identified overpayments that have not been repaid. However this is not reviewed by OCC HR to identity the root causes of overpayments to determine whether these are the result of manager or IBC error and therefore identify remedial action required to address any underlying issues.

The 2015/16 audit identified that HR record retention was inconsistent and not sufficiently transparent. Guidance to managers has been clarified, and a wider review is being undertaken of this area, however issues remain, and this audit identified a case where a manager had not stored HR records and had since left.

Follow Up

The audit followed up on the management actions from the 3 relevant Payroll related audits from 2015/16, as follows:

Payroll audit 2015/16:

Out of 14 actions from the 2015/16 audit, 12 have been reported as implemented, with 2 currently under implementation (relating to use of the ‘Regular Hours’ function on the ESS timesheet, and HR record retention). Following the audit testing, 10 can be evidenced as being fully implemented, with 2 not specifically tested as part of this year’s audit (relating to academy conversions and KIT days payments).

Design of Controls audit 2015/16:

4 out of 7 actions relating to Payroll from the Design of Controls audit have been reported as implemented, and a further 3 have been superseded.

Employee Changes compliance review 2015/16:

Only one action was agreed as part of this review, relating to updating Secondments guidance on the Intranet. This was reported as implemented and has been confirmed by Internal Audit.

Client Charging 2016/17

Opinion: Amber	11 April 2017	
Total: 13	Priority 1 = 0	Priority 2 = 13
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	13	

Overall Conclusion is Amber

Since the previous audit of Client Charging in 2015/16 there has been significant progress made by both the Financial Assessments Team and the Adult Social Care Income Team in reviewing and clarifying their processes, roles and responsibilities to confirm that they are appropriate and clearly understood post implementation of LAS, ContrOCC and IBC. The majority of these revised processes have now been formally documented.

In relation to the Financial Assessment process, whilst the audit has identified some improvements in reporting to senior management within Adult Social Care (ASC), for example that the Performance Board is now getting regular information on cases where referrals for financial assessment have been delayed or missed, the Performance Board does not yet appear to be getting all the information it needs on areas where performance has been noted as poor from the previous audit and again, from testing undertaken during the current audit (for example where the Financial Assessment Team is not receiving information on third party top ups and on instances where provisions on LAS are not being deactivated promptly).

Issues have been identified with promptness of authorisation of Care Package Line Items (CPLI's) on LAS which results in a delay in charges being raised. Issues were also noted in the closedown of CPLI's with examples noted where the CPLI / Service had not been closed down promptly, resulting in incorrect charges being made.

There are still problems with the third party top up process. Despite guidance being reviewed, revised and clearly communicated to Adult Social Care staff over the last year, examples were identified where the Financial Assessments Team haven't been advised of the third party top up (which enables them to set up the required charge) and also where ASC staff have not got the relevant Third Party Top Up

agreements in place, which could result in the Council being unable to collect the third party income due.

An action was agreed as a result of last year's audit to review the process for payment and charging of home support provided by organisations who did not use ETMS. Work is ongoing to move all non-ETMS home support providers over to a process which will enable service users to be charged based on actual care received in accordance with the SCS Contributions Policy.

Work is ongoing to resolve process issues which are currently preventing the Council from charging LD service users for respite care, in accordance with the SCS Contributions Policy. Proposals are soon to be reviewed by ASC Directorate Leadership Team and it is hoped that charging will commence around the end of June.

Issues with potential discrepancies in historic charging of some personal budget service user charge, first highlighted by Internal Audit in 2012/13 are not yet fully resolved. It has been reported that all required reconciliations have now been completed, but these now need to be checked and any refunds due processed.

ASC debt reporting has improved significantly since the previous audit, with detailed monthly dashboard information on areas including bad debt impairment, debt collection rates, unsecured debt and write offs being circulated on a monthly basis to senior management within ASC and Resources.

There is an outstanding action on the review of the process for completion of Annex 2's and who will be responsible for this process going forward. Both as part of the previous audit and from audit testing undertaken this year, on deferred payments, issues were identified with completion of Annex 2's covering the 12 week property disregard and third party top ups. It has been reported that the outstanding action is almost complete. Internal Audit will continue to monitor implementation through the routine audit follow up process.

This audit included review of adaptation loans (or deferred interest loans / DILs). All information in relation to these loans is currently held in a spreadsheet, which could be vulnerable in terms of lost or erroneous data, however as part of the 2016/17 Accounts Receivable audit, an action has been agreed to review a number of ASC charges which are currently off ContrOCC with a view to moving the charges on to ContrOCC. Adaptation loans is one of the areas being reviewed as part of this action. Some issues were also noted with the frequency of reviews and with the coding of income from redeemed loans. There are currently 109 service users with a Deferred Interest Loan, totalling £2.07M. Most have been in place a long time. In the last five years there have only been seven new cases (two from 16/17). Six were redeemed in this financial year.

Follow up

There were 44 management actions agreed as a result of the 2015/16 Client Charging audit.

25 actions have been confirmed as fully and effectively implemented through testing undertaken as part of this audit. 9 actions have been reported as fully implemented, but have not been tested as part of this audit. 1 action has been closed as superseded as it is no longer relevant. 9 actions were found to have been partially implemented, these actions are referenced within the main body of

this report. Revised or re-worded actions have been agreed where necessary; however in some instances the original action is still appropriate. In these instances Internal Audit will continue to monitor and report on the implementation of these actions through the standard Internal Audit follow up process.

Travel & Expenses Review 2016/17

Opinion: Amber	23 January 2017	
Total: 08	Priority 1 = 0	Priority 2 = 08
Current Status:		
Implemented	2	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	6	

Overall Conclusion is Amber

In 2014/15 The Council spent approximately £2.1m on travel and expenses, in 2015/16 that increased to approximately £2.6m, via the travel and expense system. It should be noted that the total amount the Council spends on travel and expenses will be higher than the figures quoted due to payments also being made on purchasing cards and via Imprest accounts. Previously all travel claims were reviewed and signed off by managers before being processed for payment. Following the implementation of the IBC system in July 2015, travel and expense claims of less than £1000 per month no longer require management checking and approval. Moving to self-certification potentially increases the fraud risk in the system. However, it is acknowledged that whilst it reduces visibility of the claims submitted, it also balances management time on excessive administration tasks against any likely losses of attempted fraud or error. In recognition of the increased fraud risk following the move to self-certification of travel and expenses, the objective of the review was to consider the sufficiency and clarity of policies and procedures in this area, adequacy and availability of management information and to complete targeted testing on a sample of employee's claims to highlight any potential fraudulent activity.

Key Findings

OCC are potentially unable to fully evidence and support VAT reclaimed for miles travelled. Nearly a quarter of those sampled (9/40) had not retained their fuel receipts, with many stating that they were unaware that this was necessary, or had apparently been informed that since the move to the IBC it was no longer required. It is unclear where they received this message as it is not consistent with advice from HR, the travel and expenses manual, or tax advice from Hampshire CC.

Managers get a monthly email through showing a high level overview of travel claimed by individuals within their teams. However this email only shows those who have claimed just mileage or mileage and expenses, it does not show those who

have just claimed expenses. Further information is available to managers through the IBC portal, however there are also known issues with what can be viewed via this report. Managers can drill down into their individual team member's travel and expense claims, to view on a line by line basis, however those members of staff that have only claimed expenses cannot be seen in the list of employees. There is currently work underway to try and resolve this.

Monitoring takes place at a cost centre level, however there does not appear to be any monitoring of travel and expenses at a strategic level to highlight any increases in spending or trends in where that is occurring. There has been a 20% increase in the value of travel and expense claims between 14/15 and 15/16.

There are good deterrent controls built into the system that requires people to sign a declaration that their claim is correct prior to submission. A further deterrent was included within the original design when moving to self-certification. This was a system selected sample requesting a sample of managers to check a sample of claims and verify with the employee the appropriateness of travel claimed and check receipts support valid expenses. This was trialled but due to inaccuracies has not been implemented. It is understood there is no longer the intention to use this function within the system, as it is considered a form of duplication of the monthly email issued to managers.

The majority of individuals sampled were able to provide reasonable explanations and account for the mileage they had claimed, the majority were also able to provide receipts to support their expense claims. A small number of instances of over-claiming expenses and mileage were noted. This included one instance where an employee had claimed expenses and also claimed the same expenses via an imprest account, potential over claiming of relocation allowance and a mileage claim that appears higher than business activity. These were referred to the relevant Directorates for investigation and appropriate action has been taken. No deliberate over-claiming has been identified.

Appendix 3

Statement of Assurance – Integrated Business Centre

2016 - 17

Southern Internal Audit Partnership

Assurance through excellence and innovation

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Chartered Institute of Internal Auditors	The Southern Internal Audit Partnership conforms to the IIA's professional standards and its work is performed in accordance with the International Professional Practices Framework *(endorsed by the IIA).*

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 (updated April 2016) [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

Oxfordshire 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 Oxfordshire 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 2016-17 Shared Services internal audit plan, was 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 seven reviews contributing to my audit opinion:

Review	Status	Assurance Opinion
Order to Cash	Final	Adequate
P2P	Final	Adequate
Payroll	Final	Substantial
Taxation (VAT)	Final	Substantial
Master Data Team	Final	Adequate
Employer Pension Responsibilities*	*WIP*	
OCC Payroll Configuration	Final	N/A (consultancy review)

*Assurance provided on processing of information received from the 'employer'

Fieldwork remains in progress in respect of 1 review (Employer Pension Responsibilities), however, I do not consider this exception to have an adverse impact on the delivery of my overall opinion for the period.

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

OCC Payroll Configuration – A review was commissioned during the year with a focus on the OCC payroll configuration within the IBC to gain independent assurance that calculation and reporting of payroll transactions were accurate; and that changes to the payroll configuration were processed accurately and in a compliant manner, ensuring changes were appropriately tested prior to release.

Testing evidenced notably low error rates within the pay runs that informed testing and change control process were generally assessed to be well controlled and compliant. There were no significant issues arising from the consultancy review albeit opportunities were identified to refine, automate and streamline elements of processes followed both within the IBC and OCC. In addition management recommendations have been put in place to enhance channels of communication and resilience in niche areas of expertise.

IT assurance – Assurances with regard the IT environment are not incorporated as part of the Shared Services plan. The HCC internal audit plan provides a comprehensive portfolio of IT coverage affording assurance across the breath of the Council's IT operations, for 2016/17 this included: Capacity Planning & Management; IT Governance; Remote Working Solutions; IT Business Continuity & Disaster Recovery Planning; PSN; Virtualization; Data Centre Security and Cyber Essentials. Our assurance opinion (incorporating these reviews) will be reported to HCC Audit Committee in June 2017 a copy of which will be provided to OCC audit colleagues.

In addition an assurance mapping exercise was undertaken to establish other sources of assurance that could be relied upon to contibute in forming our assurance opinion over the IT control and governance environment. Such assurances included accreditations held in respect of: ISO27001; ISO20000; PSN; PCI; and SAP Customer Centre of Excellence. Each accreditation is subject to ongoing assessment and independent review from its own regularity body.

5. Significant Issues

There were no significant issues evident from the work carried out on the IBC that have impact my assurance opinion.

6. Disclosure of Non-Conformance

In accordance with Public Sector Internal Audit Standard 1312 [External Assessments] requiring '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 Internal 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.

7. Quality control

Our aim is to provide a service that remains responsive and maintains consistently high standards. This was achieved in 2016-17 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.

8.
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
March 2017