Division(s): N/A

AUDIT and GOVERNANCE COMMITTEE – 10 JANUARY 2018

INTERNAL AUDIT 2017/18
PROGRESS REPORT

Report by the Director of Finance

INTRODUCTION

1. This report provides an update on the Internal Audit Service, including resources, completed and planned audits and an update on counter-fraud activity.

RESOURCES

2. The two Senior Auditors on secondment from an external firm are now working with us and covering the chargeable audit days lost through the maternity leave absence of the Principal Auditor. The Principal Auditor has returned from maternity leave, after 5 months' absence, on reduced hours until January. Using the external resource to cover the shortfall in days means that the 2017/18 plan is still on track for delivery.
3. The two Auditors within our team are currently undertaking professional study, both are undertaking the IIA's Certified Internal Auditor Qualification, one has recently passed her final exam and will now be progressing to study the next level to become a Chartered Internal Auditor, the other is due to sit her final exam at the beginning of February.

2017/18 INTERNAL AUDIT PLAN - PROGRESS REPORT

4. The 2017/18 Internal Audit Plan, which was agreed at the 26 April Audit & Governance Committee, is attached as Appendix 1 to this report. This shows current progress with each audit.
5. There have been six amendments to the plan, since the last update. Full details are outlined in appendix 1.

Directorate	2017/18 Audits	Opinion
Communities	S106 *	Red
Resources - ICT	Mobile Computing	Green
People - Public Health	Public Health - Combined Contract Management Audit / Counter Fraud Review	Green
People - Children	Thriving Families - October Claim	n/a
People – Children	Fostering	Amber
People – Adults	AMHPs (Adult Mental Health Professionals)	Amber
Resources - ICT	PSN (Public Services Network) Code of Connection Review	Amber
Resources	Sickness Management	Amber
Resources	Establishment Review & HR data	Amber

*The full report of S106 was presented to the October meeting of the Audit Working Group. Officers attended to discuss the weaknesses identified and planned actions to address and will be attending the February meeting of the Audit Working Group to provide feedback on implementation of the agreed action plan.

Grant Claim Certification:

6. The following grant claims have been reviewed and certified by Internal Audit since the last update to the Audit & Governance Committee:

Local Growth Fund

Integrated Transport and Highways Management Block Grant

Highways Maintenance Challenge Fund

Pot Hole Action Fund

Disabled Facilities Grant

Bus Subsidy Revenue Grant

PERFORMANCE

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

Performance Measure	Target	% Performance Achieved for 17/18 audits (as at 12/12/17)	Comments
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc)	48%	Previously reported year-end figures: 2016/17 60% 2015/16 58% 2014/15 52%
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	100%	Previously reported year-end figures: 2016/17 94% 2015/16 96% 2014/15 83%
Elapsed Time between issue of Draft report and issue of Final Report.	15 days	85%	Previously reported year-end figures: 2016/17 75% 2015/16 48% 2014/15 69%

The other performance indicators are:

- % of 2017/18 planned audit activity completed by 30 April 2018 - reported at year end.
- % of management actions implemented (as at 12/12/17) - 73%.

Of the remaining, there are 13% of actions that are overdue and 14% of actions not yet due.

(At 6 September 2017 A& G Committee the figures reported were 72% implemented, 9% overdue and 19% not yet due)

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

EXTERNAL ASSESSMENT UPDATE

8. Internal Audit have just undergone their external assessment against the Public Sector Internal Audit Standards (PSIAS). This was completed by Cipfa and a copy of the report is included as Appendix 4. The assessment outcome was very positive with only a small number of minor improvements to documentation required. The overall conclusion recorded in the report is that;

   “The service is highly regarded within the Council and provides useful assurance on its underlying systems and processes. I identified some minor areas of non-compliance with the standards, in particular where evidence was not available to demonstrate compliance.”

   Attached to the report in Appendix 4 is the agreed action plan to address the minor issues identified.

COUNTER-FRAUD UPDATE

9. The 2017/18 Counter-Fraud Plan, which was agreed at the 26 April Audit & Governance Committee, is attached as Appendix 3 to this report. This shows current progress.
10. Internal Audit are continuing to work with Adult Social Care to provide Fraud Awareness Training as part of the directorate's direct payment training. Adult Social Care has determined this to be mandatory training for all staff involved in direct payments. Internal Audit have also provided counter fraud training materials for sessions delivered by the Schools Finance Team, directly to schools’ staff, which focused on purchasing cards, cash and expenses.

11. Development of arrangements for working with the City Council Investigation Team, for Counter-Fraud continues. Work is currently being scoped with the City Council Investigation Team for them to lead on the work required to update the fraud risk assessment / register and delivery of proactive counter-fraud activities. They continue to work on Single Person Discount initiative. Future arrangements are now being discussed and the potential for a partnership arrangement to deliver counter fraud from April next year is currently being explored.

12. There have been a minor number of issues received during 2017/18, these have been referred to the relevant service area and are currently being investigated. Internal Audit will monitor and report on the outcome of these as completed.

13. The proactive work has been completed in Public Health, reviewing a small number of contracts to look at whether there are any data accuracy issues and to see whether the contract monitoring is sufficient to identify any potential anomalies. The executive summary for this has been included within the finalised audit reports, see Appendix 2 of this report.

14. Following the last pro-active Blue Badge Operation, led by the Service in partnership with Oxford City Council Investigations Team they have successfully identified and prosecuted the first case of misuse and abuse of the blue badge scheme in Oxfordshire. A second prosecution is currently being conducted. The Service asked that it be noted that the prosecution was undertaken by our own County Council legal team and would like to compliment them on their guidance and professionalism throughout the process which has allowed OCC to successfully prosecute the first case taken to court.

15. The Service have also undertaken a further Blue Badge Operation across Oxfordshire. This ran for 4 days in December in the run up to Christmas. The activity now also included enforcing the use of Disabled Parking Bays with the support of OCC's own Civil Enforcement Team.

National Fraud Initiative (NFI)

16. Work is ongoing to review the various match reports returned in the most recent NFI exercise. For Payroll and Creditors, the majority of these reports have now been worked through with recommended matches and random samples selected for review. There are a couple of reports to be completed. For the completed payroll reports no issues were identified. For creditors, a large number of duplicate payment matches were highlighted, these were sampled on a risk/value based approach. Further review identified a number of these were duplicate payments however these had already been identified and recovered. One duplicate payment had not been identified prior to the NFI (value £29k), this has now been recovered. The Corporate Procurement Team have been given access to the duplicate creditors (by record), so they can feed into the data cleansing exercise being carried out by the IBC.

17. Payroll to Companies House - this is a new match group this year, a review has been conducted against companies' house to identify

current employees that were listed as possible directors. This is currently being reviewed against the register of interest to ensure all potential conflicts of interest have been declared, where relevant.

18. Blue Badges, Concessionary Travel Passes and Residential Permits - These have been passed across to the service who are working through them to establish whether there are any issues. There are a large number of these to work through so the final results of this exercise are not expected until Spring 2018.

19. Private Residential Care Homes - Recommended matches have been reviewed, this highlighted £270k worth of overpayments, of which £173k had already been identified and recovered. The remaining £97k highlighted through the NFI has now also been recovered Additional work has been carried out to identify providers that have appeared in both the 2014/15 and 2016/17 exercise. This analysis has been provided to the service, along with information on whether the issues of recording the death appeared to be on the OCC side or lack of notification from the provider. One provider has been placed on closer monitoring as they have come up in the last three exercises.

20. Direct Payments and also Insurance - Recommended matches have been reviewed, along with a sample of other matches in the reports, no issues were found.

21. Pensions - The pensions matches have been reviewed, a small number have now been passed across to the Pensions Manager to review further. Death certificates for these have been requested, and once received a view will be taken as to whether they need to be investigated further / any recovery of funds to be sought.

RECOMMENDATION

22. **The committee is RECOMMENDED to note the progress with the 17/18 Internal Audit Plan and 17/18 Counter Fraud Plan and the outcome of the completed audits.**

Sarah Cox
Chief Internal Auditor

Background papers: None.
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APPENDIX 1 - 2017/18 INTERNAL AUDIT PLAN - PROGRESS REPORT

INTERNAL AUDIT PLAN PROGRESS 2017/18

Directorate	Audit	Planned start	Status	Conclusion
People	Safer Recruitment	Q3	Fieldwork	
Adults	Payments to Residential and Home Support Providers	Q1	Final Report	Amber
Adults	Client Charging (including ASC debt)	Q3	Fieldwork	
Adults	Personal budgets including Direct Payments	Q4	Scoping	
Adults	Mental Health	Q4	Scoping	
Adults	Adult Mental Health Practitioner Service	Q2	Final Report	Amber
Childrens	Thriving Familes – October Grant Claim	Q2	Final Report	N/A
Childrens	Thriving Familes – January Grant Claim	Q4	Scoping	
Childrens	Thriving Familes – March Grant Claim	Q4	Planned for March	
Childrens	CEF Contract Management	Q3	Scoping	
Childrens	Fostering Service	Q2	Final Report	Amber
ICT / Childrens	Childrens Social Care IT System Replacement	Q4	Scoping	
Public Health	Combined Contract Management Audit / Counter Fraud Review	Q2	Final Report	Green
Communities & Resources	Capital Programme - including follow up of 16/17 audit findings	Q4	Planned for Feb/March	
Communities	S106	Q1	Final Report	Red
Communities	Supported Transport	Q3	Fieldwork	
Communities	Research and Innovation	Q3	Fieldwork	

Communities	Highways Contract Payment - follow up	Q4	Scoping	
Finance	Pensions Administration	Q3	Fieldwork	
Finance	Pensions Fund	Q4	Scoping	
Finance	Accounts Receivable	Q4	Planned for March	
Finance	Payroll	Q4	Planned for February/March	
Finance	Purchasing / Procurement	Q3	Fieldwork	
Finance	VAT	Q3	Draft Report	
Finance	Insurance	Q4	Scoping	
Finance / Corporate	Grant Certification	Q1- Q4	6 complete	n/a
Finance / Communities	Security Bonds	Q3	Fieldwork	
Corporate / ICT	Fit for the Future - Digital First Platform - Programme Governance Review	Q2	Final Report	Amber
HR / Corporate	Sickness management	Q1/Q2	Final Report	Amber
HR / Corporate	Establishment control / HR data	Q1/Q2	Final Report	Amber
ICT	Cyber Security	Q2	Final Report	Amber
ICT	Disposal of Equipment	Q1	Final Report	Amber
ICT	PSN compliance (Public Services Network)	Q3	Final Report	Amber
ICT	Mobile Computing	Q3	Final Report	Green
ICT	ICT backup and recovery	Q4	Scoping	
ICT / Childrens	Childrens Social Care IT System Replacement	See above under Childrens	See above under Childrens	See above under Childrens

Since September 2017 update to Audit & Governance Committee the following amendments have been made to the Internal Audit Plan:

People (Adults & Children)	**Removed** from plan: Transitions - from Children's to Adults Service	This audit has been removed from the plan due to the fundamental review currently in progress with significant work underway to improve the processes with transitioning from Children's to Adults. This will be considered again as part of 2018/19 audit planning.
Resources – Finance	**Removed** from plan: Main Accounting – Feeder Systems. **Replaced** with VAT Audit.	The audit of Feeder Systems has been removed from the plan as some of the key feeder systems were being tested as part of other individual audits within the plan. The audit was replaced with VAT. This audit was requested by management due to a gap in governance being highlighted. The audit activity focussed on Output VAT charged on the income from our sales of supplies and services and has tested the level of compliance across the organisation.
People - Children's	**Removed** from plan: EDT (Emergency Duty Team)	From April 2017, the EDT was split into Children and Adults. The audit of AMHPs (Adult Mental Health Practitioners) has been completed however the Children's Audit of EDT has been removed from the plan due to the fundamental review and service redesign currently underway. This will be considered again as part of 2018/19 audit planning.
Resources – ICT	**Removed** from plan: ICT Incident Management	The audit has been removed from the plan as the future of the current IT incident management system is dependent on the decision on the future delivery model of ICT at the end of March. No further developments of the existing system are being undertaken.
Corporate	**Removed** from plan: Contract Management System	As reported to the AWG, Procurement and Commercial, encompassing contract management oversight, is being reviewed as it is an area identified for transformation. An Interim Head of Procurement and Commercial has been appointed to develop a new strategy, systems, processes and governance. This is being undertaken in conjunction with the work PWC are completing including an analysis of our third party spend. This audit had planned to review the implementation and utilisation of the new contract management system including the business intelligence reporting to the Commercial Service Board. The audit has been removed from the plan as it has already been **recognised** by management that the system is currently not being used to its full potential. There is a newly established ECMS Steering Group who will be overseeing the improvements required. The Commercial Services Board has not met for the last 5 months, and has been suspended pending the outcomes of the review. Therefore, assurance on contract management this year will be provided via individual audits. The individual audits covering contract management during 2017/18 are CEF Contract Management, Supported Transport, Public Health, and Capital follow up. Contract

		payments have also been reviewed as part of Adult Social Care Payments to Providers and Highways Payments audits. This will be considered again as part of 2018/19 audit planning.
Corporate	**Removed** from plan: Programme Management Office	This has been removed from the plan as this area is currently subject to review as part of the work being undertaken with PWC. This will be considered again as part of 2018/19 audit planning.

APPENDIX 2 - EXECUTIVE SUMMARIES OF COMPLETED AUDITS

These are the completed audits since last report to the Audit & Governance Committee in September 2017.

S106 2017/18

Opinion: Red		
Total:31	Priority 1 = 5	Priority 2 = 26
Current Status:		
Implemented	3	
Due not yet actioned	3	
Partially complete	1	
Not yet Due	24	

Overall Conclusion is Red

It is acknowledged that there are a number of reviews ongoing within the Communities directorate at present with the aim of improving processes. The Review of Single Response and the Development Processes Review have been taken into account by Internal Audit wherever possible in noting findings and any actions already identified as necessary as a result of these reviews.

Strategic Reporting

- The audit has identified a lack of strategic reporting on S106.
- It was also noted that there is currently no reporting on projects in the capital programme which have been forward funded and include an element of Section 106 contributions as part of the funding.

Over Reliance on Key Staff and Staff Guidance

- It was noted that there is also over reliance on several key members of staff.
- Testing has identified areas where staff guidance requires updating.

IT Systems

- There are various spreadsheets, databases and systems in use throughout the processes involved in dealing with a planning application and producing and managing a Section 106 agreement. The systems don't talk to each other, the spreadsheets are complicated and difficult to interpret for those who are not familiar with them.

Working Arrangements

- Silo working appears prevalent throughout the planning application and section 106 processes.

Roles and Responsibilities

- It was noted that there is a lack of clarity over roles and responsibilities in some areas.

Monitoring of Key Planning Application Information

- There is no systematic and consistent monitoring of committee dates, reports and recommendations or of outcomes from the planning application process.

Securing of Community Infrastructure Levy (CIL) Monies

- There is no protocol in place for the Council to secure monies for Districts where CIL has been adopted.

Lack of Sign Off of Contributions Secured via S106 Agreement

- There is no sign off, of contributions secured via a S106 agreement.

Single Response Sign Off and Scheme of Delegated Powers

- Not all single responses are currently signed off and for those that are, sign off arrangements are unclear and inconsistently applied.

Single Response Deadlines and Escalation Process

- There is no clear and consistent escalation process in place for MPAT (Major Planning Applications Team) to chase late team responses
- Performance in meeting District Council deadlines for single response is below target

Planning Appeals, Management and Recording

- Inconsistencies and omissions were identified in the recording of appeals information on the PANDA database and with appeals information saved to individual appeals folders.
- Inaccuracies were noted in the information recorded on pooling spreadsheets

Lack of Clear Evidence Trail

- Instances were identified within the single response, planning negotiations and planning obligations processes, where evidence trails were incomplete.

Review Process Once S106 Agreements are in Place

- It was noted that there are differences in the way in which Planning Obligations staff record their monitoring of live S106 agreements
- It is not clear whether there is sufficient monitoring of whether invoices have been raised as part of the review process.

Accuracy of Information Recorded on DFACS (Developer Funding Accounts Sheet)

- An instance was identified where the accuracy of the information recorded on DFACS was queried by a Service. It has not been possible to confirm whether the inaccuracy was with DFACS or with service records / understanding.

Mobile Computing Review 2017/18

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

Overall Conclusion is Green

The Council's Fit for the Future initiative has seen a significant increase in the number of mobile devices. The majority of technology users at the Council have been issued with a new laptop and smartphone as part of the Connecting You programme.

The use of mobile devices is adequately covered by a number of corporate policies, including the Acceptable Use Policy, Removable Media Policy and the Remote Working Policy. These policies cover security standards, including physical security, logical security and the requirement for mobile devices to be encrypted. Staff awareness of their responsibilities in regard to using mobile devices is through an e-learning course that is based on the Acceptable Use Policy. Whilst the course is mandatory, we have previously reported that users are not followed up if they have not completed it.

An inventory of all laptops, tablets, mobile phones and USB memory sticks is held and maintained up to date. The laptop inventory is available on Microsoft System Center Manager and the other inventories are on spreadsheets.

All laptops are encrypted during the build process using Microsoft Bitlocker. Microsoft Intune is used to enforce a security policy on smartphones that requires password authentication and encryption. It also allows devices to be wiped if they are reported as lost or stolen. The timeout setting on Microsoft Intune is 15-minutes and we understand that this is the maximum that can be set and that the default setting is one minute. Allowing a mobile device to be set with a 15-minute timeout increases the risk of unauthorised access. A new version of Microsoft Intune has recently been implemented and allows a granular level of access to be defined. It should be appropriately configured given that on the previous version the majority of users have full access.

Corporate policies stipulate that only USB memory sticks supplied by ICT should be used but this is not enforced by any technical solution. This risk has previously been reported and ICT have reviewed technical solutions and found that they are not practical to implement. In addition to the risk of unauthorised data disclosure, the control of USB memory sticks is also key

from a cyber risk perspective and hence it is important that it be kept under review by adding it to the risk register.

Public Health Proactive Fraud Review 2017/18

There are not any management actions for this report

Overall Conclusion is Green

Public Health spends around £26m on contracting out health services, such as smoking cessation, weight management and sexual health services. Payment arrangements for the contracted service vary per contract, however a number of the contracts pay a proportion of the payments as incentives based on performance.

There have been a small number of other local authorities who have been subject to attempts by providers of public health services to produce false information when submitting data for payment. The objective of the review was to provide assurance on the robustness of contract monitoring and payments processes to ensure that any potential irregularities are identified and queried.

The review looked at a sample of three contracts, considering the accuracy and integrity of source data, the robustness of contract monitoring including the review of trends and potential irregularities and also the payments processes were tested.

From the sample of contracts reviewed there were no major concerns or indications of potential fraudulent activity. It is concluded that the contract monitoring applied to each of the contracts sampled was proportionate to the value of the contract and level of risk. Whilst it is acknowledged that the risk of fraud cannot be completely mitigated, the service has established a good balance between control and risk of loss.

Troubled Families Claim October 2017/18

Opinion: N/A	04 October 2017	
Total: 3	Priority 1 = 1	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	3	
Partially complete	0	
Not yet Due	0	

Phase 2 of the Troubled Families Programme started in September 2014, and OCC has submitted between two and three claims per year since September

2015. All management actions from the audit of the previous claim (March 2017) have been reported as implemented by the responsible officer. The current claim is due to be submitted by the 31st October, and consists of 193 families for Significant & Sustained Progress (SSP) and 1 family for Continuous Employment.

19 families were removed from the SSP claim, and 4 from the Continuous Employment claim, following Internal Audit testing, due to issues with Criminality data checks, duplication with previous claims and family composition errors.

These had not been identified prior to the submission of the claim to Internal Audit. Subsequently additional data verification checks were carried out to ensure the issues found did not apply to any other families, so Internal Audit are satisfied that the current claim can therefore be signed off. The related project management issues will now be addressed during a review of the submission process which will be undertaken by the Troubled Families team.

Fostering Service 2017/18

Opinion: Amber	16 November 2017	
Total: 15	Priority 1 = 2	Priority 2 = 13
Current Status:		
Implemented	1	
Due not yet actioned	2	
Partially complete	0	
Not yet Due	12	

Overall Conclusion is Amber

This audit covered both external foster placements where children are placed with carers employed by Independent Fostering Agencies (IFAs) and internal foster placements where children are placed with foster carers employed directly by the Council. The audit followed up on the management actions agreed following the Internal Audit of Foster Care Payments undertaken in 2015/16.

In relation to external placements, since the start of the audit, the Placement Service Manager has left. It is also noted that it is planned that the Placement Service will become part of Joint Commissioning. Whilst exact timescales for this move are not clear, it is noted that this move could result in changes to responsibilities and processes around both arrangement of new external placements and contract monitoring arrangements.

In relation to internal foster placements, the Service Manager responsible has recently changed.

It is acknowledged that the Service are in the process of sourcing and implementing a new IT system which will replace Frameworki. This has

been considered during the audit and the management actions agreed have been discussed with a view to how processes could change when the new system is implemented.

IFA Foster Carer Payments

It was found that there are still missing and incomplete Individual Placement Agreement's (IPAs) for externally placed children. From a sample of 20 new placements, no IPA had been completed for sign off for 2 placements, for a further 10 in the sample the draft IPA had not been signed by OCC and / or the Independent Fostering Agency (IPA). The management action agreed in 2015/16 to reconcile current placements to IPAs held has not been completed. The IPA is the agreement between the Council and the IFA in relation to the foster placement, it is where the agreed fee rate should be documented and also contains key information on the placement, including carer details and expected outcomes for the child.

Although not to the same degree as noted during the previous audit, it was found that there are still issues in getting the information required to produce an IPA from Placement Officers. There still does not appear to be an effective process in place for escalating missing information. There is also no systematic process in place to monitor or follow up on the return of outstanding IPAs with external agencies.

Inconsistencies were again noted between the fee rates documented in the IPA or draft IPA and the fee rates that the Council were being invoiced for / paying. This included both higher and lower than expected rates. There were some instances where it appeared that the rate recorded in the IPA was incorrect, there were other instances where it was reported that the rate payable had changed from that recorded in the IPA, but there was no documentation confirming this change in arrangements (documentation of these changes was covered by a management action agreed as part of the previous audit). An instance where the Council had been overcharged by the provider was noted, it is not clear whether or not the overpayments made have been recovered. Action agreed as a result of the previous audit to provide clarity between the Placement Team, Administrators and Business Support on the rate the Council should be paying does not appear to be in place. There is no systematic process in place to ensure that fee rates agreed for individual placements are correct and in line with standard rates agreed under the two framework agreements. It is also apparent that there is no systematic monitoring or review of payments being made to ensure that these are in accordance with the IPA or with documented, appropriately approved instructions to pay charges which vary from those agreed.

A number of inconsistencies were noted between IPAs (the Council's agreement over the external placement with the IFA), Frameworki (the current Childrens management information system) and the live agency placements spreadsheet (used for monitoring and processing of payments to IFAs for external placements). There were not of the same level as noted during the previous audit, but there were some inconsistencies which could impact on financial reporting or forecasting or could cause unnecessary confusion. A management action to review inconsistencies identified as a result of the previous audit has not yet been fully implemented.

In addition to the inconsistencies noted from Internal Audit testing, in September 2017, Corporate Finance identified, through the monthly budget monitoring process, a £1M change in forecast which prompted further investigation. Whilst it was reported that not all of the £1M change was found to be in relation to placements, investigations identified inconsistencies in information recorded on Frameworki and the live agency placements spreadsheet. Work is ongoing by the Service to fully check records held for existing placements.

There is a lack of clarity over how one off payments to IFAs should be documented and approved. It was also noted that for the sample reviewed, a high proportion of purchase orders (POs) for one off payments are still being raised retrospectively. Again, this is an issue that was raised during the previous audit. Although the instruction from senior management that POs must be raised in advance of invoices being sent in by providers was give, there does not appear to have been any feedback or escalation where these instructions are not being followed.

Some delays were noted in the raising of POs for new external placements and in the processing of invoices. Improvements in both areas can be seen from the previous audit and it is acknowledged that staffing capacity issues have been reported both in relation to Placement Admin and Business Support (Finance).

From sample testing undertaken on provider invoices, there were numerous examples where providers are still addressing invoices to Oxfordshire County Council postal addresses rather than Hampshire IBC. 10 different providers covering 13/20 new placements tested and 3/4 one off payments tested were still found to be addressing invoices to OCC postal addresses. This was raised during the previous audit with a management action agreed.

Internal Foster Care Payments

Issues were noted with the timeliness of completion of movement forms. The service has a requirement that movement forms are completed and approved within 24 hours of a new placement starting. From review of all movement forms completed during 2016/17 it was found that 59% had not been approved within 24 hours of the placement start date. On average, movement forms were found to be being approved 6 working days after the placement start date.

Timeliness of completion of movement forms has been raised in the audits of Foster Care Payments carried out in 2011/12 and 2015/16. A management action is currently outstanding from the 2015/16 audit covering the production and review of management information on time taken to complete movement forms for new placements. Internal Audit have identified that management reports can be run from Frameworki and discussions have been held with the Service Manager Placements in relation to review of this information going forward.

Policies and Procedures

No significant weaknesses were identified from testing undertaken as part of this audit. It is noted that the Foster Carer Handbook has recently been

updated and will be published following review by the Service Manager Fostering.

Vetting & Assessment

Processes and controls tested in this area were found to be operating effectively. No significant findings to report.

Training & Ongoing Support

Although some issues were noted in relation to monitoring of completion of reviews and training by management in one area, it has been reported that this was due to management staff turnover. It has been reported that staffing has settled down. It has been reported that improved management information on the annual review process is now being produced from Frameworki with reporting on mandatory training in the process of being developed.

Adult Mental Health Professionals Service 2017/18

Opinion: Amber	16 November 2017	
Total: 6	Priority 1 = 2	Priority 2 = 4
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

Overall Conclusion is Amber

In April 2017, the Adult Mental Health Professional Services split from the Emergency Duty Team, as part of a service redesign. Since then it has been a standalone service.

Policies and Procedures maintained by the AMHPs team contain references to national guidance, as such help to ensure that AMHPs work in line with national and legal requirements. However, the documentation is not easily accessible, there are a number of out to date versions that are easier to access than the most up to date version.

A sample of referrals and assessments were reviewed and there were no issues noted. All had been signed appropriately and had the doctors' notes on file, from the required two doctors. Dependents needs were also taken care of, where applicable.

A lot of useful information is being recorded on referrals and assessments however it is not currently being used to support the running of the service, identify trends, or highlight issues.

Rotas were reviewed and it was found that the service were able to cover the 24-hour obligation, which is somewhat helped by reliance on agency staff.

There is an ongoing issue with HR errors with AMHP records, and inconsistencies between IBC and SAP, however the AMHP Manager is continually working through these with HR, on a monthly basis. One individual was found during the audit testing to still be in receipt of their rota'd AMHP allowance when they had taken up a substantive post. The casual and bank staff tested were found to have been paid correctly for time worked.

There is a known overspend on the AMHPs budget, mainly due to the dependency on the use of agency staff. Steps have been taken to try and reduce this, including redesigning the service and recruiting eight substantive posts. Due to recruiting issues however, not all of these positions have been filled, therefore in the interim there is still a reliance on agency staff, to be able to maintain the service. Effective forecasting is being undertaken and the data is being updated as often as possible. This helps to give the most accurate forecasting positon. The position is also being accurately reported to Cabinet.

Where clients are known to both the NHS and OCC, OCC staff do not currently have access to the NHS information. This potentially creates a safety issue for staff and clients, if they are not completely aware of the clients' mental health history. Some staff also work for the NHS and use the NHS systems and email addresses. Whilst AMHPs staff have been reminded of the need to use OCC email addresses, and send data securely, without a single document repository, and two systems to work on, there remains an inherent risk that data could be transported insecurely. This has already been acknowledged by management and efforts are being made to try and get OCC staff access to NHS systems, to at least allow for a complete history of clients to be obtained.

PSN (Public Services Network) Code of Connection Review 2017/18

Opinion: Amber	22 November 2017	
Total: 4	Priority 1 = 0	Priority 2 = 4
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	4	

Overall Conclusion is Amber

The Information Management team are responsible for all areas of IT compliance, including PSN compliance, and a member of the team has been allocated responsibility for leading on this work. The current PSN compliance certificate is valid until 21st April 2018 and there is a high-level plan in place to ensure the next submission is made ahead of this date. We have found that all PSN documents are held on the network and are accessible to all users in ICT. As some of the documents contain sensitive information regarding

security configurations and vulnerabilities, access to them should be restricted to only those staff that require it.

A core area of the PSN Code of Connection is complying with a number of Information Assurance (IA) conditions. Previously organisations were expected to demonstrate explicit compliance with these conditions, but the submission has now been simplified and compliance is referenced in the commitment statement signed by the Chief Executive. We found that no details are held of how individual conditions are met through policies, procedures and processes and hence there is a risk that any potential gaps are not identified and addressed, and that compliance cannot be evidenced should OCC be subject to an on-site PSN assessment. OCC's cloud services have also not been security assessed against the stipulated Cloud Security Principles, which is guidance issued by the National Cyber Security Centre. We also note that a declaration is made on the CoCo that two specified risks have been accepted by the business and authorised by a Senior Officer, but there is no evidence to confirm this.

An IT Health Check (ITHC) is commissioned annually and performed by an appropriately accredited supplier. The most recent ITHC was completed in October 2017 and the scope was confirmed to be in accordance with PSN requirements. The ITHC has highlighted a number of vulnerabilities and Remedial Action Plans (RAP's) are being developed to address these. A number of the remedies require patches to be applied and it is noted that the corporate patching policy is in the process of being reviewed and updated. A review of security patching was included within the cyber security audit undertaken in May 2017 and hence has not been revisited here in any detail. However, we would re-emphasise the importance of applying patches on a timely basis and both PSN and other cyber security standards suggest that critical vulnerabilities should be patched within 14 days. This is not reflected in the revised patching policy as we understand that resourcing a 14-day patch cycle is an issue. There is an open management action from the cyber security audit in regard to this point and we have further discussed the issue with the Information Services Manager to ensure it is reconsidered before the patching policy is finalised.

Sickness Management 2017/18

Opinion: Amber	14 December 2017	
Total: 4	Priority 1 = 2	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	4	

Overall Conclusion is Amber

The implementation of IBC in July 2015 resulted in changes to the process of recording and manging sickness absence. Staff became responsible for

recording their own sickness absence on IBC. IBC placed greater responsibility on managers to monitor sickness absence within their teams.

From sample testing undertaken on 10 non-school teams with little or no sickness absence recorded on IBC, 50% had sickness episodes which had not been recorded on IBC. There was one example noted where a period of sickness absence of approximately 5-6 weeks had not been recorded, the manager was not aware of this prior to being advised by Internal Audit. Sickness absences identified as missing from IBC during testing, at the time of writing this report, have not been updated.

From sample testing undertaken on 10 schools with little or no sickness absence recorded on IBC, 90% had sickness episodes which had not been recorded on IBC. 4 schools reported that they only record long term absence on IBC as inputting of sickness data is a duplication of information which has to be entered on to their Management Information System for the schools' census. Another school reported that they only record unpaid sickness leave on IBC. 3 schools sampled reported that they were not aware that they needed to record sickness absence on IBC

Where sickness absence is not recorded accurately on IBC incorrect payments may be made to staff, managers information on sickness will be inaccurate and the accuracy of strategic workforce data will be affected.

From review of the guidance available, it was found that there is clear guidance available for staff and managers on recording and managing sickness absence. Management information available to team managers via IBC and the HR dashboard was also found to be clear and comprehensive. It was noted that strategic information produced has recently been reviewed and refreshed.

Testing undertaken on both schools and non-schools staff where sickness triggers had been reached, found that although there was not always evidence of formal sickness review meetings having taken place, there was evidence that managers were reviewing and discussing sickness absence with staff.

Establishment Control & HR Data 2017/18

Opinion: Amber	14 December 2017	
Total: 5	Priority 1 = 1	Priority 2 = 4
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

Overall Conclusion is Amber

Issues with the accuracy of establishment data are recognised by Corporate HR. Reference was made to this in the Director of HR's 2016/17 Corporate Lead Statement where it was reported that 'the accuracy and credibility of workforce data is not robust'. The statement highlighted the need for data cleansing and continuous maintenance, as well as improvements to the visibility of and access to staffing data. Since then, there has been a review of organisation management which has acknowledged the critical importance of the org structure as it drives payroll, workforce planning and budget management, however it has also been acknowledged that there are challenges around the time it takes to correct this information on SAP, particularly when significant re-structures need to be reflected. It has been reported that this has been discussed at the IBC Shared Services Board and has now been referred to the IBC Strategic Partnership Board so that the issues can be reviewed and resolved.

Whilst testing undertaken as part of this audit has focussed on the accuracy of establishment data in terms of team structures, posts within the team etc, a separate audit of sickness management has identified issues with the robustness of sickness data. Testing undertaken as part of the sickness management audit identified significant instances of sickness absence not being accurately recorded on IBC.

As detailed above, the accuracy of OCC HR establishment data is a known issue. From the establishment report reviewed by Internal Audit, it was noted that there were 1931 unoccupied posts as of the 30th June 2017, many of which are obsolete and will not be recruited to in the near future. In response to this, arrangements have been made for the Information Systems Officer to receive training on the Hampshire SAP system with a view to enabling OCC access to the Hampshire system so that errors in establishment data can be corrected, vacancies can be reviewed and obsolete posts removed. There are ongoing discussions with Hampshire in relation to this.

A reminder has also been sent out to managers regarding keeping team structures up-to-date. However, currently there are clear issues with the quality of establishment data available to management and Strategic HR, reducing its usefulness for decision making and strategic planning.

Establishment Structure: Sample testing showed that 8 of 10 teams had some errors in their establishment structure or data. This mainly related to unoccupied posts (6/10 teams included obsolete posts in their structure), however there were also issues with inaccuracies in job titles and employees without an assigned line manager on the system (as of the end of June there were 95 non-casual employees without a listed line manager, and 186 unoccupied posts). This appears to be caused by a line manager leaving or moving to a new post. In these cases, any line management tasks should redirect to the next line manager in the structure, however again this causes issues with the accuracy of establishment data in the organisation. On a

positive note, job descriptions were in place and up-to-date for all 10 teams sampled.
Testing of honoraria payments identified a number of instances where honorariums were being paid where an employee was temporarily taking on additional line management responsibilities and so should have been “acted up” into the post. Where an employee is paid an honorarium instead of acting up in a role, they may not have the required system access and permissions.

Service Restructures: Restructures affecting over 10 staff are managed by the HR Business Partner, who works with the service area to determine the changes to be made and then liaises with the IBC to process these changes on the system. However, there have been issues with adhering to the timescales set by the IBC for providing the relevant data, due to longer consultation periods and difficulties with receiving the required information from managers. Minor data errors were identified during testing of service restructures, which did not affect pay. The establishment structure was not generally affected, and where this had happened the issue had been identified and corrected prior to the audit.
However, as discussed above, action is being taken by Strategic HR to enable closer working between OCC and HCC to improve the accuracy of OM restructure data.

Management Information: Line managers are able to access reports on the IBC portal in relation to their team structure. Information available includes areas including sickness, diversity, pay and DBS checks. However, accuracy issues have been identified in relation to sickness data (see separate report on Sickness Management 2017/18) with audit testing highlighting significant levels of sickness not being recorded on IBC, and the accuracy of information on DBS checks. Recording in relation to DBS checks is to be reviewed as part of the 2017/18 Safer Recruitment audit.

APPENDIX 3 - 2017/18 COUNTER FRAUD PLAN - PROGRESS REPORT

Activity	**Planned Qtr Start**
Review and update of fraud risk register. Identification of new fraud risk areas.	Ongoing
NFI 2016 match - review and investigation of data matches	Q1 - ongoing
Reactive investigations - continued from 2016/17 plus new referrals.	Ongoing
Fraud awareness sessions.	Ongoing
Proactive Fraud Review - Travel and Expenses	Complete - Final Report Green
Proactive Fraud Review - Procurement Cards	Complete - Final Report Amber
Combined contract management audit / proactive fraud review - Public Health	Complete – Final Report Green
Continue with development of working arrangements with the City Council for Counter Fraud to include: - Single Person Discount Review (including extending to other reliefs/discounts) - Support with the NFI 2016 data match (focus on areas which have previously returned positive results) - Support with reactive investigations - Development of a plan of proactive fraud reviews, potential areas for 17/18 include Procurement, Direct Payments, Deprivation of assets/Non declaration of income and Insurance.	Q1 - Q4

APPENDIX 4 – EXTERNAL ASSESSMENT AGAINST PUBLIC SECTOR INTERNAL AUDIT STANDARDS

Validation of the self-assessment of the Internal Audit Service

Oxfordshire County Council

Lead Associate: Elizabeth Humphrey, CPFA

Internal QA: Diana Melville, Governance Advisor, CIPFA

18th December 2017

Validation of the self-assessment of the Internal Audit Service at Oxfordshire County Council (November 2017)

Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS) which have been in place since 1 April 2013, were revised on 1 April 2016 and have been further revised on 1 April 2017. The standards require periodic self-assessments and an assessment or validation of a self-assessment by an external person every five years. Now that the standards have been in place for four years, Oxfordshire County Council's Internal Audit Service has undertaken the required self-assessment and commissioned this validation. The self-assessment also included checking conformance with the Local Government Advisory Note (LGAN) where this has requirements in addition to those in the PSIAS.

The validation was carried out through a process of interview and document review. A list of interviewees is included as appendix 2. I should like to thank all those who took the time to talk to me for their help. I reviewed two audits carried out during the 2016/17 financial year and, as part of the self-assessment, a further five audits were checked. I examined key documents, including the Charter, Strategy and reports to the Audit and Governance Committee.

The service is highly regarded within the Council and provides useful assurance on its underlying systems and processes. I identified some minor areas of non-compliance with the standards, in particular where evidence was not available to demonstrate compliance.

I have made some practical and pragmatic medium priority recommendations (R) and lower priority suggestions (S) to improve compliance with the standards. The Chief Internal Auditor (CIA) will need to take action to implement them and an action plan is included as appendix 1.

Summary findings and recommendations

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
Mission	Full	The Charter includes the mandatory internal audit mission		
Core principles of internal audit	Full	The core principles have been integrated into the work of internal audit and I was provided with many examples of this. One area for development is around demonstrating the alignment of the service to the strategies, objectives and risks of the organisation	See R5 and R8	

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
Code of Ethics	Full	All interviewees stressed the emphasis placed on integrity by the audit team and their independence and objectivity There is no reference to the *Seven Principles of Public Life* (the Nolan Principles) in any of the key documents	Include details of the *Severn Principles of Public Life* in the Charter or Manual	R1
Attribute standards				
1000 Purpose, authority and responsibility	Full	The Charter and Strategy contain almost all the required details and are routinely discussed with senior management and the Joint Audit Committee **LGAN p8** The Charter does not explicitly state that internal audit's remit extends to the entire control environment of the Council	Include a statement in the Charter to state that internal audit's remit extends to the entire control environment of the Council	R2
1100 Independence and objectivity	Full	The independence and objectivity of the audit section was emphasised by all interviewees		
1200 Proficiency and due professional care	Full	The working papers showed that audits are well planned and undertaken with care **Standards 1210.A2, 2120.A2 and 2210.A2** There was little evidence of broader fraud risks (ie, those where the gain was not immediately financial or involved collusion, etc) being considered as part of audit planning	Improve thinking about fraud risks to consider frauds that do not have an immediate financial gain, collusion, etc	R3
1300 Quality assurance and	Full	There is a detailed QAIP plan that covers all the required aspects.		

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
improvement programme		**Standard 1311** Self-assessments are currently carried out within the audit section, with the monitoring officer undertaking an independent satisfaction survey. It could be useful to involve others in the self-assessment process, especially the Audit and Governance Working Group	Invite others from within the Council, for example the Audit and Governance Working Group, to contribute to self-assessments	S1
Performance standards				
2000 Managing the internal audit activity	Partial compliance	**Standards 2010, 2010.A1 and LGAN p15** Although the annual audit plan is risk-based, there is no formal methodology for drawing it up. The report accompanying the annual audit plan does not include some of the specific requirements: • A statement about how the service will be developed • The connection to the Audit Charter • How the service contributes to delivering organisational objectives and priorities • Prioritisation of assignments • The resources required for each assignment • The split between assurance and other audit work	Document the methodology used to draw up the annual audit plan Include in the annual plan or covering report: • Reference to how the team will be developed (for example, outlining the training being undertaken) • Information regarding planning in accordance with the Charter • The contribution made to delivering organisational priorities and objectives Identify on the plan: • Assignment priorities • An estimate of the resources required for each assignment • The split between assurance and other audit work	R4 R5 R6

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
2100 Nature of work	Partial compliance	**Standard 2110.A1** Ethics-related objectives, programmes and activities are not routinely considered when planning audits **Standards 2120.A1 and 2130.A1** There is no specific reference to Council objectives in audit plans. Making this link would show how audit contributes to the achievement of Council objectives **Standard 2120.A2** See above for comments regarding considering fraud risks in planning audits	Undertake audits of the Council's ethical arrangements, either as a one-off or by building ethical matters into relevant audits Improve audit planning by making specific references to Council objectives	R7 R5 R3
2200 Engagement planning	Partial compliance	**Standards 2201 and 2210.A3** Audit planning and the terms of reference do not specifically address: • The strategies and objectives of the activity and how it controls its performance • The adequacy and effectiveness of the activity's governance, risk management and control processes compared to a framework • Opportunities to add value **Standard 2210.A2** See comments above regarding planning around fraud risk **Standard 2240.A1** Detailed work programmes (RACE) are drawn up to support each audit, but these are not routinely formally	Amend the audit terms of reference to address the required items Ensure that the RACE is approved before implementation	R8 R3 R9

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
		approved before implementation		
2300 Performing the engagement	Full	Audit working papers are clear and easy to follow. They deliver the objectives of the terms of reference. **Standard 2330.A1** There is no reference to internal audit in the Council's retention schedule and the information on retention in the manual is incomplete	Develop and document a retention schedule for internal audit's records	R10
2400 Communicating the results	Partial compliance	**Standard 2450** The annual audit opinion does not explicitly refer to the strategies, objectives and risks of the Council nor does it make explicit reference to governance and risk arrangements, focussing only on internal control The opinion for 16/17 does not include a PSIAS conformance statement nor reference to this validation of the self-assessment	Revise the annual audit opinion to address the strategies, objectives and risks of the Council. Include specific reference to governance and risk management arrangements	R11
		LGAN p19 Audit terms of reference give details of the report circulation list but this is not included on the audit report. If the accompanying email is detached, this information is not available to readers of the report	Include the report distribution list on audit reports	R12
2500 Monitoring progress	Full	The follow-up process is robust and meets the requirements of the standards		

Standard	Compliance	Findings	Recommendations and suggestions	Rec no
2600 Communicating the acceptance of risks	Full	Unmitigated risks have been raised with senior management and the board and resolved through this approach		

The Chief Internal Auditor has details of the findings, standard by standard.

Elizabeth Humphrey CPFA

Appendix 1: action plan

Recommendations

No	Recommendation	Response	Responsible officer	Action date
R1	Include details of the *Severn Principles of Public Life* in the Charter or Manual	These are listed for all staff on the intranet. The Charter will be updated to list these Principles.	Sarah Cox	January 2018 to update the Charter. Next presented to Audit & Governance Committee in July 2018.
R2	Include a statement in the Charter to state that internal audit's remit extends to the entire control environment of the Council	The Charter currently states that "Audit work is included to ensure an opinion can be given on the whole of the control environment". The Charter will be updated to make this more explicit.	Sarah Cox	January 2018 to update the Charter. Next presented to Audit & Governance Committee in July 2018.
R3	Improve thinking about fraud risks to consider frauds that do not have an immediate financial gain, collusion, etc	Whilst there is evidence that the team are considering fraud risks throughout their evaluation of controls, this external assessment has highlighted that evidence of the consideration of this was not always documented in detail at audit planning stage. Fraud risk is considered and documented in scoping notes, specific fraud references are included in some terms of reference where appropriate, whilst others have generic wording. At the team meeting in January there will be a session to discuss improvements to recording of fraud risk at the planning stage and how this should be documented in scoping notes, TOR and RACE. Improvements to the fraud risk register which are currently underway will assist with the documentation of fraud risk.	Sarah Cox	January 2018 team meeting to agree improvements in evidencing fraud risk considerations.

No	Recommendation	Response	Responsible officer	Action date
R4	Document the methodology used to draw up the annual audit plan	The outline methodology is documented in audit planning working papers and the overall approach outlined in the Internal Audit Strategy and Annual Plan, however it is acknowledged that a further working paper to support the final inclusion of audits within the plan should be maintained.	Sarah Cox	February 2018 as part of 2018/19 Internal Audit Planning Process.
R5	Include in the annual plan or covering report: • Reference to how the team will be developed (for example, outlining the training being undertaken) • Information regarding planning in accordance with the Charter • The contribution made to delivering organisational priorities and objectives	The Internal Audit Strategy and Plan for 2018/19 will include reference to team development. It will also confirm the connection to the Internal Audit Charter. Audit planning has already commenced for 2018/19 and improvements already in place to ensure that the plan for next year will be linked to the revised corporate objectives and be more closely aligned to the risk management process and the recently improved strategic risk register. The overall methodology documented within the Internal Audit Strategy and Plan will be updated to reflect the improvements to the planning process.	Sarah Cox	April 2018 – Internal Audit Strategy and Plan 2018/19
R6	Identify on the plan: • Assignment priorities • An estimate of the resources required for each assignment • The split between assurance and other audit work	The audit plan for 2018/19 will include a priority assessment of each assignment, using H, M, L. For 2018/19 whilst not intended to provide an estimate on the individual resources for each assignment, there will be more detail provided on the estimated overall days for different work, e.g. audits assignments, advice, other chargeable and non-chargeable activities.	Sarah Cox	April 2018 – Internal Audit Strategy and Plan 2018/19
R7	Undertake audits of the Council's ethical arrangements, either as a	Examples were discussed as part of the external assessment as to how ethical matters are	Sarah Cox	Team meeting in January 2018.

No	Recommendation	Response	Responsible officer	Action date
	one-off or by building ethical matters into relevant audits	considered as part of individual audits, for example highlighting weaknesses with management behaviours, etc. This will continue to be the approach however to ensure this continues to be considered where relevant there will be a session at the team meeting in January.		
R8	Amend the audit terms of reference to address the required items	The standard wording in the terms of reference will be reviewed and changes agreed at the team meeting in January.	Sarah Cox	Team meeting in January 2018
R9	Ensure that the RACE is approved before implementation	The RACE is always reviewed by either one of the Principal Auditors or the Chief Internal Auditor, prior to commencement of fieldwork, however this is not formally evidenced. A box can be added to the sign off section of the RACE to document this.	Sarah Cox	January 2018
R10	Develop and document a retention schedule for internal audit's records	The Council's retention schedule covers Finance and not specifically Internal Audit. This can be made more explicit for Internal Audit retention of records within our Internal Audit Procedures Manual.	Sarah Cox	January 2018
R11	Revise the annual audit opinion to address the strategies, objectives and risks of the Council. Include specific reference to governance and risk management arrangements	The wording of the annual audit opinion will be reviewed and revised where appropriate for inclusion in the Annual report for 17/18.	Sarah Cox	April 2018
R12	Include the report distribution list on audit reports	The template report will be updated to include the final audit report distribution list.	Sarah Cox	January 2018 – all reports finalised from this date.

Suggestions

No	Suggestion	Response	Responsible officer	Action date
S1	Invite others from within the Council, for example the Audit and Governance Working Group, to contribute to self-assessments	This will be discussed further with the Monitoring Officer who leads the independent review of the Effectiveness of Internal Audit	Sarah Cox	April 2018

Appendix 2: interviewees

Person	Position
Lorna Baxter	Director of Finance and s151 Officer
Jot Bougan	IT Auditor
Peter Clark	Chief Executive
Tessa Clayton	Principal Auditor
Georgina Cox	Auditor
Sarah Cox	Chief Internal Auditor
Ian Dyson	Assistant Chief Finance Officer
Martin Dyson	Senior Auditor
Nick Graham	Director of Law and Governance
Joanne Hilliar	Auditor
Owen Jenkins	Director for Infrastructure Delivery
Dr Geoff Jones	Chair, Audit Working Group
Katherine Kitashima	Principal Auditor
Graham Shaw	Director of Customer Experience