Oxfordshire County Council

Internal Audit Services

Annual Report of the Chief Internal Auditor

2017/18

OXFORDSHIRE COUNTY COUNCIL
INTERNAL AUDIT SERVICES

Author: Sarah Cox, Chief Internal Auditor. April 2018

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 and effectiveness of the internal control environment, comprising risk management, control and governance.

1.1.2 Oxfordshire County Council's Internal Audit service conforms to the PSIAS 2017.

1.1.3 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. 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 has 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 (financial and non-financial). 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 by the Chief Internal Auditor. It is a requirement of the PSIAS for an external assessment of internal audit to be completed at least every five years. This was undertaken by Cipfa in November 2017 and the results were reported to the Audit & Governance Committee in January 2018. This confirmed that the "service is highly regarded within the Council and provides useful assurance on its underlying systems and processes" Minor improvements required have been addressed.

1.4.2 The Monitoring Officer has conducted a survey of Senior Management on the effectiveness of Internal Audit. The results from this survey were presented to the July 2017 Audit & Governance Committee meeting. The conclusion from the survey was that management find the internal audit service effective in fulfilling its role.

1.4.3 The Internal Audit Strategy and Annual Plan for 2017/18 were approved by the Audit and Governance Committee, who received quarterly progress reports from the CIA, including summaries of the audit findings and conclusions. The Audit Working Group also routinely received reports from the Chief Internal Auditor, highlighting emerging issues and for monitoring the implementation of management actions arising from internal audit reports.

1.4.4 The 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.

1.4.5 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.

1.4.6 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).

1.4.7 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 2017/18 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit which is outsourced, and external resource to cover the maternity absence of one of the Principal Auditors. 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 2017/18.

2 OPINION ON SYSTEM OF INTERNAL CONTROL

2.1 Basis of the Audit Opinion

2.1.1 The 2017/18 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 seven audits originally planned have been cancelled or deferred until 2018/19 plan. There were also two audits added to the plan. (these amendments were reported to the January 2017 Audit and Governance Committee meetings):

Cancelled or deferred:

- Transitions – from Children to Adults
- Main Accounting – feeder systems
- EDT (Emergency Duty Team)
- ICT incident Management
- Contract Management
- Programme Management Office
- Capital Programme – Governance and Delivery

Additions to plan:

- VAT
- Additional Thriving Families Claim (3 in total made)

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 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.

2.1.5 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.

2.1.6 There have been 33 audits undertaken in 2017/18. There have been four audits which have been graded as RED during 2017/18; Mental Health follow up audit, S106, VAT and Security Bonds.

2.1.7 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.

2.1.8 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.

2.1.9 The Anti-fraud and corruption strategy remains current and relevant. In 2017/18 the Audit & Governance Committee have been updated on reported instances of potential fraud. Most of these are minor in nature. A recent referral has been made of more significant value, this is currently subject to initial investigation and a further update will be made to the July 2018 Audit & Governance Committee.

2.1.10 The National Fraud Initiative data matching reports for the 2016 data match exercise have now been received. The majority of the key matches have been reviewed and investigated and results are reported to the Audit & Governance Committee in the quarterly updates. Outstanding matches will be completed during Q1 of 2018/19.

2.1.11 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.

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.

2.1.12 In arriving at our opinion, we have taken into account:

- The results of all audits undertaken as part of the 2017/18 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 effects 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 Annual Opinion

In my opinion, for the 12 months ended 31 March 2018, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

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

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

Oxfordshire County Council's Internal Audit service conforms to the Public Sector Internal Audit Standards (2017)

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 2018) are attached as appendix 2;

- VAT
- Troubled Families (Claim 2)
- Insurance
- Safer Recruitment
- Innovation & Research
- ICT Back-up & Recovery
- Children's IT Replacement System

- Troubled Families (Claim 3)
- Direct Payments Follow Up
- Pension Fund
- Pensions Administration Accounts Receivable
- Client Charging
- Mental Health Follow Up
- Security Bonds
- Payroll
- Purchasing
- Supported Transport
- Children's Contract Management

2.3 Internal Audit Performance

2.3.1 The following table shows the performance targets agreed by the Audit Committee and the actual 2017/18 performance.

2.3.2 It is pleasing to report the improvement in achieving the target for issue of final reports, increasing from 75% to 92% and that 100% of the plan has been completed before the end of April 2018.

Measure	**Target**	**Actual Performance 2017/18**
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. (2016/17 this was 60%, 2015/16 this was 58%, 2014/15 this was 52%)
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	95% of the audits met this target. (2016/17 this was 94%, 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	92% of the audits met this target. (2016/17 this was 75%, 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 2018.	100% of the plan has been completed by the end of April 2018. (2016/17 this was 100%, 2015/16 this was 66%, 2014/15 this was 64%)

Measure	Target	Actual Performance 2017/18
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at 11 April 2018: 761 actions being monitored on the system. • 71% implemented • 18% not yet due • 7% partially implemented • 3% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2	Based on 8 questionnaires returned the average score was 1.03 16/17 was 1.13 and 15/16 was 1.13
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 2018

APPENDIX 1 - Implementation status of 2017/18 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 03 April 2018
People	Safer Recruitment	Amber	8	8 not yet due
Adults	Payments to Residential and Home Support Providers	Amber	11	2 not yet due, 8 implemented and 1 ongoing
Adults	Client Charging (including ASC debt)	Amber	19	18 not yet due and 1 implemented.
Adults	Direct Payments	Amber	5	5 not yet due.
Adults	Mental Health Follow Up	Red	10	10 not yet due.
Adults	Adult Mental Health Practitioner Service	Amber	6	2 not yet due, 2 implemented and 2 overdue
Childrens	Troubled Families – October Grant Claim	n/a	3	3 implemented.
Childrens	Troubled Families – January Grant Claim	n/a	1	1 implemented.

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 03 April 2018
Childrens	Troubled Families – March Grant Claim	n/a	2	2 not yet due.
Childrens	CEF Contract Management	Amber	7	7 not yet due
Childrens	Fostering Service	Amber	15	4 not yet due, 7 implemented and 4 ongoing.
ICT / Childrens	Childrens Social Care IT System Replacement	Amber	16	9 not yet due, 1 implemented and 6 overdue
Public Health	Combined Contract Management Audit / Counter Fraud Review	Green	0	n/a – no management actions arising
Communities	S106	Red	31	14 not yet due, 7 implemented,7 partially implemented and 3 overdue.
Communities	Supported Transport	Amber	31	31 not yet due
Communities	Research and Innovation	Amber	5	4 not yet due and 1 overdue.
Communities	Highways Contract Payment - follow up	n/a	0	n/a

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 03 April 2018
Communities	Security Bonds	Red	17	17 not yet due
Finance	Pensions Administration	Amber	14	12 not yet due, 1 implemented and 1 overdue.
Finance	Pensions Fund	Green	1	1 not yet due.
Finance	Accounts Receivable	Green	4	4 not yet due
Finance	Payroll	Amber	2	2 not due
Finance	Purchasing / Procurement	Amber	10	10 not yet due
Finance	VAT	Red	6	1 not yet due, 3 implemented, 1 partially implemented and 1 overdue.
Finance	Insurance	Green	2	2 not yet due.
Corporate / ICT	Fit for the Future - Digital First Platform -Programme Governance Review	Amber	8	7 implemented and 1 partially implemented.

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 03 April 2018
HR / Corporate	Sickness management	Amber	4	2 not yet due and 2 implemented.
HR / Corporate	Establishment control / HR data	Amber	5	4 implemented and 1 overdue.
ICT	Cyber Security	Amber	20	18 implemented, 1 partially implemented and 1 overdue.
ICT	Disposal of Equipment	Amber	8	8 implemented.
ICT	PSN compliance (Public Services Network)	Amber	4	1 not yet due, 1 implemented and 2 overdue.
ICT	Mobile Computing	Green	3	2 implemented and 1 partially implemented.
ICT	ICT backup and recovery	Amber	3	3 not yet due.
Corp	Grant Certification (requests throughout year for CIA sign off)	n/a	n/a	n/a
Corp	Proactive review - Travel &	Green	0	

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 03 April 2018
	Expenses			
Corp	Proactive review – Purchasing Cards	Amber	5	5 overdue.

APPENDIX 2

Summary of Completed 2017/18 Audits since last reported to the Audit & Governance Committee - January 2018.

VAT Audit 2017/18

Opinion: Red	26 January 2018	
Total: 6	Priority 1 = 1	Priority 2 = 5
Current Status:		
Implemented	3	
Due not yet actioned	1	
Partially complete	1	
Not yet Due	1	

Overall Conclusion is Red

VAT Coding Accuracy

The audit identified a 41% error rate in output VAT coding in the sample of 96 transactions reviewed across 10 service areas during the audit (errors were identified in nine of the 10 Cost Centres tested), highlighting significant deficiencies in the controls in place across OCC relating to VAT coding.

These errors included an absence of a VAT code altogether; use of incorrect tax codes for 0% VAT; VAT charged when it should not have been & vice versa and VAT being charged but not subsequently coded to the VAT account. For example, in four individual cases, VAT had been incorrectly charged to service users. In twelve individual cases, VAT had been charged on services but not subsequently coded to VAT and therefore was retained within the cost centre budget.

There is a risk therefore that the monthly amount paid to/reclaimed from HMRC is incorrect. A further risk is the impact upon the 'partial exemption' calculation which could be incorrect when the wrong 0% VAT code is used, resulting in the Council being pushed above the 'partial exemption' threshold of 5%. However, the VAT Manager at IBC has informed OCC that the risk of this is low due to the ongoing checks in place which monitor the partial exemption threshold.

Staff Training and Guidance

From interviews with the Cost Centre managers and their finance support, it was clear that sufficient training has not been provided to ensure that output VAT is coded correctly, as there was a degree of misunderstanding about what each VAT code means and what the proper treatment of charges levied by the Council ought to be. In many cases the current VAT coding process was the same as had been followed for many years, despite a recognition that it may be incorrect.

The VAT Manual on the Intranet is comprehensive; however, it is not the most up-to-date version. The Fees & Charges document is reviewed annually; however, it had already been identified prior to the audit that there are several errors in VAT coding in this document and a correction process is underway. Internal Audit

noted during site visits and discussions that the VAT Manual and Fees & Charges document are not routinely used or referred to by services to ensure correct VAT coding or to seek answers to queries.

The audit also noted deficiencies relating to inconsistency of income practices across OCC, as well as incorrect practices continuing over a number of years, indicating a lack of corporate oversight on VAT coding accuracy.

Oversight and checking

VAT coding checks are undertaken by IBC on all output VAT over £20k and on a further risk-based sample (as this is an IBC process, this was outside the scope of this audit). Internal audit did note errors that had previously been identified by the IBC checks, indicating that these are taking place in some areas. However, whilst the sample checking resulted in correction of specific transactions and journals, it did not address the root cause of the errors, which is a lack of understanding and training on correct VAT coding amongst cost centre managers and operational staff responsible for VAT coding. There is currently no assurance provided to OCC on the sample checks undertaken and issues arising, for example specific service areas who are continuously making errors.

As already identified within OCC, there is currently an absence of VAT strategic oversight and a nominated VAT lead Officer in the Council to identify and take forward VAT issues, however this audit was requested as a first step towards putting this in place.

Troubled Families – January 2018 Claim (Claim 2)

Opinion: n/a	29 January 2018	
Total: 1	Priority 1 = 0	Priority 2 = 1
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	0	

OCC have submitted between two and three Troubled Families claims per year since September 2014, under Phase 2 of the Troubled Families programme. The current claim is due to be submitted by the 31st January, and consists of 67 families for Significant & Sustained Progress (SSP) and 6 families for Continuous Employment. This claim covers the period from April to September 2017.

All management actions from the audit of the previous claim (September 2017) have been reported as implemented by the responsible officer.

The audit checked a sample of at least 10% for both claims (7 families from the SSP claim, and 2 from the Continuous Employment claim) to ensure that they met the relevant criteria for payment and had not been duplicated in the current or previous claims. Their initial eligibility criteria for inclusion in the Programme were also checked.

Conclusion

3 families were removed from the SSP claim following Internal Audit testing. These families had been identified by the Troubled Families team as being ineligible for the claim, but had not been fully deleted from the claim list due to a spreadsheet filter error. This issue had not been identified prior to submission of the claim to Internal Audit. The claim has since been checked again by the Troubled Families team, and no further issues were found, so Internal Audit are satisfied that the current claim can therefore be signed off.

Insurance Audit 2017/18

Opinion Green	13 February 2018	
Total: 2	Priority 1 = 0	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	2	

Overall Conclusion is Green

The sample of 20 Insurance claims reviewed had a 100% pass rate, as they had all followed the correct process detailed in the Insurance Claims Manual. They had all been thoroughly investigated, fraud red flags highlighted and examined where necessary, correctly signed-off and accurate payments made.

The Insurance Claims Manual is comprehensive and details the different processes and controls for each type of claim. The Manual does not, however include detail on the correct Sign-off for claims closure. The Insurance team are currently upgrading their claims handling system to a new software. The Manual will be updated and improved following the embedding of the new system.

A very comprehensive Anti-Fraud Policy is used by the team to screen for fraud risks and this was evidenced in the sample with the use of fraud ‘Red Flags’. The new system will also have an automated fraud RAG rating screening function.

Management information is currently produced for Children’s and Communities (Highways), as these are the areas of highest numbers and values of claims. However, there are plans to develop further areas of management information, especially as a new performance dashboard will be integrated in the new system.

From review of the Zurich 'Imprest' account, it was noted that the account balance was higher than necessary, and the Insurance Manager was due to undertake a review of this.

Safer Recruitment 2017/18

Opinion Amber	20 February 2018	
Total: 8	Priority 1 = 3	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	8	

Overall Conclusion is Amber

Policies and Procedures

Comprehensive, up-to-date and accessible Safer Recruitment policies and procedures are available at the Council. These set the strategic objectives and control requirements for all aspects of safer recruitment, including recruiting manager training, interview requirements and DBS checks.

Recruitment

A review of recruitment practices for 15 new starters in 'sensitive' posts across the Council found the majority of processes had been followed correctly; references had been obtained as appropriate, DBS checks completed at the correct level, and risk assessments completed where necessary (where an employee starts in post before the DBS has been completed or where a positive disclosure is made).

However, issues were identified around retention of interview notes on employees' HR files, with only half being saved to 'Hantsfile'. The audit also found that of the 15 recruitments reviewed, the mandatory Recruitment and Selection training had been completed by at least one panel member in only 4 cases and the mandatory (for sensitive posts) Safer Recruitment training in only one case.

Management Information and Data

There are significant inaccuracies in the SAP DBS data, as SAP is not always updated when DBS checks are completed. This is a known IT issue and IBC has reportedly been trying to fix it over the past year. As a result, OCC have been unable to effectively monitor whether staff have up to date DBS checks or not since the responsibility for managing the DBS process transferred to IBC in 2015. From our audit testing, there was a 67% error rate with the DBS data on SAP in our sample of 45.

There is a further issue where the 3-yearly DBS checks are not being routinely undertaken by all managers. In just over half our sample of 15 where the DBS was recorded as expired on SAP, the DBS had indeed expired and the Manager had not requested a Renewal. The Renewal Reminder is not consistently used by Managers to ensure they are reminded when the 3-yearly Renewal is due (two thirds of the New Starters checked did not flag this Reminder). However, in almost half the cases checked, the Reminder had been used but not acted upon.

Due to the inaccurate data, management information on DBS checks is therefore not currently being produced nor used. Furthermore, there is a known issue that posts are not always flagged as 'sensitive' when they are created. This is now a manager responsibility, under the IBC HR Recruitment work flow system. Without flagging a post as 'sensitive' it is difficult to data match against DBS records in order to identify gaps. The inaccuracy of SAP DBS data against both posts and personnel records on SAP is a known issue within Corporate HR, and work has been underway to identify and resolve inaccuracies.

Management response provided since report finalisation:

The system fault that was preventing DBS checks from being uploaded on to the SAP workforce database was fixed on 6 March and backdated records have now been uploaded. The council's HR team is reviewing records held on SAP to ensure all employee records are up to date with the right level of check and contacting managers where any rechecks have not been carried out in line with the council's policy. This work will be finished by 30 April 2018 and will continue to be monitored. All managers who have not done the safe recruitment e-learning in the last three years are being asked to complete this training by the end of June 2018. Classroom training on all aspects of recruitment vetting and checking is also being delivered by HR from May. All processes and systems in relation to DBS checking are being reviewed by Hampshire Shared Service and OCC HR including looking at better ICT solutions and a cost/benefit analysis of paying for relevant employees to register with the DBS update service to make the rechecking of criminal records easier, quicker and more cost effective.

Innovation & Research Audit 2017/18

Opinion Amber	20 February 2018	
Total: 5	Priority 1 = 0	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	1	
Partially complete	0	
Not yet Due	4	

Overall Conclusion is Amber

Although initially a small team, it has been reported that due to the success of the team over the last 4 years in generating funding, projects and collaborations, the Innovation & Research Team have grown rapidly. New staff are being recruited to complete projects underway as a result of successful bids for funding.

Whilst it was found that there were processes in place for the production of bids, sign off of funding agreements, management of projects etc, a number of inconsistencies in approach were noted. As the team grows, it will be increasingly important to ensure that there are clearly documented processes in place with well-defined and appropriate governance arrangements.

Policies & Procedures: There is currently a lack of clearly documented procedures for I&R staff covering key processes including the production, review and sign off of bids, the agreement and sign off of legal agreements, project management including the maintenance of appropriate financial records and production of grant claims and the monthly project reporting process. There is therefore a risk of inconsistent or inappropriate practices in these areas.

Sample testing identified examples where there were inconsistencies in approach (for example obtaining and documenting of appropriate sign off prior to a bid submission and the location and structure of project folders).

Governance: Current governance arrangements for the review and sign off of bids prior to submission were not found to be operating consistently. From testing undertaken, it was only possible to evidence review and sign off of bid submissions in 1/5 instances tested. It was also noted that reported sign off arrangements are not in accordance with the Council's Scheme of Delegated Powers.

The current process for the sign off of funding agreements is not currently documented and the process in place, as reported during the audit, is not in accordance with the working version of the Scheme of Delegated Powers.

ICT Backup and Recovery Review 2017/18

Opinion Amber	13 March 2018	
Total: 3	Priority 1 = 1	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	3	

Overall Conclusion is Amber

Internal Audit identified that there is generally a sound system of internal control, however, some significant risks have been noted and there is therefore the possibility that some objectives will not be achieved.

A daily backup of IT systems and data is undertaken using the Tivoli Storage Manager (TSM) solution. Backups are taken to local disk and tape and are also copied to an off-site location. This happens automatically and does not require any manual intervention. ICT receive a daily report showing any backup jobs that have failed or been missed and it is reviewed and all reported items investigated.

The TSM solution has been out of support for a number of years and is causing operational issues, including the inability to take full system backups of Windows 2012/2016 servers. ICT are looking to replace TSM with a Backup as a Service (BaaS) solution, which will involve buying backup and recovery services from a third-party. As BaaS entails a copy of all corporate data being held by the third-party on their infrastructure, its critical that a security risk assessment is undertaken as any data breach could lead to financial penalties under the Data Protection Act 1998 and GDPR from May 2018.

We found there is no documented corporate policy on ICT backup and recovery and the document detailing how TSM backups are undertaken is also out of date. Recovery testing is also not performed to validate backups and ensure they can be used to fully recover ICT systems in agreed timescales

Children's Social Care IT System Replacement Review 2017/18

Opinion Amber	13 March 2018	
Total: 3	Priority 1 = 1	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	3	

Overall Conclusion is Amber

The implementation of the new Liquidlogic Children's System (LCS) and ContrOCC is being managed by an LCS Implementation Board, which is chaired by the Deputy Director Safeguarding. A review of the project governance arrangements identified the following issues:

- The terms of reference for the LCS Implementation Board are in draft and do not include all relevant details on how it should operate e.g. frequency of meetings, name of chair, numbers for quorate, reporting requirements;

- A Project Initiation Document (PID) has been documented but there is no evidence of it being approved. The roles and responsibilities within the PID are also incomplete or inadequately defined;

- The LCS Board receive a monthly Highlight Report of key activity. Whilst the report includes risks from the RAID log, we found that some of the highest scoring risks had not been reported in the last monthly report (Jan 18). Issues are not recorded on the RAID log or reported to the board.

- A ‘Project Approach’ document is used to define the purpose of each workstream, its scope and deliverables. However, not all workstreams have a Project Approach document and the ones that exist have not been approved.

System security is in the process of being set-up and configured. On LCS, all primary accounts will authenticate using single sign-on based on network authentication and secondary accounts will require a separate login to the system. LCS can enforce a minimum password length but it is not clear if passwords can be expired; this should be confirmed with the supplier. An account lockout policy is available and should be configured prior to go-live. Access rights are currently being worked through to ensure all users have the right level of access to the system and will be signed off by a Principal Social Worker. This sign-off is a key control and should be formally documented and evidence retained. LCS has an audit trail facility which is enabled by default. However, it was noted that the audit trail does not report updates on certain system screens and this should be raised with the supplier. System security on ContrOCC is at an early stage of development but is likely to be similar to what was set-up for adult social care, given that the users are the same and processes will be similar.

A Data Migration Strategy has been documented but not yet approved, despite the first data migration cycle having already been completed and the second about to start. Data migration is being undertaken by external consultants who have expertise in this area and four data migration cycles are planned. Source data from frameworki has been identified and mapped to LCS and data quality checks and cleansing are being undertaken. Data errors are logged on a defect tracking tool and reconciliation reports are used to confirm the completeness of data migration. However, the procedures and processes for dealing with data quality defects are not documented as per the Data Migration Strategy. The LCS Implementation Board are being kept abreast of progress and issues.

Testing of the system will start in March and further cycles are planned for later in the year. However, we have found that a Testing Strategy has not been developed to outline the approach and standards to be used. Test scripts are in the process of being developed and will go through a validation process which includes a review by operational leads to confirm that they include all key business processes. A review of a test script found that the details recorded are adequate and clearly show what is being tested and if it was successful or not. Testing will be performed by a range of different users from each business area, including administrators and social workers. There is no specific test script for user access levels as it is envisaged that this will be included as part of the general testing of the system. However, given the nature of the system and sensitivity of data, we are recommending that specific testing is performed to confirm that user access levels are configured correctly.

Whilst the project has attempted to engage users, for example by asking them to volunteer as ‘champions’ whose responsibilities will include promoting engagement with LCS, the level of user engagement can be further improved through formalising some of the existing relationships between the LCS Implementation Board and Childrens Services. A one-month change freeze is planned, ahead of the 1st October go-live and we believe this should be extended to ensure there is an adequate period of system stability.

End user training will be commissioned from Liquidlogic. They have delivered a proposal which is based on a training needs analysis undertaken by the project

team. Training will include half-day online courses and full day classroom sessions which will be service specific. There will be a facility for users to complete evaluation records for each course they attend and the project team should ensure they have access to the results so that they can assess the quality of the training being delivered.

Troubled Families Claim March 2018

Opinion n/a	23 March 2018	
Total: 2	Priority 1 = 0	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	2	

Overall Conclusion

One issue was identified during the audit in relation to inaccurate Excel formulas being used to track School Attendance, although this did not result in any families being removed from the claim. This had not been identified prior to the audit, however the claim has since been re-checked by the Troubled Families team and no further issues were found. Internal Audit was therefore able to sign off the claim.

Direct Payment Follow Up 2017/18

Opinion Amber	29 March 2018	
Total: 5	Priority 1 = 0	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

Overall Conclusion is Amber

Follow up

The 2016/17 Personal Budget and Direct Payments audit contained 13 management actions, of which 4 have been closed. 9 are still open and overdue against their original target date (however only 2 are overdue against their updated target date). Further to the current audit check of these actions, it can be confirmed that 7 have

been fully implemented (although 3 of these have not been closed down); 2 partially and 4 not yet implemented, as follows:

- The RAS review has commenced but is not yet complete, so this is partially implemented.
- Assessment to Review Guidance update is not yet completed but is being incorporated in to the FFF work – not implemented.
- Support Plan and budget authorisation accuracy in LAS – audits have started in order to check compliance and will be continued until a more systematic control is in place – partially implemented
- The ASC Scheme of Delegation has been updated and uploaded to the Intranet – implemented.
- Purple DP Escalation process – this is implemented as the Transaction Protocol was updated and no further issues were identified during this audit.
- Response to DP Finance Queries – this is implemented as a new process for escalating self-managed accounts' unresolved finance queries via the ASC Performance Board has been embedded. The action to RAG rate these DP queries has not yet been implemented however it was agreed this is no longer required so can be closed. The action for the ASC FBP to participate in this escalation has also been implemented.
- Annual Review and DP Usage - a checklist has been developed for Social Care staff to use when reviewing Direct Payments, although Social Workers are yet to start using and uploading it to LAS/SharePoint, so this is implemented but will take some time to embed.
- Direct Payments checks – A new form is also being used by the DP Team to check whether PAs are listed on the DP return form, so this has been implemented, as the Manager has also been checking correct usage.
- The two high value DP Cases with actions were re-reviewed. The first case has completed the Review and new Support Plan and is awaiting the Agreement to be signed, so this is partially implemented. The second case where the business start-up costs were queried has been implemented as the Service Manager agreed to the costs. However, a policy on setting up DP-funded care companies has not yet been agreed so this is not implemented.
- These actions will be continued to be monitoring on the action implementation system.

<u>High Value DPs</u>

The audit reviewed 10 high value DPs ranging from £1k to £8.3k per week (excluding those reviewed in previous years). The audit identified in half of these cases, the annual Reviews were overdue (3 were last reviewed in 2016 and 2 in 2014). In those where a Review had taken place, it was still not possible to evidence that the DP expenditure and arrangements had specifically been reviewed by the SW (as reported under Follow Up).

From the sample of 10, the audit also found that only 3 have signed DP Agreements for the current DP; 5 had signed Agreements for previous DP amounts and 2 had no Agreement at all. Following a previous DP audit, it was agreed that at annual Reviews, the SW would check a signed DP Agreement for the current DP was in place. However, in 3 of the cases where there was no current DP Agreement, these had had a review within the last year, so it seems this control is not taking place consistently.

In one case, the audit highlighted concerns where the DP was increased six-fold last year, however a new Agreement was not signed with the account manager. The case also raises issues once again with regards conflict of interest in managing the DP Account and paying family members as carers who reside in the same household without prior authorisation.

Direct Payments Processes – Surpluses and Management Information

The audit reviewed the process for monitoring and managing DP account surpluses, to ensure that surpluses are recovered and social workers are made aware. It found that whilst there is a process for alerting the Social Care Service Manager of surplus recoveries for managed accounts, this is not happening for self-managed accounts, relying instead on the DP Team to inform Social Workers on a case by case basis. However, from a review of a sample of 5 surplus recoveries, in 4 cases there was no evidence that social care had been informed of the surplus recovered.

From audit analysis of DP surpluses, a total of £1.7m was recovered in the last 12 months from open DPs, for 419 (29%) of DP accounts (this equates to 5.6% of DP expenditure). Of these, one third had in fact had two surplus recoveries within the year reviewed. The current volume of recoveries indicates that DP reviews are not systematically taking place when carrying out service user's annual Reviews, or Reviews are not taking place following a surplus recovery.

Pension Fund 2017/18

Opinion Green	04 April 2018	
Total: 1	Priority 1 = 0	Priority 2 = 1
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	1	

Overall Conclusion is Amber

Governance over the Pension Fund continues to remain strong, throughout the course of the audit it was observed that controls were generally well designed and that procedures and controls for general management of the fund were robust.

Risk management and control activities were well-established and have not changed significantly since the previous audit. There is one management action arising from this audit where it was identified that the Internal Control Reports from the Pension Fund Managers have not yet been reviewed for 2017/18.

The Brunel Partnership, a new investment pooling arrangement affecting Oxfordshire Pension Fund along with 9 other local authority pension funds will take effect from 1 April 2018. As the Brunel Partnership pooling does not begin until the next audit year, audit testing was not required relating to the effects on asset allocation and financial position of the fund. Instead the audit reviewed the Pension Fund Governance and Strategy, and particularly risk management in relation to the preparation for this new partnership. The risk management arrangements in place were deemed to be appropriate

Pensions Administration 2017/18

Opinion Amber	10 April 2018	
Total: 14	Priority 1 = 6	Priority 2 = 8
Current Status:		
Implemented	1	
Due not yet actioned	1	
Partially complete	0	
Not yet Due	12	

Overall Conclusion is Amber

Whilst the overall opinion for this audit is Amber, there are two significant issues arising.

Firstly, the segregation of duties issues identified in previous audits undertaken in 2015/16 and 2016/17 have not been resolved with the management action agreed not yet implemented. The same individual still runs the payroll, corrects administrative errors before it is released for payment, undertakes the reconciliation and uploads the payment files via the Business Data Upload (BDU) facility into SAP. A process introduced to improve controls in this area whereby a report is downloaded from the Altair system showing functions performed by those with Administrator rights is ineffective as it is run by the same individual who completes the previously described payroll tasks. The information is also downloaded into a spreadsheet which could easily be manipulated. As such, this remains a significant control weakness in the system. It has been reported that the delay in resolving these segregation of duties issues has been partly due to resourcing issues within the team. Management have reported that these issues are now resolved and that the required changes will be introduced imminently.

Performance in relation to the processing of deferred benefits and in the issuing of Annual Benefits Statements has not been at the required level, resulting in breaches in pensions regulations which have been reported, by the Pensions Service, to the Pensions Regulator. The Pensions Service is in the process of responding to

requests for further information from the Pensions Regulator which includes detailed plans for the resolution of the breaches reported and associated timescales. This information will be used by the Pensions Regulator to determine what penalties will be enforced.

In relation to the processing of deferred benefits, 13 of 20 deferred benefits cases sampled as part of audit testing had been processed outside of the regulatory limit of 3 months (65%), and in the majority of these cases the delays were within the Pensions Admin Team, rather than at the employer end.

Whilst improvements in the quality of the Monthly Admin Return Spreadsheet (MARS) data received for OCC employees were noted in comparison with the previous audit, issues remain with the data received from other scheme employers (including end of year data) which has led to delays in issuing Annual Benefits Statements to scheme members (77% were issued by the end of August 2017, and 91% by Christmas), in breach of pensions regulations. The Employer team has now been created to work with employers to obtain the required data and revisions being made to the Administration Strategy will clarify expectations of the employers which should further improve performance.

Furthermore, performance reporting has shown a decrease in the timeliness of processing other scheme member lifecycle tasks, including deaths, member estimates, refund of pension contributions, issuing of Previous Pensions Forms (PPF's). No issues with the accuracy of processing of these tasks was noted from the limited testing undertaken as part of this audit.

To resolve the performance issues identified, increased resources have been brought in (including an external company to clear the backlog of deferred benefits to be processed), a restructure of the Pensions Administration Service has been partially implemented, which has included the creation of a new Employer team who will work with the scheme employers to address the issues with accuracy and timeliness of data. The Administration Strategy has also been reviewed and updated to make responsibilities of employers in relation to the accuracy of data they supply clearer, to bring forward the deadline for monthly data submissions and simplify the process of issuing fines for non-compliance. It is planned that the revised strategy will be implemented in early March following approval by the Pension Fund Committee.

Delays were also noted in relation to processing new scheme employers, due to both resourcing issues and difficulties in receiving the required information from the employers. Guidance is currently being updated in this respect with the aim of improving the efficiency of this process.

The Pensions Service is currently preparing for the implementation of the new General Data Protection Regulations (GDPR) in May 2018. A project plan is being developed, and a consultant is due to start work with the Team in February in order to ensure readiness and compliance of the Service in time for the implementation date.

Accounts Receivable 2017/18

Opinion Green	10 April 2018	
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 Green

OCC have yet to define a debt management strategy. It is planned that the strategy will be produced following the development of the new Operating Model, work which has been supported by PwC, and the completion of the Financial Management Review being undertaken by the Director of Finance and Assistant Chief Finance Officer.

Operating procedures have been developed and agreed with Hampshire, clarifying roles and responsibilities of HCC and OCC and what is expected under each area of the debtor process. The document has been adopted by both councils and is being worked to. It is planned that a reference guide will be produced from this, for both OCC and school staff to refer to, however this has yet to be produced and published. On a wider financial governance level, the project set up to undertake a fundamental refresh of the finance guidance on the intranet has yet to be completed.

Delegated approval for the write off of debts has been confirmed by the Director of Finance and the approved process is in operation, however it is not accurately reflected in the published version of the Scheme of Financial Delegation.

The responsibility for customer creation now falls within Hampshire's remit, as such assurance is taken from the work undertaken by their Audit Team. However, guidance was reviewed and found to be comprehensive to support OCC staff in creating customers and ensuring a check is undertaken for duplicates.

The level of debt, including aged debts, are now monitored via a dashboard, which is shared with senior management in Finance at OCC. Legacy debts are also being worked through and managed down, within 2017/18 the legacy debt level reduced by around £1.3m, and currently sits at around £2m. Write offs were also found to be managed well, with approvals in all cases tested being appropriate, and the level of write offs are reported through to Cabinet.

This audit also followed up on management actions agreed following the 2016/17 Accounts Receivable audit.

11 management actions were agreed. 5 actions have been confirmed as fully implemented, 2 have been superseded and 4 have been partially implemented. Those actions which are not fully implemented are detailed within the audit report

with updates on progress made and estimated completion dates. Internal Audit will continue to monitor and report on the implementation of these actions through the audit follow up process.

The Hampshire County Council Audit Team have completed their Order to Cash audit, which has covered the processes HCC perform on behalf of OCC, we place reliance upon the work they undertake. Adequate assurance was provided overall, which they define as; Basically a sound framework of internal control with opportunities to improve controls and / or compliance with the control framework. The audit highlighted no OCC specific issues.

Client Charging 2017/18

Opinion Amber	10 April 2018	
Total: 19	Priority 1 = 1	Priority 2 = 18
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	18	

Overall Conclusion is Amber

Subsequent to the implementation of LAS and ContrOCC in 2015, a number of system and process improvements required were identified by the Service. These were to be resolved as part of the LAS Phase 2 project, managed and monitored by the Business Efficiencies & System Improvement (BESI) group. BESI no longer exists and LAS Phase 2 has made limited progress. The limited progress in resolving known issues has been reflected in the findings of this audit. Similar issues to those raised in the previous two client charging audits undertaken in 2015/16 and 2016/17 have been identified again this year.

However, as part of the Council's transformation programme the ASC Pathways & Process Group has been formed. This group is sponsored by the Service Manager for SI Reviews and ILS, has PMO input and is tasked with picking up on the required service improvements which include those identified as required as part of LAS Phase 2. FOB (Finance Overview Board) and OMM (Operational Managers Meeting) have now reviewed and signed off a simplified pathway for the sourcing and arrangements of care along with proposals for service improvements in a number of key areas. This should lead to improved processes in relation to client charging.

There are areas where it appears that the ASC Contributions Policy needs to be updated, for example contingency care is not specifically covered nor are changes to the way in which contributions for day centre attendance is charged for.

Although some delays were noted in the process for referring service users for financial assessments, reporting processes being carried out by the Financial

Assessments Team are enabling prompt identification and follow up of missing referrals.

In terms of the financial assessment process, some issues were identified in relation to the evidencing of decisions and the saving of evidence on various different parts of the financial assessment process. Sample checking on new residential financial assessments was not found to be happening. It was reported that this was due to a change in staffing during the year, a new Team Leader is now in post so this should not be an issue going forward.

Accuracy issues were noted in relation to the processing of some of the manual adjustments and assessment reductions sampled, resulting in one refund within the sample being lower than it should have been and in two assessment reductions not being processed. In one case the calculation itself was inaccurate. Despite having been signed off as checked by the Team Leader, this inaccuracy had not been identified (ineffective checking and sign off of assessment reductions was also identified during the Client Charging audit in 2015/16).

Further inconsistencies in the charging of arrangement fees were noted during the audit, this was also noted during the 2016/17 Client Charging audit and a management action was agreed to implement a reporting process that would identify instances where these fees had not been charged. Testing identified that this management action had not been implemented effectively as the report being run only identified instances where an arrangement fee *had* been charged.

LD respite care is not yet being charged for in accordance with the ASC Contributions Policy. Work is ongoing to ensure that the correct information is recorded on ContrOCC to enable charging to commence.

Debt Recovery processes are generally being carried out promptly and effectively, however it was noted that safeguarding training and guidance for the team is in the process of being reviewed. From review of instalment plans, it was noted that there are a number of instalment plans in place for more than £1000 or which will take longer than 12 months to repay. In these circumstances, the decision to agree the instalment plan should be made by the Team Leader. This approval / agreement is not currently being evidenced. The testing undertaken on instalments plans did confirm that plans are under regular review.

Limited testing was undertaken on deferred payments as part of this audit. It was noted that a number of significant weaknesses in relation to UDPA's (Universal Deferred Payment Agreements) were identified by the Service last summer and were documented in a Client Charging PID The weaknesses identified included a lack of clarity over roles and responsibilities, not meeting of statutory requirements (for example in terms of statements being offered, capture of statutory data for returns), lack of robust data over secured debts, process for completion of UDPA was not lean as well as issues with appropriate charging and availability of online information and applications. Whilst it has been reported that improvements have been made in some areas, for example statutory reporting, there are still areas that require action. It has been reported that the issues identified within the Client Charging PID have been incorporate into the work being undertaken by the ASC Pathways & Process Group referred to above. This group will also be reviewing the third party top up process with a view to making this simpler and more efficient.

During the 2017/18 audit of Mental Health, issues were identified in relation to the charging of Mental Health service users receiving care from providers who use paper invoices. Cases were identified where service users had not been referred for financial assessments, and for service users where financial assessments had been carried out in the past there was no process within OCC to add these charges manually to client accounts. This issue was raised during the 2016/17 Mental Health audit, however no action has been taken, which raises risks regarding both lost income for OCC and inequitable treatment of service users in relation to Client Charging. This issue will be reported on in further detail as part of the Mental Health audit report for 2017/18.

Follow Up

13 actions were agreed as a result of the 2016/17 Client Charging audit, 3 of these have been confirmed as fully and effectively implemented from testing undertaken during the current audit. 3 were reported as fully implemented, but were found not to have been fully and effectively implemented. 3 actions were reported as fully implemented, but implementation has not been tested as part of this audit. 2 actions have been superseded. 2 actions are still outstanding. The management actions outstanding relate to the completion of the review of historic charges for personal budget clients who may have been overcharged and the processing of any refunds due and the review of adaptation loans.

3 actions outstanding from the 2015/16 audit were also followed up during this audit. All are still outstanding, however work is being undertaken to resolve the issues involved. Outstanding issues relate to the updating of the spot contract template to remove reference to third party top ups, lack of consistency with the contributions policy in the invoicing of service users who user providers who do not use ETMS and the review of the process for the completion of Annex 2's.

Outstanding management actions will continue to be monitored and reported on through the standard audit follow up process. Where the implementation of management actions has been tested as part of this audit and found not to have been implemented effectively, revised management actions have been agreed to address the remaining control weaknesses identified.

Mental Health Follow Up 2017/18

Opinion Red	10 April 2018	
Total: 10	Priority 1 = 6	Priority 2 = 4
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	10	

Overall Conclusion is Red

This follow up audit has taken place approximately a year and a half since the completion of the previous audit. Overall, there has been insufficient progress in addressing the weaknesses previously identified. Whilst the implementation of many of the agreed actions has commenced, very few of these have been fully and satisfactorily completed. Out of the 24 agreed actions, only 9 can be confirmed as fully implemented.

Governance

One of the key actions from the last audit was to complete an **options and risks appraisal** for the future delivery model for Mental Health social care. At the time of the current audit, no changes to governance had been made, although the options discussions were underway, with a decision pending. Whilst some improvements have been made, such as the resumption of the monthly **Provider JMG meetings**, progress at these meetings in agreeing and delivering outcomes has been slow resulting in many **actions not being fully implemented**, although progress has improved in recent months. Senior leadership have been keen to address the issues and in the past 3 months have had monthly Director-level meetings to provide steer and focus through a S75 Action Plan.

A new interim Social Care Leadership **structure** has been agreed and implemented, along with a review and change process to make the MH Social Worker job descriptions social work-specific. The S75 Action Plan captures actions underway to ensure SW good practice is embedded, with a new Draft Supervision policy and staff training plan in place.

There is no 'contract' between both sides; relying instead on the '**partnership model**', which is currently not working effectively and is based on the outdated 2012 Provider Pool S75 Agreement. OCC have not clarified and documented enhanced **assurance and performance** requirements so MH have in turn not been providing the necessary assurance over operational effectiveness and quality. The current Performance dashboard agreed between the partnership is limited to data on assessment timescales, 12-month Reviews and Caseloads and doesn't include wider quality assurance indicators, such as staff supervision, case audits, SW training, Placement quality monitoring, Care package costs, Care Act compliance, Complaints, S117 accuracy, etc.

Much of the difficulty within the partnership is due to the **dual recording** requirements. The Provider JMG agreed that LAS must be used as the primary recording system for social care cases covered under the S75 Agreement, training has been provided and licences purchased. However, LAS usage continues to be insufficient, resulting in inadequate oversight and visibility within OCC of case notes, Support Plans, Reviews, etc. From the sample testing of 30 care packages, the audit found over half had inadequate LAS records.

On a positive note, the audit reviewed the **Support Plans and Reviews** for 30 MH care packages in Care Notes (across Adults, Abated and Older Adults). All 30 had recent Support Plans which looked detailed, and all but one had Reviews completed within the last year - the issue is they are not always captured on LAS and therefore not visible within OCC.

Funding Approval and Financial Assessments

The audit found **funding approval** for all the 30 care packages reviewed. All the Older Adults MH care packages must be approved within OCC by the Service Manager, South, irrespective of package value. This includes a large volume of care packages sent for approval, including packages which would normally be below their authorisation level to ensure consistency of practice across the localities.

Overall, the audit found that service users were referred for **Financial Assessments** where necessary. However, there are 56 MH care packages paid by **paper invoice** and not via ContrOCC. The last audit raised the issue of paper invoices not being sent for financial assessments and the current audit has found the same issue again. From the sample of paper invoices tested, where a Financial Assessment was required they were either not referred for one and had no record on ContrOCC, or where a Financial Assessment had been completed in the past, the client charge was then not applied, resulting in missed income.

Placements Quality Monitoring

A new process for **quality monitoring** Adult MH residential placements has recently been agreed and implemented between Oxford Health and OCC, which is progress. It is too early to check whether the process is working effectively, as quality monitoring visits have only just begun.

For Older Adults MH care packages, these are supposed to be **sourced** by OCC's CSPO's and subject to OCC quality monitoring, however the audit found multiple cases where this had not happened. There is therefore still a gap in sourcing and quality monitoring the Older Adults MH placements (some are done by OCC if an OCC OP service user has been placed there).

There is also a gap in quality monitoring of the 26 'Abated' service user placements, as well as the 5 OBC partners, as neither of these categories are covered by the new process (however the numbers here are not as high).

S117

There continue to be significant issues with the **inaccuracy of S117 recording** despite a reconciliation having been completed in 2016/17 in order to identify potential errors.

The new **S117 policy** has not yet been agreed between OCC and OCCG (the Local Joint Agreement), despite work being underway on this throughout 2017. Until this is complete, the Oxford Health S117 policy cannot be updated. There is no reference to S117 in the S75 Agreement.

The audit identified potential queries of the central S117 records maintained by the Mental Health Act Office of all service users detained within Oxford Health. In 1 case of the sample of 30, the Office did not have records of a service users' S3 detention and did not have them marked as eligible, despite being marked as S117 eligible in Care Notes and ContrOCC. In 3 further cases, LAS records indicate S3 detentions for the service users from dates several years earlier than the dates recorded by the MHA Office. The dates provided to audit as the 'S117 eligible from' dates were from

the most recent detention in cases of multiple detentions, and not their first detention dates in a further 3 cases, indicating a practice of over-writing earlier dates.

There is significant discrepancy in the S117 eligibility records in LAS, ContrOCC, SharePoint documents and Care Notes. Out of the audit sample of 30 reviewed, 10 had inconsistent S117 records between the different systems.

The audit identified 1 case in the sample where their S117 **status was incorrect**. The service user was marked as S117 in ContrOCC by the Financial Assessment team, upon incorrect advice from an OT in the OAMHT back in 2014. They are in fact not eligible, so they should have had a financial assessment, resulting in potentially missed client charging income.

The audit re-checked the two cases identified in the previous audit where the S117 status was incorrect. Both cases had been followed up and corrected after the audit, however different treatment in terms of repayment was applied.

Data Recording

Data recording in LAS remains inadequate. From the audit sample of 30 care packages, there were issues with the completion of Support Plans on LAS in 19 cases (mostly Adults) – either they did not exist or were minimal in content (they were in existence on Care Notes however). The latest Reviews were not recorded in LAS in 20 of 30 cases (8 Adults, 4 Abated service users and 8 Older Adults) - in Care Notes all but one had Reviews recorded. Gaps also existed in basic personal data and addresses were incorrect or out of date in 6 cases. Safeguarding cases are now being recorded in LAS, and although there had been some issues with delays in completing and closing these down correctly on LAS, although this is being actively monitored by OCC via the daily monitoring report and performance has improved.

Staff reported a continued struggle with dual recording in LAS and Care Notes and a lack of business process mapping to explain how this needs to work in practice.

The audit again found that OCC MH staff seconded to MH were still not recording some HR data such as annual leave on the OCC systems.

Follow Up

The 2016 audit contained 24 management actions; of these 8 have been closed by management. All actions were checked during the current follow up audit. Work has commenced on all actions, with some progress having been made during 2017 but only 9 have been fully implemented, with 7 partially implemented and 8 not yet implemented.

Security Bonds 2017/18

Opinion: Red	10 April 2018	
Total:	Priority 1 = 3	Priority 2 = 14
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	17	

Overall Conclusion is Red

This audit has identified overall a lack of management information and reporting and documented procedures in relation to the security bond process, this includes S106 bond agreements and S38/S278 bond agreements. Security bonds are sought by the Council, within a S106 agreement, as a means of ensuring that deferred contributions are received from developers. S106 bonds are currently only sought where a specific piece of infrastructure is to be provided on the development site, this policy was approved by the Capital Asset and Programme Board (CAPB) in 2016. There are also, within the majority of S106 agreements, standard, alternative means of encouraging prompt payment of deferred contributions, for example a 4% interest is charged on contributions if the developer fails to inform the Infrastructure Funding Team that a trigger point has been reached and has not paid the contributions on time. S278 and S38 security bonds are sought for all schemes. Cash bonds are sometimes provided for these agreements (S278 / S38), in this case the developer transfers an agreed amount of cash to the Council until such time as the works are completed when the cash is returned to the developer.

Management Information & Accounting Treatment

There is currently no management information or management reporting on security bonds either for those secured for S106 agreements or S278 / S38 agreements at any level, either within the Infrastructure Funding Team, Road Agreements Team or to Service Manager or Director level. Management currently have no information which provides them with assurance that security bonds are being arranged as they should be or at an appropriate level. There is also currently no reporting to Corporate Finance on S106 bonds, S278/S38 bonds, including cash bonds. There also does not appear to be a clear understanding within the teams responsible for the arrangement of security bonds of the related Corporate Finance processes and the significance of these.

Although there are records of security bonds in place at individual development level, there is no list, schedule or report available which sets out for S106 security bonds, information such as which S106 agreements have security bonds in place, the amount of the bond and who the bond has been arranged with. For S278 and S38 agreements, there is no detailed listing showing the security bonds in place (including cash bonds). Whilst the situation in relation to these types of agreements is different to S106 in that all S278 and S38 agreements will have security bonds arranged, there is a lack easily accessible source data covering for example, the total value of bonds in place at any one time, information on who bonds are arranged with (to enable an effective and accurate risk assessment during vetting). Whilst Corporate Finance have reported that they have asked for register of bonds in place from both areas in the past, no information has been provided to them.

The lack of detailed information on security bonds in place makes it impossible to produce any meaningful management information.

Policies & Procedures

There is a lack of clarity over roles and responsibilities within Communities for some parts of the security bond process, for example it is not clear who is responsible for the monitoring of S38 and S278 bonds once in place or for taking the decision to call the bond in. There is also a lack of clarity over roles and responsibilities in relation to cash bonds. Although these are secured instead of security bonds for some S278 or S38 agreements, the Planning Obligations team process money coming in from and back out to the developer. Corporate Finance are not involved in this process (this is significant in terms of the investment decisions made within Corporate Finance as well as the way in which these bonds should be accounted for).

Whilst the completion of vetting checks on financial institutions who developers put forward to provide security bonds is the responsibility of Corporate Finance, the role which currently has responsibility for completion of vetting checks requires review. These checks are currently undertaken by the Financial Manager for the Pension Fund as he was responsible for this as part of a previous role.

Policy in relation to the seeking of security bonds for S106 agreements requires review and clarification. Whilst arrangements were approved by the Capital & Asset Programme Board in January 2016 with circumstances where developers refuse to provide a bond referred to the Deputy Director for Planning & Infrastructure, different escalation arrangements were reported during the audit.

There is a lack of clear and up to date process guidance for staff in relation to the S106 security bonds. There is no documented / shared guidance for planning negotiators in key areas such as identifying the need for a bond or for completing the bond calculation. There is also a lack of up to date guidance for Planning Obligations staff in relation to monitoring and management of the bond. Guidance is also incomplete in relation to the bond calling in or release process and no guidance on the tasks performed by Planning Obligations for S278 and S38 cash bonds.

For S38 and S278 security bonds, it was found that there are some draft process maps covering the call-in process, adoption and sign off processes. There is no process guidance on the process for arranging the bond (includes the use of the bond calculator and the need for a vetting check by Corporate Finance) and nothing specific on the use of cash bonds.

Formal approval arrangements for calling in a bond were unclear in both areas.

Vetting

Corporate Finance's current role in the vetting process is limited to the completion of vetting checks and communication of the outcome of these checks to the Service. They do not receive any further information in terms of bonds that actually go on to be put in place following the vetting check, the information provided to Corporate Finance in relation to the vetting check was also noted as being limited. For example, there is no information on which scheme the bond is being sought for. Due to the limited information provided to Corporate Finance and the lack of any form of register of bonds in either area, they also have no way of being able to provide any assurance that vetting checks have been completed where required. This limits the effectiveness of the vetting process

as Corporate Finance are unable to see the total value of bonds in place, in relation to Council schemes, with individual institutions and so cannot accurately assess the Council's risk exposure.

From sample checking undertaken on S278 and S38 schemes, it was only possible to confirm vetting checks had been completed by Corporate Finance in 1/5 cases reviewed. It was reported that bonds arranged with one specific institution are not vetted as they provide so many bonds. This exception has not been formally agreed.

Security Bonds for S106 Agreements
Sample testing identified 2 instances where, from the S106 agreement, it appears that a security bond should be in place but was not. For one agreement the last communication with the developer in relation to the security bond was in February 2017 (bond required for £3.5M), for the other the last communication with the developer in relation to the security bond was in May 2017 (bond required for £1.44M). There does not appear to be any clear escalation or follow up process to ensure that the bond is arranged as agreed.
From review of the calculation of the bond amount, there is a lack of formally documented sign off.

Security Bonds for S278 and S38 Agreements
From sample testing undertaken, it was difficult to confirm that the bond value was appropriate or that the correct process had been followed in agreeing the bond amount. For 3/6 schemes reviewed, it was not possible to confirm that the developers estimate had been obtained and compared with the bond value calculated as required from the team's bond calculator. There were also inconsistent versions of the bond calculators noted, along with examples where it was not clear who had completed the calculation or when and in one case, it was not clear which scheme the calculation related to. There is no documented process for the review or sign off of the bond calculation.

Payroll 2017/18

Opinion: Amber	10 April 2018	
Total:	Priority 1 =	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	2	

Overall Conclusion is Amber

The payroll control environment and compliance has improved since the 2016/17 audit. HR policies and procedures are up to date and accessible; detailed management information on HR processes is provided to DLTs; and processes have been reviewed and simplified. However, some issues remain regarding certain payroll processes, particularly around the promptness of submitting HR forms.

Policies and Procedures

Guidance relating to payroll related processes is appropriate, up to date and accessible, for both OCC policy and IBC processes. The issues identified in the 16/17 audit have been corrected.

Starters and Leavers

Timeliness of processing HR forms for starters and leavers continues to be an issue. From the audit sample of 10 starters, 2 were processed late, resulting in delays of one and two months of salary payments. For the sample of 10 leavers, 2 were processed late, resulting in one overpayment, which was recovered. This is reflected in the audit analysis of all leavers, where it was identified that 25% of leavers in the past 12 months (including schools) were processed after the employee had left the Council. The overpayments report from IBC shows that in this timeframe, 103 out of 149 overpayments were due to late notification of changes.

However, further to action being completed following the 16/17 audit to remind and train managers in these processes, as well as process simplification; timeliness has improved. For Q1 and Q2 approximately 35% of leavers were processed after the employee's leaving date; this decreased to 15% for Q3 and Q4 (as at 13th March).

Variations, Overtime and Overpayments

As identified in the 2015/16 and 2016/17 audits, Regular Hours and Triple Time attendance codes continue to be used for overtime claims, however these now require authorisation by a line manager prior to payment and overtime claims are being monitored by HR. The triple time identified were low in value but were in the same team as last year, where some very high levels of overtime were also paid and where an audit action from last year is outstanding to review their Overtime Policy (see Follow Up).

Management Information

HR Payroll Control reports on additional pay are shared at DLTs on a quarterly basis. An overpayments report provided by IBC is now being routinely reviewed by OCC HR to identity the root causes of overpayments and address underlying issues.

In order to simplify recruitment, use of the HR approval form is changing from April 2018. Decisions involving recruitment will be devolved to managers, and new forms for honorariums and merit increments will replace the current HR Approval form. Other processes currently requiring the form will be submitted through the portal.

Follow Up

Out of 11 actions agreed at the 16/17 Payroll audit, 9 have been reported as implemented, with 2 partially implemented (relating to HR Approval Forms, and the Overtime Policy for Edge of Care and Residential Services). Following audit testing, 7 can be evidenced as being fully implemented. The remaining two actions (removal of two time codes on My Time) could not be implemented as IBC were unable to remove the codes. A work around has therefore been implemented, monitoring the use of specific time codes.

Purchasing 2017/18

Opinion: Amber	12 April 2018	
Total:	Priority 1 = 1	Priority 2 = 9
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	10	

Overall Conclusion is Amber

As part of the Fit for the Future Programme a number of initiatives are being considered which are fundamental to driving better performance from the Council's Procurement, Contract Management and Commercial Activities. The governance structure, including roles and responsibilities are being reviewed and were therefore not included within the scope of the audit. Work is planned to review and develop the OCC Procurement Strategy and OCC Procurement Policy, there is a review of the Council's Contract Management Framework and further development and modification of the newly implemented eCMS (Electronic Contract Management System). Improvement actions have been noted within the Corporate Lead Statement for Purchasing, which forms part of the Annual Governance Statement Process.

General issues were noted with guidance needing to be updated and hyperlinks to information were broken. A review of all finance intranet guidance was taking place over a year ago, however it is not clear how far through that project is, or whether it was fully completed. However, the Fit for the Future Programme will provide the opportunity to update the Procurement Strategy and associated guidance. Hampshire also provide guidance pages, which help guide staff through how to carry out various transactions. These were not reviewed as part of the audit.

Management information has not been reviewed in any detail as part of this audit. A new suite of information has been introduced for a number of areas across the council's performance, including accounts payable processes. The first joint working group meeting met in October 2017, with the intention to meet on a quarterly basis. An overview of the information has highlighted that there is substantial information being produced for accounts payable processes which should help target areas of poor performance including the raising of retrospective purchase orders, delays in goods receipting and late invoice payments.

There are currently two embedded cards used within the Council. They bring advantages of bypassing overly bureaucratic processes for simple/urgent purchases. This saves both time and administrative costs. There is oversight of the transactions, and limits in place on the cards to avoid any excessive expenditure. However, there is currently no plan to formally review opportunities for more cards and roll these out more widely across the Council.

A list of new suppliers set up this financial year was obtained and checked against the contract management system. Less than 1% of the suppliers had been set up on contract on the eCMS system. It is acknowledged that a contract would not be

expected for all of these, however there were instances identified during the audit where a contract would have been expected. Further detailed work is now being undertaken by OCC following the recent PwC third party spend analysis. This had highlighted that there is scope for the Council to review the number of suppliers it is setting up and where there is spend without contracts in place.

An interface has been developed which has enabled Adult Social Care payments to automatically upload via the BDU system. This is a positive improvement in the control environment since the previous audit. However, there is still work to be done to rationalise the number of manual uploads. It is recognised that the BDU process lacks system enforced controls / segregation of duties, is inefficient, time consuming and prone to errors. This was highlighted during testing undertaken on the 2017/18 Supported Transport Audit where a high level of errors were noted, this included errors identified and corrected prior to the upload taking place as well as errors that had not been picked up and were identified by Audit testing.

OCC do not retain an up to date list of Data Stewards and Business Owners and therefore responsibility for preparation and processing of these uploads is not clearly documented. It was identified during the 2017/18 Pensions Administration audit that Pensions are not following the corporate process for submitting BDU uploads. Testing on this audit identified a lack of segregation of duties in the process with the same officer acting as Data Steward and Business Owner.

The role of the Finance Assistant in the BDU process was considered. It was noted that there is currently no management oversight of the role performed and that checks undertaken are currently limited to reviewing for duplicate payments and confirming that the upload as sent by the Data Steward is what is uploaded via the BDU by the Business Owner.

There is currently no guidance for how to use BDU accessible on the intranet.

Follow Up

The audit followed up on the actions raised as part of the 2016/17 Accounts Payable Audit, the 2016/17 BDU Compliance Review, and one BDU related action from the 2015/16 Design of Controls work

Of the 3 actions agreed as part of the 2016/17 Accounts Payable Audit, 1 action has not yet been fully implemented, this action is referred to within the findings below and implementation will continue to be monitored and reported on through the normal audit follow up process. The other 2 actions have been reported as implemented, but have not been tested as part of this audit. both actions relate to recently introduced management information reporting arrangements. It is planned that effectiveness of implementation will be tested as part of the 2018/19.

Of the 7 actions agreed as part of the 2016/17 BDU Compliance Review, 1 was confirmed as fully and effectively implemented. The other 6 could not be confirmed as effectively implemented and so have been combined and re-worded into a new management action agreed as part of this audit.

The remaining outstanding management action from the 2015/16 Design of Controls audit in relation to the review and rationalisation of the use of BDU for payment uploads was found to have been partially implemented. A re-worded action has been agreed as part of this audit.

The Hampshire County Council Audit Team have completed their Purchase to Pay audit, which has covered the processes HCC perform on behalf of OCC, we place reliance upon the work they undertake. Adequate assurance was provided overall, which they define as; Basically a sound framework of internal control with opportunities to improve controls and / or compliance with the control framework. They noted a small issue specifically relating to OCC, around the promptness of goods receipting, prior to invoices being able to be processed.

Supported Transport 2017/18

Opinion: Amber	12 April 2018	
Total:	Priority 1 = 2	Priority 2 = 29
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	31	

Overall Conclusion is Amber

The audit of Children's Safeguarding – Transport 2014/15, report finalised in April 2015 had an overall grading of Red. Significant weaknesses were identified and assurance could not be provided that there were adequate controls in place to manage external transport arrangements. The action plan within the Internal Audit report contained 42 agreed management actions. The Supported Transport Governance group was formed which was responsible for overseeing the implementation of the agreed actions and other associated improvements.

This audit (2017/18) has a wider scope than the original safeguarding review, however has followed up on the original action plan to ensure that all actions have been implemented and are working effectively. This audit acknowledges the significant improvements made since 2015 which include the implementation of Risk Assessments and Child Passports, the development and implementation of the Transport Safeguarding Standards, Driver training and DBS and vetting processes, closer working with the City & District Councils responsible for licencing, Policies and Procedures, Provider Quality Management, Complaints Management and Management Oversight.

It is positive to note that of the 42 actions agreed within the 2015 report, the audit has tested that 33 actions reported as implemented are working effectively, 7 actions are reported as implemented but have not been tested as part of this audit and 2 actions reported as implemented were found to be partly effective and new management actions have been agreed within this report. These were in relation to the use of taxi's by Children's homes and also reporting of information from the provider quality monitoring visits to the Quarterly Transport Complaints & Allegations meetings.

Referrals:

Issues were noted with the process used to determine the charge for concessionary travel (spare seats). The charge is determined by the students address on the EMS system and on whether this is more or less than a set distance from the school, however testing has identified a number of instances where this address is incorrect. Address data on EMS is also owned by the school not the transport hub so in order for permanent changes to address details on EMS to be retained, the school record must be updated. This is not under the control of the transport hub. Incorrect address data could impact on the accuracy of charging as well as on assessment of eligibility.

Testing has identified that, although bus passes should not be issued prior to full payment being made, there are no system controls in place to enforce this and no management reporting on cancelled invoices. An example was identified during testing where a pass was issued when full payment had not been received and other examples where invoices had been cancelled and bus passes issued without sufficient evidence being retained to document why. There is therefore an increased risk that badges could be issued fraudulently or in error and that income due will not be recovered.

Commissioning & Allocations:

Limited progress has been made with recording supported transport contracts to the corporate ECMS system. It has been reported that this has been due to unexpected staff sickness and the need to prioritise other tasks.

Although historically, there has been no process in place to review or re-assess SEN transport provision once it has been agreed, as part of the work undertaken on the SEN Transport Project, existing cases are being reviewed in relation to the suitability of the mode of transport. Going forward, it is planned that regular reassessments of the suitability of transport provision will be part of the business as usual process. It is noted that parents are given the opportunity to review and update information in their child's passport on an annual basis

Some updates are noted as being required to website information, including review of the Safeguarding Manual which should be reviewed annually. The current version is dated May 2016.

Payments & Income:

From review of the provider payment process, it was noted that there is currently no management information being produced or reviewed in relation to manual adjustments made to payment values on EMS. Whilst the risk of fraud as a result of collusion between Council staff and transport operators is reduced due to the number of officers processing invoices and the way in which invoices are allocated to individual officers for processing, there is still a risk that EMS records could be amended to increase operator payments without any independent oversight or challenge, there is also the risk of error. Some delays were noted in relation to updating of EMS records by the Contracts team, therefore necessitating manual adjustments by the team processing payments.

Payments are made to supported transport operators / providers via BDU upload. The BDU process lacks system enforced controls / segregation of duties, is inefficient, time consuming, and as demonstrated by the testing undertaken as part of this audit, prone to input error. From the sample of 10 uploads reviewed by Internal Audit during testing, errors were picked up by the Business Owner for 50% of cases. There were also errors picked up by Internal Audit which had not been identified by the Business Owner prior to the upload being processed. This included 2 examples where the wrong vendor had been paid. It has been reported that alternative payment processes to BDU upload have been considered, but as yet, no suitable alternative has been identified.

Contract Monitoring:

Although, when testing was initially undertaken, it appeared that provider visits and establishment checks were not on track to have completed the required number of visits by the end of the year, it appears that performance has recently improved. Issues were noted with the coverage of provider visits in that they were not covering DBS and badging checks, despite establishment check records indicating that there were problems found in this area in 1 in 3 visits (this includes less significant issues such as a driver having forgotten their badge as well as cases where a driver didn't have a badge or hadn't been DBS checked). Since audit testing was completed, the team have begun to complete DBS and badging checks as part of provider visits.

From review of safeguarding complaints about supported transport provision, dealt with by the CEF safeguarding team, some inconsistencies were noted in the process followed and documentation maintained. Both the transport hub and the CEF safeguarding team report that information is shared well between the teams. Management oversight of the decision-making process, once a complaint has been investigated has been limited, however a new form has been introduced since the completion of audit testing which includes line manager sign off of the outcome of the complaint / investigation.

Communication in relation to supported transport concerns, complaints etc between Children's and the Transport Hub at management level was noted as having moved from monthly to quarterly meetings. The last confirmed meeting took place in September 2017, so the next meeting is now overdue. It was also noted that although there was evidence that these meetings included review and discussion in relation to themes of complaints, it was not possible to see that themes coming out of provider visits were being discussed.

Management Information:

There are various different systems and spreadsheets in use for different processes in relation to the arrangement of transport and routes, payments made to transport operators, driver vetting checks and complaints. The use of different systems and spreadsheets, whilst unavoidable in some areas at present, means that there are areas where the same data has to be input more than once, taking up staff time and increasing the risk of input errors and inconsistencies. This has been observed in a number of areas during this audit for example in relation to the data recording for both mainstream and SEN referrals and allocations, as well as the BDU process as detailed in the payments and income section of this executive summary.

Additionally, limitations have been reported in relation to the EMS ONE system in being able to use the data recorded on it to obtain reliable information on the reasons for increases or decreases in spend in a particular area. Although data can be obtained from the EMS system, it has to be manually manipulated and then it is often difficult to reconcile.

It is understood that development of an integrated IT solution for the supported transport service is to be considered as part of phase 2 of the implementation of the new Children's IT system. Whilst a new IT solution for supported transport has yet to be formally agreed or scoped, the new IT Children's system provides an opportunity to make improvements and efficiencies in a number of areas where there are currently issues.

Children's Contract Management 2017/18

Opinion: Amber	12 April 2018	
Total:	Priority 1 = 2	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	7	

Overall Conclusion is Amber

Introduction

There have been significant governance changes to Children's Contract Management in the People Directorate since the previous audit in 2014/15. The management of the larger Children's contracts (including blocks and Framework/Regional Agreements) now comes under the remit of the Joint Commissioning team, with support from the operational teams. This has seen positive results in terms of the consistency and quality of contract monitoring and management. Additionally, from March this year, the Placements teams for both adults and children's have merged and brought together under Joint Commissioning.

It is recognised that the placements budget is considerably overspent. Projects have been commissioned as part of the Fit for the Future Programme to review a number of the high cost placements, to ascertain whether there are any opportunities to improve contract management and achieve better value for money.

Contract Management and Monitoring

Block and larger Contracts

The audit found adequate oversight of the children's contract monitoring carried out by the Joint Commissioning team. Evidence was in place to support the reviews of the contract outcomes and performance of the providers. Additionally, the payments to each provider had been set up correctly, in line with the contractual agreements. Quality Monitoring is undertaken on an agreed risk based approach.

The audit identified issues with payment information within ECMS (Electronic Contract Management System) not matching SAP – this is thought to be due to a delay in payment information passing from SAP to ECMS and does not affect payment accuracy. As part of the Fit for the Future Programme a number of initiatives are being considered, including a review of the Council's Contract Management Framework and further development of ECMS. Improvements to ECMS are required to ensure improved business intelligence, visibility of contract and supplier performance and better management reporting.

Spot Placements

Individual Placement Agreements (IPAs) should be in place for every children's placement, as they form the contract between OCC and the spot provider and they document the placement outcomes for the child. There were finalised IPAs in place for only 30% of the placements sampled (the issue with missing IPAs was also noted as part of the Fostering Audit carried out earlier this financial year). However, the audit noted that every placement sampled had a care plan in place and LAC reviews had been completed, to ensure the child was being supported.

The Placements Team should be undertaking pre-placement vetting checks and regular monitoring checks on providers, however evidence was not always available to show that these were taking place fully. This is something that the new Placement Team arrangements will reportedly address.

Management Information

Strategic information is presented and considered by the Placement Review Programme Board, which includes the review of high cost placements, the work on demand management and review of SEND placement spend. However, there is a lack of strategic management information considered by DLT which provides commercial information across Children's Contracts, including supplier spend analysis (including spend not subject to contract or framework agreement and also spend against forecast/contract value), contract risk, performance and quality monitoring assurance and overall contract key issues / themes.

This issue was previously highlighted in the 2014/15 audit and whilst some management information has been developed this has not yet been considered by DLT. It is also acknowledged that improvements corporately to the ECMS system are required to enable better management reporting around supplier spend and performance. Examples were provided to audit to confirm that significant issues are being communicated upwards where necessary, on individual contract issues. However, there is insufficient strategic information to enable adequate oversight by senior management on the overall performance, including the financial position, of Children's contracts.

Follow Up

There were 12 actions agreed as part of the 2014/15 CEF Contract Management audit. 10 of these have either been implemented or superseded with changes to processes. The two that have not been fully implemented relate to management information being presented to DLT, as reported above and will be superseded by a new action.

Appendix 3

Statement of Assurance
Integrated Business Centre
2017-18

Southern Internal Audit Partnership

Assurance through excellence and innovation

Contents

Section Page

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).*

3 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 2017) [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 organisation's 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 (IBC) 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 (IBC) that these arrangements are in place and operating effectively.

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

4 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;
- 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.

5 INTERNAL AUDIT OPINION

Oxfordshire County Council joined the Shared Services Partnership in July 2015, meaning that Oxfordshire's transactional HR and Finance functions 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.

6 INTERNAL AUDIT COVERAGE AND OUTPUT

The 2017-18 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 8 reviews contributing to my audit opinion:

Review	Status	Assurance Opinion
Payroll	Final	Substantial
Payroll Support	Final	Substantial
Purchase to Pay (P2P)	Final	Adequate
Order to Cash (OTC)	Final	Adequate
BACS	Final	Adequate
Governance Arrangements	Final	Substantial
Debt Collection	Draft	*Adequate*
Recruitment – Pre employment checks	Draft	*Limited*

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

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 2017/18 this included: IT Change Management; Network Management & Monitoring; SAP (Operational Basis Support); Platform Monitoring (Windows & Linux); Database Management & Security; Identity Management; PCI Compliance; Business Applications; and ISO 27001. Our assurance opinion (incorporating these reviews) will be reported to HCC Audit Committee in June 2018 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 contribute 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.

7 MAIN ISSUES

RECRUITMENT – PRE EMPLOYMENT CHECKS

Our review of pre-employment checks resulted in a limited assurance opinion. Whilst testing confirmed that the pre-employment checks requested by recruiting managers (in conjunction with HR advice) are being undertaken on prospective employees, a number of weaknesses were identified in the identification of the pre-employment checks to be undertaken, recording of DBS details and the setting-up of tasks for DBS re-checks in SAP. Linked SAP records for employees with multiple employments were not always updated with DBS check details. There are

also opportunities to improve and expand documented guidance to ensure consistency of advice and that expectations for all preemployment checks are clear.

8 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.

9 QUALITY CONTROL

Our aim is to provide a service that remains responsive and maintains consistently high standards. This was achieved in 2017-18 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 complemented 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 conforms to all Standards within the IPPF, PSIAS and LGAN. This is supported by ongoing annual self–assessment.

10 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 April 2018