Oxfordshire County Council

Internal Audit Services

Annual Report of the Chief Internal Auditor

2018/19

OXFORDSHIRE COUNTY COUNCIL INTERNAL AUDIT SERVICES

Author: Sarah Cox, Chief Internal Auditor. May 2019

AUDIT & GOVERNANCE COMMITTEE – 8 MAY 2019

ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR

RECOMMENDATION

1. The Committee is RECOMMENDED to consider and endorse this annual report.

Executive Summary

2. This is the annual report of the Chief Internal Auditor, summarising the outcome of the Internal Audit work in 2018/19, and providing an opinion on the Council's System of Internal Control. The opinion is one of the sources of assurance for the Annual Governance Statement.

3. The basis for the opinion is set out in paragraphs 22 – 34, followed by the overall opinion for 2018/19 which is that there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

Background

4. 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.
5. Oxfordshire County Council's Internal Audit service conforms to the PSIAS 2017.
6. 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.

Responsibilities

7. 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.

8. 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.

Internal Control Environment

9. 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.

10. 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.

11. 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.

The Audit Methodology

12. 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”

13. 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 March 2019 Audit & Governance Committee meeting. The conclusion from the survey was that management find the internal audit service effective in fulfilling its role.

14. The Internal Audit Strategy and Annual Plan for 2018/19 was presented to the April 2018 Audit and Governance Committee. The Committee then 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.

15. 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.

16. 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.

17. 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).

18. To provide quality assurance over the audit output, audit assignments are allocated to staff according to their skills and experience. Each auditor has a designated Audit Manager 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.

The Audit Team

19. During 2018/19 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 Senior Auditor vacancy which has recently been recruited. The team also worked in collaboration with the Oxford City Council Investigation Team who provided counter-fraud resource throughout 2018/19.
20. 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.
21. 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 2018/19.

OPINION ON SYSTEM OF INTERNAL CONTROL

Basis of the Audit Opinion

22. The 2018/19 Internal Audit Plan has been completed, with all reports finalised.
23. The plan is intended to be dynamic and flexible to change. It was revised during the year, and eight audits originally planned have been cancelled or deferred until 2019/20 plan. There were also two audits added to the plan. (these amendments were reported to the January 2019 Audit and Governance Committee meetings):

Cancelled or deferred:

- Oxfordshire Housing and Growth Deal – Accountable Body
- ICT – Back-up and Recovery
- ICT - IT Incident Management
- ICT - Data Centre Refresh
- Fit for the Future – new Target Operating Model
- Foster Payments
- Children's Social Care Payments
- Children's Placements – walkthrough testing of placements completed by the end of March 19 as planned, scope of audit widened and now included within 2019/20 plan. Fieldwork started in April 19. (This was not previously reported to Jan 2019 Committee, as decision taken since then)

Additions to plan:

- Security Bonds reconciliation
- Broadband project

24. 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.

25. 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.

26. 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.

27. There have been 33 audits undertaken in 2018/19. There have been five audits which have been graded as RED during 2018/19; S106 follow up, Health & Safety, Business Continuity, Contingency Care, Facilities Management Governance.

28. 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 below takes into account the implementation of management actions.

29. As part of governance arrangements developed when Oxfordshire County Council joined the Hampshire 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 partnership. 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 partnership's key financial systems by Southern Internal Audit Partnership have been shared with Oxfordshire County Council.

30. The Anti-fraud and corruption strategy remains current and relevant. In 2018/19 the Audit & Governance Committee have been updated on reported instances of potential fraud. Most of these are minor in nature. One current investigation is potentially of a more significant value. Updates are made to the Audit Working

Group on this issue. Work has been undertaken to address the control weaknesses identified in this area to reduce the possibility or reoccurrence.

31. The National Fraud Initiative data matching reports for the 2018/19 data match exercise have now been received. Key matches are now being reviewed and investigated. Results will be reported to the Audit & Governance Committee in the quarterly updates.

32. 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.

33. 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.

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

    - The results of all audits undertaken as part of the 2018/19 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.

Chief Internal Auditors Annual Opinion

In my opinion, for the 12 months ended 31 March 2019, 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)

Audits completed since last report to A&G Committee

35. 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 2019) are attached as appendix 2;

- Samuelson House
- Treasury Management
- Waiting List Management
- Waste Contract Management
- Better Broadband of Oxfordshire Programme
- Pensions Administration
- Troubled Families March Claim
- Facilities Management
- S106 Follow Up
- Highways Payments
- The Oaks Assessment Home
- Capital Governance Follow Up
- Internet and Email Access Review
- Client Charging
- Supplier Resilience
- Accounts Receivable
- Payroll
- Training & Development
- Thames Valley Adoption Service
- Business Continuity (Executive Summary not included as the full report was considered at the February AWG).

Internal Audit Performance

36. The following table shows the performance targets agreed by the Audit Committee and the actual 2018/19 performance.
37. It is pleasing to note that 100% of the plan has been completed before the end of April. The team have worked exceptionally hard to meet this target again.
38. 2018/19 has been a challenging year for the team, managing initially a Senior Auditor vacancy and more recently the Auditor vacancy. Short term resources from an external firm have been used to cover most of the lost chargeable days however there have been issues with this arrangement. This has therefore impacted on the in-house team (in particular the Audit Managers), who have had to spend additional time supporting this work. This has impacted on the target indicators for issuing both draft and final reports. The new Senior Auditor has been recruited and will be in post from the beginning of May.

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	69% of the audits met this target. (2017/18 this was 60%, 2016/17 60%, 2015/16 58%, 2014/15 52%)
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	82% of the audits met this target. (2017/18 this was 95%, 2016/17 94%, 2015/16 96%, 2014/15 83%)
Elapsed time between issue of draft report and the issue of the final report	15 Days	85% of the audits met this target. (2017/18 this was 92%, 2016/17 75%, 2015/16 48%, 2014/15 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 2019. (2017/18 this was 100%, 2016/17 100%, 2015/16 66%, 2014/15 64%)
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at 10 April 2019: 907 actions being monitored on the system.

Measure	Target	Actual Performance 2017/18
		• 80% implemented • 11% not yet due • 5% partially implemented • 4% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2	Average score was 1.07 17/18 was 1.03, 16/17 was 1.13.
Directors satisfaction with internal audit work	Satisfactory or above	The review of the effectiveness of internal audit is undertaken by the Monitoring Officer - results of this was reported to the March 2019 Audit & Governance Committee – Satisfactory.

Sarah Cox, Chief Internal Auditor, May 2019

Background papers: None

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APPENDIX 1 - Implementation status of 2018/19 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 10 April 2019
People	Financial Management	n/a	n/a	Cipfa Self-Assessment completed and Financial Management Action Plan developed.
People	Financial Management – establishment audit – The Oaks, Children's Assessment Centre	Amber	6	6 not yet due
People	Contract Management - Supplier Resilience	Amber	12	11 not yet due and 1 implemented.
People - Adults	Payments to Providers (Home Support and Residential)	Amber	23	2 not yet due, 15 implemented, 6 ongoing
People – Adults	Waiting List	Amber	8	5 not yet due, 1 implemented and 2 ongoing
People - Adults	Client Charging (including ASC debt)	Amber	10	10 not yet due
People – Adults	Contract Management – Reablement – Contingency	Red	25	1 not yet due, 19 implemented, 2 ongoing and 3 ongoing
People – Children	Implementation of IT system	Amber	7	2 implemented and 5 ongoing

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 10 April 2019
People – Children	Retention, including training and development	Amber	5	5 not yet due
People – Children	Thriving Families – September Claim	n/a	7	7 implemented
People – Children	Thriving Families – March Claim	n/a	5	5 not yet due
People – Children	Thames Valley Adoption Service	Amber	12	12 not yet due
People – Children	EDT (Emergency Duty Team)	Green	4	4 ongoing
People – Children	Census Team	Amber	11	3 not yet due, 6 implemented, 2 ongoing
Communities	Financial Management	n/a	n/a	Cipfa Self-Assessment completed and Financial Management Action Plan developed.
Communities	Financial Management – Income	Amber	3	2 not yet due and 1 implemented
Communities	Financial Management – establishment audit – Samuelson House	Amber	5	1 not yet due, 1 implemented and 3 ongoing
Communities	Security Bonds reconciliation	n/a	n/a	n/a

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 10 April 2019
Communities	Highways Contract Payments	Amber	9	9 not yet due
Communities	Waste - Contract Management	Amber	6	5 not yet due and 1 implemented
Communities	S106 follow up audit	Red	4	4 not yet due
Communities	Facilities Management	Red	8	8 not yet due
Communities	Broadband Project	Green	0	n/a
Communities / Resources	Capital Programme – Governance and Delivery – follow up audit	Amber	5	5 not yet due
Resources	Financial Management	n/a	n/a	Cipfa Self-Assessment completed and Financial Management Action Plan developed.
Resources	Finance - Pensions Administration	Amber	6	5 not yet due and 1 implemented
Resources	Finance - Payroll	Green	1	1 not yet due
Resources	Finance - Accounts Receivable	Green	1	1 not yet due
Resources	Finance - Treasury Management	Green	0	n/a
Resources – ICT	ICT - Network Management	Green	3	3 implemented

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 10 April 2019
Resources – ICT	ICT - Internet and Email Access (Cyber Security)	Amber	6	1 not yet due and 5 implemented
Corporate / Cross Cutting	Fit for the Future – governance arrangements	Amber	16	16 implemented (or superseded)
Corporate / Cross Cutting	GDPR – General Data Protection Regulation	Amber	12	1 not yet due, 7 implemented and 4 ongoing
Corporate / Cross Cutting	Health & Safety	Red	27	1 not yet due and 26 implemented
Corporate / Cross Cutting	Business Continuity	Red	12	10 not yet due (but partially implemented) and 2 implemented.
Corporate / Cross Cutting	Grant Certification • Disabled Facilities Grant (DFG) • National Productivity Investment Fund Grant (NPIF) • Highways Maintenance Challenge Fund Grant (HMCF) • Integrated Transport (IT) and Highways	n/a	n/a	All complete – signed off.

Directorate	Audit	Overall Conclusion at Final Report Stage	Number of Management Actions agreed	Reported implementation status as at 10 April 2019
	Maintenance (HM) Block Grant • Safer Roads Fund Grant • Pot Hole Action Fund (PAF) Grant • Flood Resilience Fund Grant • Bus Subsidy Revenue Grant • Better Broadband Grant			

APPENDIX 2

Summary of Completed 2018/19 Audits since last reported to the Audit & Governance Committee - January 2019.

Samuelson House Review 2018/19

Overall conclusion on the system of internal control being maintained	A

Opinion: Amber	15 February 2019	
Total: 5	Priority 1 = 0	Priority 2 = 5
Current Status:		
Implemented	1	
Due not yet actioned	3	
Partially complete	0	
Not yet Due	1	

An assessment of Financial Management was undertaken within OCC during 2018/19. As part of this, several establishments are being visited by Internal Audit to review the efficiency and effectiveness of financial management at a local level. Property Business Management was one of the areas selected for review, as significant sums of cash are processed through the 4 offices. All 4 Imprest accounts had been repeatedly overdrawn during 2018, as the account reconciliations were not being undertaken frequently. Following a review by the Finance Business Partner, it has been confirmed that the Imprest accounts are now being reconciled frequently. The Council intends to reduce the level of cash payments and introduce pre-paid cards for all social care payments as far as possible. Samuelson House in Banbury was visited by Internal Audit in December 2018 to review the monitoring and control of income & expenditure, cash security and budgetary oversight, as well as the efficiency and effectiveness of these processes. The Office follow the Local Office Finance Procedures, which formed the basis for the audit review.

The overall conclusion is 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. Whilst there was adequate compliance overall to the Local Office Finance Procedures, issues were identified regarding cash carrying security and non-retention of service user cash receipts which present a risk of cash theft, as well as a risk to staff safety. Wider issues regarding the high volumes of cash usage were also noted and action agreed with Children’s Services to review and implement options for non-cash payments, i.e. pre-paid cards, to reduce children’s social care cash payments currently paid from the offices.

Treasury Management 2018/19

Overall conclusion on the system of internal control being maintained	G

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
IT Systems	G	0	0
Strategy, Policy & Procedures & Reporting	G	0	0
Investments	G	0	0
Borrowings*	N/A	N/A	N/A
Cash Flow Management	G	0	0
		0	0

** No borrowings have taken place in the last 12 months, so no testing has been undertaken in this area as part of this audit*

IT Systems – The audit found that access to the key treasury management systems and information was appropriately controlled. No issues were noted in relation to the level of service or accuracy.

Strategy, Policy & Procedures & Reporting – It was found that the Treasury Management Strategy was in place in line with recommended practices and legislation and had been appropriately approved and reported on. Reporting on treasury management activity and performance to senior management and members was found to be appropriate. Staff guidance was found to be comprehensive and accessible. Some minor accuracy issues were noted in relation to accuracy documented staff guidance, a supplementary issue has been agreed to address these.

Investments – Loans and money market fund / call account transactions reviewed as part of audit testing followed the correct process, were accurately recorded and appropriately authorised in accordance with delegated responsibilities.

Borrowings – No borrowing has taken place in the last year so no testing has been undertaken in this area. Internal Audit have confirmed that there have been no changes to process or controls since the previous audit.

Cash Flow Management – Cash flow arrangements were found to be operating effectively with appropriate monitoring of bank accounts taking place and being considered as part of the investment process.

Follow up - This audit included follow up on the effectiveness of the implementation of management actions agreed when Treasury Management was last audited in 2016/17. 4 priority 2 management actions were agreed. All have been confirmed as effectively implemented during audit testing.

Waiting List Management 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Policies and Procedures	A	0	3
IT Systems	A	0	2
Management Information	G	0	0
Budget Management	G	0	0
Waiting List	A	0	3
		0	8

Opinion: Amber	27 February 2019	
Total: 8	Priority 1 = 0	Priority 2 = 8
Current Status:		
Implemented	1	
Due not yet actioned	2	
Partially complete	0	
Not yet Due	5	

The area of the Council responsible for the management of the waiting list for residential and non-residential Adult Social Care referrals and the sourcing of care has and is still going through a period of significant change. There have been changes to team structures and reporting lines, interim team management arrangements for much of the year, process reviews and a new IT system is in the process of being implemented for the recording and management of waiting list referrals. There is also work ongoing in relation to the next phase of the implementation of LAS (implementation of LAS Option A and system blocker work) which will impact on the Care & Support Brokerage teams function and processes. It is anticipated that changes such as the move of wait data recording on to LAS and the outputs from the system blocker work will result in improvements in some of the areas detailed below where weaknesses have been identified (for example better visibility of sourcing work, clarity over the third party top up process, removal of time consuming and repetitive approval processes). Some of the issues identified as part of this audit were also noted as part of the 2018/19 Contingency Home Care audit (including monitoring of timeliness and accuracy of HART referrals, Care & Support Brokerage Team guidance on contingency care, the recording of sourcing activity on LAS and monitoring of those who have been on the waiting list for an extended period of time). These findings have either been reported in the separate Contingency Home Care audit report or are referred to in the findings below. Additionally, some of the areas reported on within this report will be addressed by management actions agreed following Client Charging audits from 2015/16 and 2017/18 and from the 2018/19 Payments to Providers audit. Implementation of these

actions will be monitored and followed up in accordance with the standard Internal Audit process.

Policies & Procedures – There is an ongoing review of the structure and staffing of the placements service. Team processes are also being reviewed and refined as part of this work. Current documented guidance in place for staff requires review and updating to reflect changes to process as a result of the move of wait data recording on to LAS and as a result of the process review. There is currently no documented guidance for Care Support Placement Officers (CSPOs) who source residential placements.

IT Systems – The service is in the process of moving recording of wait data from complex spreadsheets, maintained by the Care & Support Brokerage Team, over to recording on LAS. The need to move over to the new system is recognised in the Adult Social Care risk register and although progress with implementation has not been to the planned timescale, the new system is now running in parallel with the old while data integrity checks are completed. There are also mechanisms in place for progress reporting on the implementation of the new system.

Waiting List – It was noted that there is currently a requirement for Home Support Placement Officers (HSPOs) to obtain "permission to place" from team management for any community referrals before home support is arranged. The purpose of this process is to ensure that available home support provision is prioritised appropriately, however as the process is not currently consistently documented, it is not possible to evidence that the process is being followed consistently and there is a lack of accountability for any decisions made. It has been proposed that this will be addressed within the team by reviewing how best to evidence the decision-making process and within Adult Social Care as a whole through the strengths based practices work.

Inefficiencies were noted in relation to the residential sourcing approval process. The current process is inefficient, requiring multiple sign offs prior to sourcing a placement. Sample testing carried out as part of this audit identified that the current process is not being followed consistently with Funding Authorisation Form (FAF) approvals either not being obtained at all or being obtained after the placement had been made. Instances were also noted where Annex 2's (the Council's contract with the provider) were not approved until after the start of the placement. The Service acknowledge that the current process is inefficient and have changes planned as part of the LAS process improvement work. Along with management action on the referral and placement authorisation process agreed as part of this audit, management actions have already been agreed as part of Client Charging Audits in 2015/16 and 2017/18 (relating to the annex 2 process and process review) and as part of the 2018/19 Payments to Providers audit (review of the support planning process) which will improve efficiency in this area once implemented.

An example was identified from sample testing where a lack of communication between Social Care staff and Care & Support Brokerage staff appears to have led to inconsistencies in the top up arrangements for a residential placement. This will be fully investigated by the team manager. Going forward communication between the different teams will be improved through the recording of wait data on LAS, allowing better visibility of information to both teams, and should also be improved as a result of increased efficiencies introduced following the process review

Waste Contract Management 2018/19

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	**AREA CONCLUSION**	**No of Priority 1 Management Actions**	**No of Priority 2 Management Actions**
A: Contract Governance	**A**	**1**	**1**
B: Risk Management*	**n/a**	**n/a**	**n/a**
C: Contract Performance	**G**	**0**	**0**
D: Payments, Incentives & Penalties	**A**	**0**	**4**
		1	**5**

**No detailed testing was undertaken in this area*

Opinion: Amber	12 March 2019	
Total: 6	Priority 1 = 1	Priority 2 = 5
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

There have been significant changes to staffing, team structure and roles and responsibilities in relation to waste contract management during 2018/19. In addition to this, the 25 year Energy Recovery Facility (ERF) contract has been renegotiated resulting in significant financial savings for the Council. Overall, from testing undertaken as part of this audit, it has been confirmed that waste contracts are being effectively managed, with appropriate information being sought and received from waste contractors to provide assurance over the service being provided in relation to waste treatment. Some areas for improvement have been identified as noted below, however these have been received positively by the team and wherever possible, process improvements have been made immediately.

The way in which the Council manages the treatment of the Counties waste is determined by agreed strategies. This includes the Joint Municipal Waste Management Strategy (JMWMS) which is agreed with the District Councils and is currently in the process of being reviewed. The County Council also has a Household Waste Recycling Centre Strategy. This was agreed by Cabinet in 2015 and involves the rationalisation and reduction of Oxfordshire's Household Waste Recycling Centres (HWRC) from 7 to 3 or 4, however to date it has not been possible to identify suitable sites for the new centres. This has meant that developer contributions have not been able to be sought in relation to waste infrastructure for new housing developments, and scope for the spend of developer contributions already secured for waste

infrastructure is limited. It has been reported that some of the contributions already secured are at risk of claw back due to longstop clauses. A review of the strategy is required so that changes necessary to enable the Council to develop the required infrastructure for waste treatment can be made, utilising existing developer contributions and being able to agree developer funding for new residential developments where appropriate. The strategy will become increasingly important due to the scale and pace of housing development anticipated across the County in the coming years.

Risk management reporting was not looked at in detail as part of this audit. Communities are in the process of reviewing and refreshing the way that risk are identified, captured and reported on.

Contract performance was found to be being managed and monitored appropriately with evidence that there is good communication with contractors. Where issues arose with individual contractors, these were clearly identified by the service and were being addressed.

It was noted that the annual recycling percentage on which the HWRC incentive or penalty payment is based has not yet been confirmed for year ending September 2018. It has been reported that this is as a result of some anomalies in the data submitted which are in the process of being investigated.

Improvements were also agreed as part of the audit in relation to the evidencing of invoice approvals and documentation of contract payment variations.

Better Broadband for Oxfordshire Programme 2018/19

Overall conclusion on the system of internal control being maintained	**G**

RISK AREAS	**AREA CONCLUSION**	**No of Priority 1 Management Actions**	**No of Priority 2 Management Actions**
Governance	**G**	**0**	**0**
Management Information & Reporting	**G**	**0**	**0**
		0	**0**

Opinion: Green	22 March 2019	
Total: 0	Priority 1 = 0	Priority 2 = 0
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	0	

The Better Broadband for Oxfordshire Programme began in August 2013 with delivery of the programme extended from December 2018 to September 2019 with the final payment due to be made in June 2020. The aim of the programme, consisting of 3 phases, was to deliver Superfast Broadband (>24Mbps) to 78,007 premises in total throughout Oxfordshire.

Governance – It was found that there are clear governance processes in place for the management and delivery of the Better Broadband Programme. Although it is noted that there is a delay in completion of the programme from December 2018 to September 2019, programme performance is regularly reviewed and discussed by different programme groups involving Council staff up to Director level. Testing also confirmed that there are effective processes in place for review, scrutiny and approval of contractor invoices prior to payment being made.

There is currently ongoing discussion over the treatment of the programme underspend and the gainshare income via the standard capital governance process with a report due to go to CIDG (Community Infrastructure Delivery Group) and CIPB (Community Infrastructure Portfolio Board).

It was noted that whilst some work is required to bring documented procedure guidance in relation to the role of the Programme Director up to date, however this is underway and is due to be completed by May 2019.

Management Information & Reporting – There are clear structures and processes in place for reporting on programme progress and finances which, from testing undertaken as part of this audit, appear to be operating effectively. Whilst current reporting arrangements are at Programme level (weekly project review meetings, monthly project board meetings and quarterly strategic management meetings attended by both OCC and programme partners), it is noted that corporate monthly reporting to CIDG on programme delivery will start from April 2019 bringing programme reporting in line with the Council's capital governance process.

The governance and project management of the project was also audited in 2015/16 and was rated Green. There were no management actions to follow up on.

Pensions Administration 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Regulatory Framework	G	0	0
Scheme Member Lifecycle	A	1	2
Admitted Bodies	A	0	1
Debtor Management	A	0	2
		1	5

Opinion: Amber	28 March 2019	
Total: 6	Priority 1 = 1	Priority 2 = 5
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

Performance in 2017/18 in relation to the processing of deferred benefits and the issuing of Annual Benefits Statements had not been at the required level, resulting in breaches in pensions regulations which were reported, by the Pensions Service, to the Pensions Regulator during 2017/18. This has resulted in an Improvement Plan, agreed by the Pensions Regulator, covering the issuing of Annual Benefits Statements, processing of deferred benefit cases and data quality issues, as well as other key risks relating to the Pensions Administration Service. Significant work has been completed by the team to implement the improvements. The team report that the historic deferred benefit processing task has now been completed, Annual Benefits Statements have been issued for all employers except one (there are outstanding data issues with this employer), and that they are seeking further clarification on the national standard for data quality (this doesn’t impact on the reporting submitted, but it is felt that this clarity would be of benefit to the LGPS as a whole).

Resourcing remains an issue within the Pensions Administration Service; at the time of audit testing it was reported that there is a vacancy gap of around 9 FTE, affecting the timeliness of completion of key processes, including scheme member lifecycle tasks and review of Monthly Administration Return Spreadsheets (MARS) returns from employers.

The team have a recruitment strategy in place to try and address these challenges and are also developing a new Administration to Pay process with the aim of improving process efficiency.

Scheme Member Lifecycle

Ongoing issues with recruitment and resourcing (as discussed above) continue to have an impact on the timeliness of completion of lifecycle tasks. Delays were noted during testing in relation to processing Transfers In, member deaths and Pension Sharing Orders, and deferred benefits (for scheme leavers), although it is noted the Team are currently experiencing high workloads in relation to the latter task. There had also been delays in issuing Previous Pension Forms (PPFs) to new OCC starters.

Following issues identified in this area during previous audits, Payroll processes have been re-designed in order to ensure sufficient segregation of duties. However, reports showing tasks completed by individuals with access to both the Administration and Payroll functions on Altair were not being run on a regular basis prior to the audit, although it has been reported that this will be carried out monthly going forward. Furthermore, these reports do not cover actions taken by the Pension Services Manager, who also has access to both sides of the system.

Admitted Bodies

There have been delays in reviewing MARS data by the Employer Team within the Pensions Administration Service (for 4 employers, returns had not been reviewed and vetted since April 2018). This increases the risk that data errors may not be identified promptly. It is planned that MARS data checks will be up-to-date for all employers by the end of March 2019. A new project (I-Connect) is also currently in progress which will enable employers to upload their returns automatically to Altair. At the time of the audit, this project was at the staffing and resource review stage.

A new Pensions Administrator has also joined the Pensions Administration Service to work on new employer admissions, in order to ensure sufficient resource in this area. The process for new employers has been reviewed and changes agreed in order to improve efficiency. These are in the process of being implemented.

Debtor Management

Pensions debts, relating to scheme member death overpayments, are not currently being chased and followed up consistently, which has been reported as due to resource and workload pressures within the team. Sample testing of member deaths identified 2 cases where overpayments due from deceased member accounts had not been chased for recovery in a timely manner. However, it is reported that this is now being addressed by one of the Team Leaders.

Follow Up

Of the 14 actions agreed as part of the 2017/18 audit, 13 have been reported as fully implemented. One is partially implemented, and this will continue to be monitored for implementation. One action reported as implemented has been identified as not being fully and effectively implemented (relating to segregation of duties). A revised action has been agreed to further improve controls in this area.

Troubled Families March Claim 2018/19

Opinion: n/a	26 March 2019	
Total: 5	Priority 1 = 0	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

A number of issues were identified during the audit of this claim in relation to progress against various eligibility criteria, duplication, family residency in the county and family composition. These issues had not been identified prior to the initial submission of the claim to Internal Audit, and a subsequent re-check did not pick up all issues. Further to satisfactory responses being received against all queries raised by Internal Audit, the claim was signed off for submission A new process has been agreed going forward to address these issues.

Facilities Management 2018/19

Overall conclusion on the system of internal control being maintained	R

Opinion: Red	03 April 2019	
Total: 8	Priority 1 = 4	Priority 2 = 4
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	8	

This audit was scheduled one year on following the collapse of Carillion and bringing the Facilities Management services back into the Council. Following initial audit meetings with senior management and review of documentation, it quickly became clear that whilst a service is being delivered, which management believe to be at a satisfactory level, the high-level governance arrangements are still in development.

It was therefore agreed that Internal Audit would report in a management letter on the high-level governance issues that currently exist and a more detailed audit of progress against plans and the operational activities would be undertaken in the second half of 2019/20 and combined with a planned audit of Property Management.

Whilst it could be expected that the high-level governance arrangements would be established and embedded in the FM unit by now, it is acknowledged that the scale of the task in implementing the in-house delivery model, the delays in recruitment to key posts and the move of FM into a different service area have all contributed to the delay. This is a new area of business for the Council to assimilate and the circumstances surrounding it given the abrupt nature of the transfer posed a challenge. Despite these challenges, Facilities Management has continued to deliver the cleaning, catering, maintenance, minor works and corporate FM services across Council sites, which management believe are being delivered at a very satisfactory level and which have started gaining back the confidence of clients and stakeholders.

According to the high-level summary of actions, it is anticipated that all key governance and improvement actions should be complete by end of April 2020. This will address the absence of a detailed and documented Strategy / Service Delivery Plan, including a review and costing of delivery models. It will also see the implementation of the new structure, with permanent appointments in the key management positions and development of a robust framework and processes for risk and performance management, HR, budget management and procurement.

In order to pick up the pace of change required and address the areas of risk, a concerted effort of the service and support functions working jointly will be required. By applying a project management methodology, this will provide governance and oversight and ensure that all required tasks and deliverables are identified, prioritised and have clear timescales for implementation, as well as risks being identified and escalated promptly.

S106 Follow-Up 2018/19

Overall conclusion on the system of internal control being maintained	**R**

Opinion: Red	03 April 2019	
Total: 4	Priority 1 = 0	Priority 2 = 4
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	4	

The 2017/18 audit of S106, graded Red, identified key weaknesses around governance and internal control, including strategic reporting, the use of multiple IT systems, and a lack of clarity around roles and responsibilities. A Follow Up audit of S106 was therefore scheduled for Quarter 4 2018/19, to review progress against the agreed actions.

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. Out of the 31 agreed actions, 16 have been closed by management, 13 of which can be confirmed as fully implemented. Where further improvements are required as implementation has not been effective, new management actions have been agreed.

15 actions remain open, with 3 partially implemented, and 12 not yet implemented. All 15 are overdue against their original target date, but have been updated on the action tracking system, with their target date extended. Little progress has been made in the areas of policies & procedures; IT systems; and monitoring of S106 agreements.

The overall conclusion therefore remains graded as **Red**. In addition to key actions not being implemented, various teams responsible for the S106 process currently hold vacancies, including the Development Monitoring Team Leader and Planning Obligations Manager, examples were noted where there had been significant delays in raising invoices for S106 contributions or where invoices had not been raised at all, and the lack of progress around the implementation of an overall IT system means separate systems continue to be used by the various teams, resulting in duplication of effort and increased risk of errors.

The latest management update on the audit tracking system indicates all actions should be complete by August 2019, however it is reported that a number of these rely on the successful recruitment of a Development Monitoring Team Leader and a Planning Obligations Manager.

Both outstanding and new actions will continue to be monitored and reported on by Internal Audit.

Highways Payments Follow-Up 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Risk Area A: SkanWorks System Improvements	A	1	3
Risk Area B: Hot Costing	A	0	1
Risk Area C: OCC Cost & Payments checks	A	2	2
		3	6

Opinion: Amber	03 April 2019	
Total: 9	Priority 1 = 3	Priority 2 = 6
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	9	

Previous audits of Highways Payments in 2015/16, 16/17 and 17/18 have highlighted serious weaknesses with a lack of transparency over cost accuracy in the contractor's cost management system, resulting in an inability for OCC to adequately monitor cost and payment accuracy. Promised developments to the system to improve this had not been forthcoming over the past 3 years since these issues have been raised, resulting in the contractor not being awarded several contract extensions.

This year's Highways Payments Follow up audit reviewed whether the key weaknesses previously identified as outstanding have been addressed, namely the inability to move costs between Task Orders, resulting in inaccurate costs not being corrected; inability to close down Task Orders on the system, resulting in a risk that completed works could have costs added to or removed from them; and inaccuracy and lack of transparency of gang costing and productivity data, resulting in a higher risk of payment inaccuracies not being identified.

A: SkanWorks System Improvements

The contractor's improvement plan to address the system weaknesses is being implemented, the key component of which is the development of the Resource Allocation Model (RAM). This is an Excel-based system designed to more accurately capture gang costing, feeding into the SkanWorks systems prior to generating payment values. The audit has positively noted that this new system is a significant improvement in terms of cost transparency and data capture. The audit reviewed this new system and noted the following:

- It does address the system weaknesses previously identified, including greater transparency of cost allocation to each work order. It also allows greater accuracy of costs allocated to the correct Work Order and therefore a more accurate picture of actual costs per defect. This is therefore positive progress.
- It has been in use since August 2018 however the costs were not uploaded to SkanWorks for payment until February / March 2019 (and these are not yet complete as the sub-contractor costs have not yet been uploaded). This has resulted in a delay to payment requests this year, however budget forecasts have been maintained via the offline 'hot costing' method.
- Due to the delay in data upload, Task Order budget holders have not reviewed costs in detail this year. The audit also noted that budget holders have not yet been trained in the new arrangements and guidance developed for budget holders to follow for reviewing costs in SkanWorks. A suite of reports to monitor usage, costs and productivity have not yet been developed as the system is still 'bedding in' – but there are plans to do this going forwards.
- As it is Excel-based, there are inherent risks of data errors where data is input and manipulated in spread sheets. Furthermore, the process allows Site and Depot Supervisors to over-write on the downloads from SkanWorks where times against each Work Order need amending. However, any changes will be seen when uploaded to SkanWorks as the original data remains visible on the system.
- The audit also noted that the start and end times of different Work Orders overlap or the duration is inconsistent. This has been identified already by management and is a training issue which is reportedly being addressed.
- The audit noted cases where incorrect or incomplete photos had been attached to Works Orders, which is an issue that has been raised in previous audits and is particularly causing the insurance team issues when defending claims

Costs can now be moved between Works Orders in SkanWorks, to correct costs that have been posted in error. Only the Skanska finance team members can do this and they are working through a back log of costs that require transfer.

Works Orders can now reportedly be closed down in SkanWorks, once all PO's have been paid and queries resolved. It was reported to Internal Audit that approximately 75% of the 10k Works Orders currently open on the system require closing down (the applications and final accounts for these have been completed but they just need closing on the system, thereby freezing their accounts so costs can no longer be posted in or out). Multiple closedowns are scheduled to occur during April 2019 in order to start clearing this backlog.

Overall, the audit noted that the contractor has committed to addressing the issues raised in previous audit reports and despite taking longer than hoped to resolve the system weaknesses, these have now been suitably addressed. The challenge going forwards will be in embedding the new system into a smooth business as usual, and in implementing procedures to monitor cost and payments data from the new system.

B: Hot Costing

Only 3 Task Orders have payments generated via the offline 'hot costing' process (as opposed to recording via SkanWorks): Dragon Patcher, Winter and Incident Response. The audit testing of the Dragon Patcher costs identified an issue where an incorrect (higher) Purchase Order was sent to a supplier and paid. The mistake was not identified prior to the audit, but a credit note has since been issued and a new administrative process is being considered to address the issue which in this case was due to human error. A further discrepancy was noted in the Incident Response Task Order where the manual recording of call-outs did not match the payments spread sheet data. 5 out of 10 reviewed did not match, with 2 of these resulting in the incorrect amounts of low value being charged. These administrative errors were also reportedly due to human error.

The Winter Task Order review did not identify any errors, however due to the delay in uploading RAM data (as described in section A) the majority of costs for the current financial year have not yet been uploaded for payment in SkanWorks This meant that the audit could not reconcile offline cost records against the amounts paid.

C: OCC Cost and Payments Checks

Processes have not yet been developed within OCC to check the costs in SkanWorks following the introduction of the new RAM process. As Budget Holders have not undertaken robust checks of costs in recent years due to the lack of transparent cost data in SkanWorks and frustrations with the system, there is no clear process in place for managers to follow detailing the type, level and quantity of cost checks to undertake and these should be evidenced. This will therefore constitute a culture change and will require adequate training, support and guidance to ensure budget holders are adequately monitoring costs and addressing issues identified.

Follow Up

The 2016/17 audit contained 16 actions, of which 11 have been reported as implemented and 5 as still open. This audit can confirm that of the 11 reported implemented - 6 have been fully implemented, 2 have not been fully implemented (budget holder reviews in SkanWorks and adequacy of photos) and 3 were not re-tested. Of the 5 actions still open the audit confirms that 3 have been partially implemented and 2 are still outstanding – where applicable these have been superseded by actions in the current report.

The Oaks Children's Assessment Home 2018/19

Overall conclusion on the system of internal control being maintained	A

Opinion: Amber	03 April 2019	
Total: 6	Priority 1 = 3	Priority 2 = 3
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	6	

An assessment of Financial Management was undertaken across OCC during 2018/19. As part of this, several establishments were visited by Internal Audit to review the efficiency and effectiveness of financial management at a local level. The Oaks Children's Assessment Home was one of the establishments selected for review and was visited by Internal Audit on the 6th and 7th March 2019. The Oaks is one of two OCC Children's Assessment Centres, part of the Residential Edge of Care service, where children stay on a part-time or full-time temporary basis, usually for a maximum of 90 days. The Oaks has capacity for up to 6 Young People.

The audit concluded that overall the financial management practices at the Home were good and many of the issues identified apply to the Directorate more widely as they are issues of policy.

Financial Management Roles and Responsibilities & Budgetary Control

Roles and responsibilities for financial matters were clear within the home, with overall responsibility assigned to the Home Manager and the Administrative Officer taking a lead for the day-to-day finance matters and implementing robust processes for cash handling and procurement card reviews.

At the time of the audit, the responsibility for budget management was in the process of shifting from senior management to the Home Managers across the service and training was being provided to the new Cost Centre Managers.

Cash Management & Security

The home primarily uses procurement cards for purchasing, so the level of cash is relatively low and the home doesn't have an Imprest account. Approximately £500 is obtained quarterly from Knight's Court. Previously this had been withdrawn as a cash advance against one child's name, however going forwards a generic cash float will be requested.

Cash is used for daily pocket money payments. From discussions on the use of children's bank accounts or electronic payments methods, the audit noted an absence of a corporate policy on savings and bank accounts for looked after and edge-of-care children.

Purchasing and Procurement

The audit noted that all Purchase Orders were authorised by the Corporate Parenting Manager, which is too high level, however this is being delegated now to the Home Manager.

Procurement card transactions were not consistently authorised on the electronic system, however this was being done offline on paper copies. There is a good process in place for card holders to print, review and attach receipts on a monthly basis, which is then reviewed and signed off by the Home Manager.

From a sample check of transactions, receipts could be provided in 7/10 cases. Expenditure was appropriate, however the audit noted an absence of a Directorate policy on acceptable expenditure on food and drink for Home staff when accompanying children & young people.

Travel & Expenses and Overtime

Travel and Expenses were being reviewed at a high level but not in detail due to system training and access issues to allow the Home Manager to drill down into the detail of trips.

The overtime codes used are complicated and there is a lack of a clear and documented overtime policy & guidance on which codes to use for different circumstances. There is currently a consultation on the Overtime policy, so this should be clarified with staff very soon and clarity on the codes will be provided.

The audit noted that sickness and annual leave is recorded on offline spread sheets as the IBC system does not accommodate shift and out of hours patterns.

Internet and Email Access Review 2018/19

Overall conclusion on the system of internal control being maintained	A

1.

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Corporate Policies	G	0	1
Management Tools	A	0	3
Security Administration	A	0	1
Reporting	A	0	1
		0	6

Opinion: Amber	03 April 2019	
Total: 6	Priority 1 = 0	Priority 2 = 6
Current Status:		
Implemented	5	
Due not yet actioned	0	
Partially complete	1	
Not yet Due	0	

Internet and email access is covered within the Acceptable Use Policy and also within the separate Email Policy. The Acceptable Use Policy forms the basis of the e-learning training that all users have to complete. The two policies were reviewed and confirmed to include details on prohibited activity, personal use and the monitoring and auditing of access. In terms of security, the two policies both state that file attachments from unknown or unexpected sources must not be opened but they do not include any details on the dangers of clicking on embedded links within emails. Whilst this information is available on the Intranet, it should also be included within these policies to ensure there is a good awareness of the risk, especially as embedded email links are used in phishing attacks which are one of the most common type of cyber-attack.

ICT have management tools in place to filter all web access for both corporate and guest users. A gateway is used on the corporate network to block access to inappropriate websites. We have reviewed the filtering policy and identified some further categories of website that should be blocked. The scanning of Internet downloads for malware/viruses can also be strengthened.

All emails are subject to filtering for spam and malware. A review of access to a management tool found that all ICT system engineers use the same account and thus there is no individual accountability for changes made to the system. Similar to other organisations, there is no proactive monitoring of web access because of the resources required to do this effectively. The focus is on being reactive to any reports of Internet facilities being misused but we have found that there is no logging of web access and hence it is not possible to review a user's surfing history should their access need to be investigated.

Capital Follow Up 2018/19

Overall conclusion on the system of internal control being maintained	**A**

Opinion: Amber	09 April 2019	
Total: 5	Priority 1 = 0	Priority 2 = 5
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

The 2016/17 audit of Capital, graded Red, identified key weaknesses around the governance structure in place in relation to the delivery of schemes within the Capital Programme, including strategic oversight and a lack of clarity around roles and responsibilities. A Follow Up audit of Capital was therefore scheduled for Quarter 4 2018/19, to review progress against the agreed actions.

Overall, there has been good progress in addressing the governance weaknesses previously identified, including the set up of new Boards, improving oversight and challenge of the Capital Programme.

Out of the 20 agreed actions, 17 have been closed by management, 15 of which can be confirmed as fully implemented. Where further improvements are required as implementation has not been effective, new management actions have been agreed as part of this year's audit.

3 actions, relating to Capital Finance, remain open, but have been partially implemented. These actions will continue to be monitored through the audit action tracking system. It is noted that one of these actions will now be incorporated into the Finance redesign which is part of the Transformation Programme.

This follow up audit has noted improvements in the governance of the Capital Programme, with the majority of actions effectively implemented to address the weaknesses originally identified. It is acknowledged some areas will continue to develop over time, including the performance dashboard, which currently holds a limited amount of information relating to projects, and the two new project closedown reports which have recently been implemented.

Further progress still needs to be made in terms of budget monitoring and forecasting, although it is anticipated new systems will be in place by May 2019. Work is also ongoing within the Capital Governance Team around financial risk and the management of contingency budgets. The Capital Finance Team's role also needs to be reviewed and clarified. This improved clarity will further facilitate the joined-up working required between Capital Finance and the Capital Governance Teams.

Our overall conclusion has therefore moved from a grading of Red to Amber.

Client Charging 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Policies & Procedures	A	0	0
Financial Assessments & Client Charging	A	0	9
Debt Recovery	G	0	1

Deferred Payments	**A**	**0**	**0**
		0	**10**

Opinion: Amber	08 April 2019	
Total: 10	Priority 1 = 0	Priority 2 = 10
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	10	

A new ASC Contributions Policy was implemented in October 2018, with the main changes to client charging relating to Disability-Related Expenditure (DRE) for non-residential financial assessments (25% of a person's disability benefit is now disregarded, with individual DRE assessments being carried out on an exception only basis), the removal of couples' assessments, the implementation of a full-cost recovery policy for home support care and changes to arrangement fees for full-cost non-residential people.

Work on improving the efficiency of ASC processes, including those with an impact on Client Charging, is currently ongoing as part of the System Blocker project managed by the System Blockers Project Group. This group reports into a transformation group which is chaired by the Director for Adult Services. A new Project Manager was appointed at the end of 2018 to oversee the delivery of this work. There is also now a LAS / LCS project whose remit includes determination of responsibility going forward for a number of client charging processes (for example completion of annex 2's and the third party top up process).

This audit has included review of the implementation of management actions agreed as a result of the previous audit of client charging in 2017/18. In 2017/18 19 management actions were agreed, 9 actions have been reported as fully implemented and have been confirmed as having been implemented effectively from testing undertaken as part of this audit. 3 actions have been reported as fully implemented, but as testing undertaken as part of this audit have not been found to have been implemented effectively. 2 actions have been superseded due to changes in controls or processes. 5 actions have not yet been implemented, the implementation of these actions will continue to be monitored and reported on by Internal Audit.

There are also management actions outstanding from previous client charging audits in 2015/16 and 2016/17, progress with the implementation of these actions have also been reviewed as part of this audit. There are 3 actions from the 2015/16 audit and 2 actions from the 2016/17 audit which are still outstanding, the implementation of these actions continue to be monitored and reported on by Internal Audit.

A number of the actions which have yet to be implemented are key in resolving control issues and inefficiencies in client charging processes and whilst there have been a number of issues and errors noted as a result of testing undertaken as part of this years audit, this is unsurprising as management have not been able to fully implement the actions previously agreed to make improvements.

Policies & Procedures – There are 2 outstanding management actions in this area which includes the completion of the Systems Blockers Project. Once completed, it is

anticipated that this project will resolve key performance and efficiency issues identified in relation to the client charging process following the implementation of LAS and ContrOCC. This includes changes to the financial assessment referral and approval process, further staff training clarifying roles, responsibilities and expectations in dealing with new financial assessments. Performance reporting is also being reviewed and refined to ensure that it is fit for purpose. There is also a management action outstanding on the updating of Financial Assessment Team process documentation. Although there have been further examples of where the current process is not working as efficiently as it could be, there are no new findings for this risk area.

Financial Assessments & Client Charging – The process and responsibility for the charging of arrangement and management fees, introduced as part of the new Contributions Policy effective from 1st October 2018, for non-residential clients is not yet clear. There is an interim process in place (effective from the middle of December 2018), with social workers needing to inform a member the Service Improvement Team so that they can add the relevant information to the client record on LAS to generate the charge. Management reporting to provide assurance that management and arrangement fees are being charged consistently and in line with the Contributions Policy has now been developed.

Delays in the processing of mismatched visits (where visits on ETMS cannot be matched to a care package on ContrOCC) were noted, this was also noted as an area of weakness as part of the 2018/19 Contingency Homecare Internal Audit Report. A permanent solution for dealing to the problems currently posed by mismatched visits is being sought and an interim process is being developed to try and minimise errors.

Problems with saving of documentation to Sharepoint have been noted as part of this years audit, following on from the same issues having been noted in 2016/17 and 2017/18, this extends to the ASC Income Team as well as the Financial Assessment Team. Alternative options for document retention are being explored, but management have reported that whilst they are continuing to monitor and address evidencing issues as they arise, whilst the current system (Sharepoint) is in place, the issues noted are a reality.

Outstanding management actions in this area include the updating of the spot contract template, changing the method of client charging for where home support providers do not use ETMS and historic reconciliations of personal budget accounts.

Debt Recovery – Management acknowledge that they have been delays in the debt recovery process during 2018/19. It has been reported that this has been as a result of resourcing issues which are in the process of being addressed. A Senior Recovery Officer has been recruited and recruitment is currently underway for a further Debt Recovery Officer. Further instances of non-compliance with agreed process for the agreement of instalment plans have been noted as part of this audit. This was also an area where issues were noted in the previous client charging audit. Management action has been agreed to strengthen staff guidance in this area and increase senior staff oversight in the process.

A management action in relation to the provision of finance specific safeguarding training has been partially implemented. This is being developed in conjunction with the Adult Safeguarding Team to provide both ASC Income Team and Financial Assessment Team staff the required guidance in relation to relevant safeguarding

issues, for example potential indicators of financial abuse and how to deal with these appropriately.

Deferred Payments – There are two outstanding management actions from previous audits in relation to review of the third party top up process and the process for the completion of Annex 2's. Processes in both areas are being reviewed as part of the System Blocker Project and responsibility for the revised processes resulting from this project is to be determined by the LAS / LCS project. There are no additional findings to report in relation to this risk area.

Supplier Resilience 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Risk Area A: Governance and Escalation	A	2	2
Risk Area B: Due Diligence and Procurement	A	0	5
Risk Area C: Contract Management	A	0	3
Risk Area D: Contingency Plans	G	0	0
		2	10

Opinion: Amber	05 April 2019	
Total: 12	Priority 1 = 2	Priority 2 = 10
Current Status:		
Implemented	1	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	11	

A: Governance and Escalation

Whilst there is generally a high level of understanding of supplier resilience risks in the organisation and Supply Chain Resilience is on the strategic risk register, improvements are required to support this with a robust framework to assess risks and apply controls in a consistent manner at each stage of the contract cycle. There is no documented policy or procedure on supplier resilience to clarify the process to follow for supplier resilience checks at each stage from procurement through contract monitoring. As noted in Section B, the checks applied are inconsistent and the thresholds for escalation of issues to senior management and Finance are not clearly documented. Whilst a risk-based approach is reportedly used, so contract management activity is focussed on higher risk contracts, this is not supported by a documented risk assessment - however a team exercise is held annually to re-assess the risk level of platinum contracts.

There is evidence that supplier resilience is discussed at DLT meetings, for example a recent major supplier failure was overseen by Adults DLT. DLTs receive Performance Reports which cover areas such as service user satisfaction and indicators around sustainable and good quality services (i.e. number of providers rated as CQC outstanding/good) as well as working in partnership and collaboration - however none of these indicators specifically cover supplier resilience. There is no agreed and documented risk escalation process in place to ensure supplier resilience risks are identified and escalated up to DLT on a regular basis.

Practices between Adult's, Children's and Public Health is different and good practice in terms of documenting and evidencing the supplier resilience checks were noted within Public Health. Roles and responsibilities between Contracts and Finance at the procurement stage are clear, however the process for referral to Finance for further checks is not always consistent or clear and discussions and conclusions between both parties are not always documented in an easily accessible format.

B: Due Diligence and Procurement

The Procurement team lead on supplier resilience checks at the procurement stage. These include review of information in the Invitation to Tender (ITT) and ensuring these are issued with consistent standards, such as business continuity plans, parent company information and financial accounts. Finance are requested to review financial assessment forms for suppliers above the OJEU thresholds, including an assessment of financial credit scores. All ITTs were issued for the sample of 20 tested, however inconsistencies in application of these checks were noted as follows:

- In two instances the supplier was asked if they had incurred a non-payment of tax and not in the other 18, without there being a discernible reason why this was asked in these two cases and not others. This is not a standard question in all ITTs and nor is it a question asked on-going by contract management.
- In some cases, 2 years of audited accounts were requested and in other cases, 3 years were requested, without any obvious reason for this difference.
- For a Public Health supplier, the two sets of accounts requested were not identified as being unaudited by Procurement nor Finance. Furthermore, Finance identified that the supplier had a parent company however the supplier had declared in their submission they did not have a parent company and this was not followed up with the supplier.
- The audit noted that business continuity disclosures in supplier contracts were in some cases more thorough than in others. Some contracts (but not all) required suppliers to confirm their agreement to comply with the Civil Contingencies Act and if requested, partake in joint continuity exercises, whereas others did not include this clause. There was no discernible reason why there was this inconsistency.
- The inclusion of specific resilience-related performance indicators in contracts was also variable. For example, in 11 out of the 20 contracts reviewed, a continuity plan must be issued to the Council for review on an annual basis or audited accounts must be provided annually, but in the others this was not stipulated.

- In 6 contracts in the audit sample, the contract had not been signed ahead of services commencing ranging from a few days to 4 months before services commenced.

C: Contract Management

The approach to assessing Supplier Resilience on an on-going basis via contract monitoring varies depending on the risk level of the contract, with higher risk contracts receiving greater scrutiny than lower risk ones. Each contract reviewed in the audit sample had a Contract Managers assigned. Whilst there is an understanding amongst Contract Managers which suppliers are higher risk, the risk assessment supporting this is not documented.

The audit noted that whilst contracts set out the frequency and type of reporting expected once the services commenced, these are not always followed. In terms of supplier resilience, each Contract Manager works with the supplier to set an agenda however there is not a standard set of supplier resilience questions for all contracts which have to be covered at minimum set intervals. Therefore, Contract Managers are not consistently receiving information on supplier resilience in order to inform an assessment of whether there is a concern or not. For example, in certain contract meetings there is an annual agenda item to discuss business continuity, receive the suppliers plan and minute a discussion on whether plans are adequate, however this does not apply to all contracts.

Out of the sample of 20 contracts reviewed, the audit noted 7 contracts with low levels of scrutiny in terms of infrequent meetings and lack of documentation of discussions – however these may have been deemed lower risk contracts, therefore subject to less monitoring. For example, one contract in the audit sample of an Adult supplier highlighted several weaknesses in approach. Contract meetings were not held regularly and in the 3 meetings held in the past 2 years, records were kept in emails and handwritten notes rather than saved to a shared folder. From review of these notes, it was apparent the provider had raised concerns over their viability, however this was not reported to DLT as a potential risk. This particular contract also did not have any supplier resilience related indicators in the contract.

An exercise in 2018 to further assess the resilience of the Help to Live at Home suppliers was undertaken by issuing a set of 8 resilience questions for their completion. It is recognised that this process has not been as successful as intended because the majority of suppliers either did not engage with the questions and/or did not provide the information requested as it is not a requirement included in the contracts.

Whilst there is some evidence of good communication between Finance and Procurement there is also no structured approach to utilise Finance Business Partners to support Contract Managers in ongoing discussions with and evaluations of suppliers, with triggers identified in contract meetings or other assessments to refer concerns to the FBP.

D: Contingency Plan

The audit noted the existence of a comprehensive documented Sudden Market Failure Plan to guide Officers in the event of a significant supplier failure. This Plan had to be implemented in 2018 when a home care provider failed. From a high-level review of this implementation, it appeared to have complied with the Plan and a lessons learned exercise is being undertaken. Furthermore, due to the challenges faced by Brexit the Council have taken proactive steps, for example by issuing a questionnaire to suppliers to identify risks depending on the outcome of Brexit.

Accounts Receivable 2018/19

Overall conclusion on the system of internal control being maintained	G

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Policies & Procedures	G	0	0
Customer Creation	G	0	0
Invoices Raised	G	0	0
Adjustments, Credit Notes & Refunds	G	0	0
Debt Recovery / Allocation of Income	G	0	1
Management Information /Aged Debt Reports	G	0	0
		0	1

Opinion: Green	08 April 2019	
Total: 1	Priority 1 = 0	Priority 2 = 1
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	1	

Policies and Procedures – No significant issues were noted in relation to the coverage, clarity or availability of guidance in place for the raising of invoices, the debt recovery process or in relation to roles and responsibilities in this area.

Customer Creation – It was found that there was a clear process and guidance in place for the creation of customers which should limit duplicate customer records. It is noted that customer master data is the responsibility of Hampshire County Council. No significant issues were reported from the OCC side in terms of problems caused as a result of duplicate customer records.

Invoices Raised – Testing found that the invoices sampled during the audit had been raised in a timely manner, in accordance with the Council's scale of fees and charges.

Adjustments, Credit Notes & Refunds – Sample testing on adjustments found that for all cases sampled, it was possible to evidence that the adjustment was appropriate. Controls in place for monitoring duplicate cancellations and refunds were found to be operating effectively.

Debt Recovery and Allocation of Income – Sample testing on write offs found that controls in place around debt write off and management were operating effectively.

Delays were identified with the pensions administration debt monitoring and follow up process (this is the responsibility of the Pensions Administration Team, not the Corporate Income Team). The Corporate Income Team are working with Pensions Administration to improve the process and management actions have been agreed as part of the separate 2018/19 Pensions Administration Internal Audit Report to address the control weaknesses identified.

A potential control gap in relation to consistency of charging for overstays by the Street Works team was identified by the Corporate Income Team earlier this year. The Group Manager is in the process of producing a paper on the process to be agreed with Communities Senior Management and the Finance Business Partner, staff guidance will then be produced and circulated. The Corporate Income Team have been providing advice.

Management Information / Aged Debt Reports – Management information produced on the Council's aged debt was found to be regular and transparent.

Follow Up – There were 4 actions agreed as part of the 2017/18 Accounts Receivable Audit, all 4 have been confirmed as having been fully and effectively implemented. There were a further 4 management actions outstanding from the 2016/17 Accounts Receivable audit which had not been implemented at the time the 2017/18 Accounts Receivable audit was finalised. Of these actions, 1 has been superseded and the other 3 were confirmed as having been fully and effectively implemented.

This audit provides assurance over the controls implemented and operated by OCC. Hampshire Internal Audit provide separate assurance over the IBC operated controls and processes.

Payroll 2018/19

Overall conclusion on the system of internal control being maintained	G

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Policies & Procedures	G	0	0
Starters & Leavers	G	0	0
Variations, Adjustments, Deductions & Additions to Pay	G	0	1

Management Information	**G**	**0**	**0**
		0	**1**

Opinion: Green	11 April 2019	
Total: 1	Priority 1 = 0	Priority 2 = 1
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	1	

Policies and Procedures – Testing undertaken as part of this audit has confirmed that there is relevant guidance in place for staff on key payroll processes. In addition to intranet guidance on the OCC intranet and IBC help pages, there is also additional sources of help available via the IBC helpdesk and web chat function and a dedicated HR advice email address.

Starters and Leavers – It was noted that OCC HR currently do not have direct access to new staff contracts. Since the launch of Success Factors, pdf versions of staff contracts are not being automatically uploaded. This is a known issue which is in the process of being resolved with IBC and a workaround is in place pending this. Sample testing noted that there are still some timeliness issues in relation to management completing leaver actions promptly. However, there is ongoing monitoring of retrospective actions and overpayments by OCC HR which enables identification and resolution of issues in specific areas.

Variations, Adjustments, Deductions and Additions to Pay – There is a known issue with retention / uploading of supporting documentation in relation to honorarium payments. This was reviewed within OCC HR earlier in 2018/19. The team are in the process of developing a web based form which will make the process more automated and workflow completed forms directly to HRBPs.

Management Information - Regular detailed management information is produced for HRBP's on key payroll areas (for example overtime payments, honorariums and casual claims). It was also confirmed that there is a clear process in place for discussion of payroll issues between OCC and the IBC with appropriate escalation routes in place.

Follow up - 2 management actions were agreed as part of the 2017/18 Payroll audit. Both actions have been confirmed as having been fully and effectively implemented. There were also 2 management actions from the 2016/17 Payroll audit that were partially implemented when the 2017/18 audit was completed. Both of these actions have now been reported as fully implemented. Testing undertaken as part of this year's audit has confirmed that 1 action has been fully and effectively implemented and the other is no longer relevant due to changes in process.

This audit provides assurance over the controls implemented and operated by OCC. Hampshire Internal Audit provide separate assurance over the IBC operated controls and processes.

Children's Training, Development and Rentention 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Training & Development	A	2	3
Workload Management	G	0	0
Supervision & Staff Support	G	0	0
Incentives & Additions to Pay	G	0	0
Sickness Management & Monitoring	G	0	0
		2	3

Opinion: Amber	10 April 2019	
Total: 5	Priority 1 = 2	Priority 2 = 3
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

It is widely recognised that recruitment and retention within Children's Social Care is a fundamental issue and there is evidence of significant work by the service to improve this. The ASYE Programme has been introduced to develop and support NQSWs and work is ongoing to further develop the virtual academy, which will also improve support to social workers following completion of the ASYE. There are robust mechanisms in place to enable effective monitoring of sickness, workload management and staff supervision. There is also work ongoing in relation to review and development of a retention strategy and the Workforce Development Strategy.

Training & Development –There are clear processes in place for the completion of the ASYE programme and the management of it. There are clearly defined goals or objectives for individual NQSW and progress in meeting these is reviewed and assessed at set intervals during the year. Panels are held which involve the Principal Social Worker to sign off individual portfolios or to highlight where additional work is required. Whilst no issues were identified with the ASYE programme in terms of process or management, it was noted that there is currently no management reporting on the activities of the ASYE programme or its effectiveness.

Issues were identified in relation to the completion and monitoring of completion of mandatory training. Whilst completion of a number of courses have been reported as mandatory, it is not clear whether there are or should be any agreed exemptions to this (for example for new starters with significant previous social care experience). Additionally, timescales for completion of mandatory training after employment start date are not clearly defined.

Internal Audit testing compared a list of new starters in CSC with mandatory training course records for several courses and noted that mandatory training is not being completed by all those that should be. In relation to mandatory specialist safeguarding training it was found that only 14% of new starters, from the 12-month period tested, were recorded as having completed the training on the Councils Learning & Development system.

Discussions with the Workforce Development Manager ascertained that there is annual reporting on attendance at mandatory training. However, this does not provide assurance that the required people have completed mandatory training or provide information on those who haven't. It is acknowledged that there are known issues corporately with the availability of this type of information.

No detailed testing has been undertaken in relation to the operation of the virtual academy. It has been reported that this is an area that is currently being developed by the Service. It is planned that the remit of the Academy will be widened to offer post graduate support to NQSWs after they have completed the ASYE programme. This links in to where retention issues have been experienced. It is also planned that there will be closer working with Organisational Development to enable maximisation of the potential benefits of the Academy.

There is monthly reporting and monitoring by HR on HCPC registration and renewals. Although some delays were noted in the updating of HCPC renewal information on IBC which resulted in inaccurate management information, sample testing confirmed that renewals were taking place as required and that this process was being adequately monitored.

Workload Management – It was noted that there is appropriate reporting on the caseloads of individual social workers from team manager level up to DLT. Both the Principal Social Worker and the Children's HR Business Partner have reported that caseload monitoring down to individual social workers is under constant review within the Service as it is recognised that having a manageable caseload is a key issue in terms of being able to retain social workers. It was felt that there was sufficient reporting, review and scrutiny of reduced caseload allocations for NQSWs.

Supervision & Staff Support – Audit testing found that supervision of NQSWs is appropriately monitored as part of the ASYE programme, this includes reflective supervision. It was also noted, from the staff spoken to as part of the audit, that there are mechanisms in place for NQSWs to request additional support with complex cases where required.

Incentives & Additions to Pay – There are financial and non-financial incentives in place to recruit and retain staff. The way in which these are working is under review and the Principal Social Worker and Children's HR Business Partner are in the process of agreeing a retention strategy which will develop this area further. It has been reported that work undertaken in this area includes benchmarking with other local authorities including comparative neighbours.

Sickness Management & Monitoring – There is regular reporting and review of sickness absence amongst CSC staff including quarterly reporting to DLT. Stress related sickness absence is an area of focus. There is work underway by the Children's HR Business Partner and a member of the Health & Safety Team reviewing specific teams where there are high levels of absence due to stress to work with team managers and ensure that there is appropriate support in place. This work also links to the retention strategy mentioned above.

Adopt Thames Valley (ATV) 2018/19

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance	A	0	3
B: Finance	A	0	5
C: Performance Management	G	0	0
D: Staffing & Training	G	0	1
E: Adoption & Permanence Support Process	A	0	3
F: IT & Data Protection	G	0	0
		0	12

Opinion: Amber	10 April 2019	
Total: 12	Priority 1 = 0	Priority 2 = 12
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	12	

The Adoption and Children Act 2002 places a statutory responsibility on local authorities to maintain an adoption service within their area. A paper published by the Department for Education in 2015 encouraged local authorities to work together and promoted the concept of Regional Adoption Agencies (RAAs). The regionalisation reforms set out in the DfE's *Regionalising Adoption* document (June 2015) aimed to reduce the number of adoption agencies to 25-30 nationally. It set an expectation that all local authorities would be part of an RAA by 2020. The aim of the RAAs is to

improve the life chances of damaged children; improve adopter recruitment and adoption support and reduce costs. It was envisioned that RAAs could help to speed up the adoption process, via pooling of resources and the sharing of best practice between existing adoption agencies.

Oxfordshire County Council is the host Authority for regional adoption agency Adopt Thames Valley (ATV) a partnership of seven local authorities (Bracknell Forest Borough Council, Reading Borough Council, Royal Borough of Windsor and Maidenhead, Swindon Borough Council, West Berkshire District Council and Wokingham Borough Council). The ATV Service launched on 1 December 2017.

Since the launch of ATV, and over the course of the audit, it can be seen that considerable progress is being made to integrate teams from different authorities into one Service.

Governance – There is a formal agreement in place, signed by Agency partners which sets out the role, purpose and terms and conditions of the service being provided by the Agency. Governance arrangements are clearly defined with a Partnership Board in place with representation from the different partners. The Oversight Board, which is a mechanism for enabling member engagement in these arrangements, has yet to be formed, but the first meeting is now planned for July. Although progress has been made in updating staff policies and procedures, there are still some areas of guidance that require review and updating (mainly in relation to permanence support processes). It was also noted that although risk is considered in the operation of the agency, work is ongoing to produce a formally documented and agreed risk register.

Finance – Audit testing confirmed regular budget monitoring is taking place and that there is quarterly reporting to the Partnership Board. Although currently budget monitoring is completed by the Service Manager and Senior Financial Adviser, going forward other Cost Centre Managers will have a role. Additional training is in the process of being provided to enable cost centre managers to monitor their budgets and produce forecasts to feed into budget monitoring and reporting for the service as a whole. Some delays in recovery of income from partner authorities were noted which has highlighted the need for more regular monitoring of income expected to income received (currently completed annually). Although no issues were identified with authorisation of expenditure, it was identified that delegated approval levels require review to ensure that they are fit for purpose. The Service Manager does not currently have the required financial authorisation level to be able to approve high cost interagency placements which means that there is a duplicated authorisation process with financial approval being provided by the Children's Admin team. The current budget for the Agency is set assuming a cost neutral position for interagency placements, financial reporting on the cost v income relating to these placements since the Agency came into being in December 2017 demonstrates that this is not a realistic assumption with consistent overspends in this area.

Performance Management – The audit noted comprehensive reporting to the Partnership Board in relation to performance which includes statutory recording requirements. It has been reported that there is now a Performance Framework in place and it is planned that performance reporting will continue to develop and evolve with more comparative reporting as historical data is collected. It is recognised that there are difficulties in producing information from the current information system and manual spreadsheets, however the implementation of the new LCS system provides

opportunities to develop automated performance reporting directly from the system which would be more efficient and reduce scope for inaccuracies.

Staffing & Training – Whilst there have been challenges in ensuring that there are adequate staffing levels within the Agency, it appears that the staffing situation is now more stable with significant progress reported in filling vacancies. The audit has noted that there is a process in place for staff to raise concerns and that these concerns are taken seriously and acted on by management. Some inconsistencies were noted in the monitoring of training provided to staff between different offices and it was agreed that it would be helpful for training requirements for ATV staff to be reviewed and clarified. Monitoring of completion of mandatory training is acknowledged as being an area where there are known issues corporately.

Adoption & Permanence Support Process – Some inconsistencies were identified from sample testing on the information recorded on adopter and children's files. This appears to be partly due to some documentation not having been uploaded to Frameworki, but also in a lack of guidance on expectations. This is an area where the Partnership Board have already had discussions and have agreed that further training is required. In one Authority, a specific contact has been nominated to act as a liaison point between that Authority and ATV to improve knowledge sharing and assist in ensuring that ATV processes and requirements are understood.

IT & Data Protection – Audit testing has confirmed that there are appropriate information sharing agreements in place and data security is actively considered. The Service Manager has reported that she has been involved in various workshops relating to the development and implementation of LCS to ensure that ATV processes and requirements (including performance reporting) are considered and addressed by the new system.

Appendix 3

Statement of Assurance – Integrated Business Centre

2018 - 19

Southern Internal Audit Partnership

Assurance through excellence and innovation

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

1. Role of Internal Audit

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

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

The standards for 'proper practices' are laid down in the Public Sector Internal Audit Standards [the Standards – updated 2017].

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

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

2. Internal Audit Approach

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

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

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

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

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

3. Internal Audit Opinion

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

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

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

Annual Internal Audit Opinion 2018-19

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

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

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

4. Internal Audit Coverage and Output

The 2018-19 Shared Services internal audit plan was informed by internal audit's 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 7 reviews contributing to my audit opinion:

Review Status	Assurance	Opinion
Governance arrangements	Final	Adequate
ICT – user access	Draft	
Payroll Final	Substantial	
Order to cash	Final	Adequate
Purchase to Pay	Final	Adequate
Debt Collection	Final	Adequate
Master Data Team	Final	Adequate

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

A copy of each 'final' report has been issued to the Chief Internal Auditor at Oxfordshire County Council. The recruitment audit planned for 2018/19 was deferred to 2019/20 due to the implementation of Success Factors and ongoing improvement programme which is subject to support and review from the Transformation Team.

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 2018/19 this included: IT Service Management – Asset Management, IT Operating Systems, Wireless Security, IT Business Continuity and Disaster Recovery, PCI Compliance testing, Business Applications, Cloud Application Governance, and ISO 27001. Our assurance opinion (incorporating these reviews) will be reported to Hampshire County Council's Audit Committee in July 2019, 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.

5. Main Issues

There are no significant issues of concern to report from the outcomes of our audit work during 2018/19.

The 2017/18 annual opinion reported weakness 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 were also opportunities to improve and expand documented guidance to ensure consistency of advice and that expectations for all pre-employment checks are clear.

Extensive work has been carried out by the Transformation Team and IBC staff during the year to ensure that these issues are addressed both historically and moving forward and this is due to be completed early in 2019/20. A further review of DBS and wider review of recruitment (Success Factors) has been incorporated in the 2019/20 internal audit programme.

6. Disclosure of Non-Conformance

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

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

There are no disclosures of Non-Conformance to report.

7. Quality control

Our aim is to provide a service that remains responsive and maintains consistently high standards. This was achieved in 2018-19 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;
- 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.

8. Acknowledgement

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

Neil Pitman, Head of Southern Internal Audit Partnership
April 2019