AUDIT AND GOVERNANCE COMMITTEE
10 MAY 2023
ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR
Report by Chief Internal Auditor

RECOMMENDATION

1. **The Audit and Governance 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 2022/23, 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 – 35, followed by the overall opinion for 2022/23 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 2017 (PSIAS), 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 May 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. The external assessment is now due and has been booked for the beginning of October 2023, the results will be reported to the January 2024 Audit & Governance Committee meeting.

13. The Monitoring Officer last conducted a survey of Senior Management on the effectiveness of Internal Audit in 2019. 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. The next survey has been requested by the Director of Finance and will be completed during the summer of 2023, and subsequently reported back to the Audit & Governance Committee.

14. The Internal Audit Strategy and Annual Plan for 2022/23 was presented to the May 2022 Audit and Governance Committee. The Committee then received quarterly progress reports from the Chief Internal Auditor, 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 2022/23 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit. From April 2020 under a joint working arrangement the team also provided the Internal Audit Service to Cherwell District Council, this has continued since the de-coupling and the service is provided to Cherwell District Council under a service level agreement. This has enabled us to continue to build a more sustainable team with the skills and capacity resilience to help embrace current and future challenges.

20. Throughout the year the Audit and Governance Committee and the Audit Working Group were kept informed of staffing issues, challenges with recruitment of senior internal auditors 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 2022/23.

Opinion on System of Internal Control

Basis of the Audit Opinion

22. The 2022/23 revised plan has been completed, subject to 7 audits at exit meeting / draft report stage which will be finalised during May.

23. The plan is intended to be dynamic and flexible to change. 30 audits were undertaken in the year (26, in 2021/22 & 22 in 2020/21). Since the last report of amendments to the plan at the January 2022 Audit and Governance Committee meeting, there has been 1 further amendment; the audit of S106 & the new IT system has been deferred for 3 months due to pressures within the service. It is now included within the 2023/24 internal audit plan.

24. The completed internal audit activity and the monitoring of audit actions through the action tracker system enable the Chief Internal Auditor to provide an objective assessment of whether systems and controls are working properly. In addition to the completed internal audit work, the Chief Internal Auditor 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 our 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. Of the 30 audits undertaken for 2022/23, one was graded as RED: a school audit. In 2021/22, one audit was graded red, 2020/21, one audit was graded red, in 2019/20, two audits were graded as Red and in 2018/19 five were graded Red. (See also paragraph 36 for trend analysis on individual audit overall conclusions)

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 reported to Directorate Leadership Teams, Strategic Leadership and the Audit Working Group. The Chief Internal Auditor's 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 (SIAP) 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, via the Integrated Business Centre (IBC). Due to the onboarding of three additional partners, since 2019/20 the assurance arrangements were amended. The Hampshire Partnership/IBC commissioned Ernest and Young (EY) to undertake a Service Organisation Controls review under International Standard on Assurance Engagements (ISAE 3402). (This provides a framework for reporting on the design and compliance with control objectives related to financial reporting. In addition to this Partners can separately take a view on any additional risk-based pieces of assurance work that could be commissioned from SIAP covering any core elements of the control environment.

30. The ISAE 3402 report covering both the design and operating effectiveness of the internal control environment for 2022/23 has been shared with the Director of Finance and the Chief Internal Auditor. This report provides assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. The report concludes that the controls related to the control objectives were suitably designed and operated effectively, with no exceptions noted.

31. The anti-fraud and corruption strategy remains current and relevant. In 2022/23 the Audit and Governance Committee have been updated on reported instances of potential fraud. Most of these are minor in nature. Work has been undertaken to address the control weaknesses identified in each area identified to reduce the possibility or reoccurrence.

32. Internal Audit continue to manage the National Fraud Initiative data matching exercise which is completed once every two years. Key matches are investigated, and results are reported to the Audit & Governance Committee in the quarterly updates.

33. It should be noted that it is the responsibility of management to operate the system of internal control, not internal audit's responsibility. 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.

34. 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.

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

- The results of all audits undertaken as part of the 2022/23 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;

  (Priority 1 = Major issue or exposure to a significant risk that requires immediate action or the attention of Senior Management. Priority 2 = Significant issue that requires prompt action and improvement by the local manager)

- 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 ISAE 3402 report, covering both the design and operating effectiveness of the Hampshire Partnership/IBC internal control environment.
- Corporate Lead Assurance Statements on the key control processes, that are co-ordinated by the Corporate Governance Assurance Group (of which the Chief Internal Auditor 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 2023, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

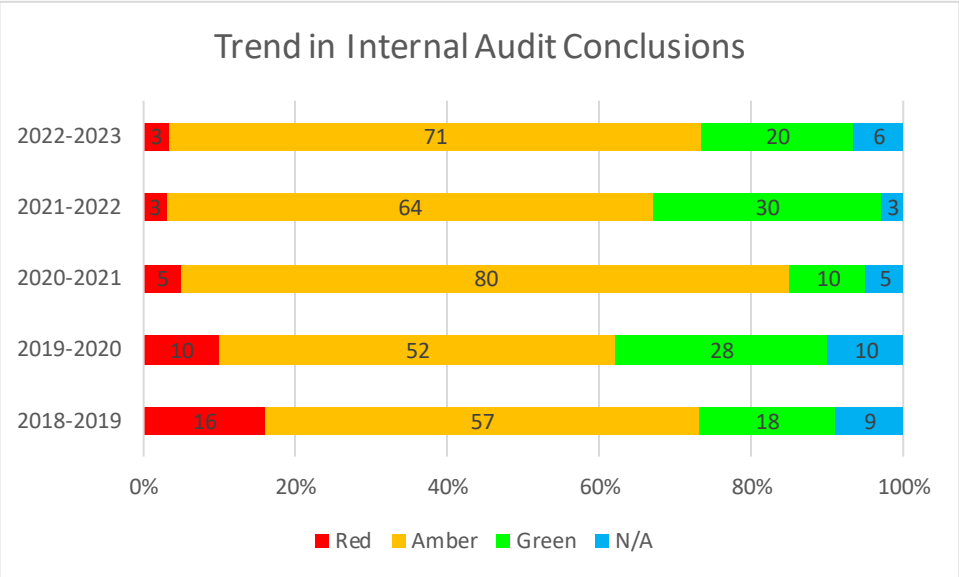
Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective action and timescale for improvement.

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)

See appendix 2 for definitions of overall assurance opinion.

36. The following table shows the percentage trend in individual audit conclusions. It is pleasing to note the positive position, including the number of audits with an overall green grading and that only 1 red graded report was issued for 2022/23.



Audits completed since last report to Audit and Governance Committee

37. 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 2023) are attached as appendix 3.

- IT Application Audit LAS
- IT Application Audit GIS
- Primary School Audit 1
- Supported families
- Leases
- Children's finances
- HR Contract Management
- Climate Change
- Property/FM Follow up
- Capital Programme – Highways Asset Management
- SEND
- Pensions Administration
- Payroll

38. The following audits are currently at exit meeting / draft report stage. The outcomes of the audits are included within the annual opinion, the executive summaries of the reports once finalised will be included in the next internal audit quarterly update to committee.

- YPSA
- Primary school 2

- HR Employee Relations
- Shared Lives
- Capital Programme – Major Infrastructure
- Street Lighting Contract
- Adults – Providers Quality Assurance

39. The overall conclusion for the primary school audit – 1 has been graded Red.

40. Since the last report to the January 2023 Audit & Governance Committee the following broadband grant certifications have been completed:

- Business in Rural Oxfordshire Airband
- Business in Rural Oxfordshire BT
- Better Broadband for Oxfordshire
- Top-up Vouchers
- Gigahubs

Internal Audit Performance

41. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2022/23 performance.

42. Despite the staffing issues, including managing a vacancy throughout 2022/23 performance has improved in achieving the target date for the exit meeting for each audit assignment. This continues to be an area of focus for improvement. Performance for the issue of draft and final reports is good.

43. We are pleased to report the continued improvement with the implementation of management actions by the organisation, with the majority implemented or not yet due (90%)

44. Our customer satisfaction questionnaires continue to provide positive feedback.

45. We had planned at the beginning of 2022/23 to report on the percentage of repeat management actions; however the tracking system did not allow for us to easily capture or report on this data. If any actions are repeated within audits these are flagged within individual audit reports. We will review how we can capture and start reporting on these going forward.

Measure	Target	Actual Performance 2022/23 – as at 19/04/2023
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	67% of the audits met this target. 2021/22 59% 2020/21 50% 2019/20 61%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	93% of the audits met this target. 2021/22 86% 2020/21 85% 2019/20 74%
Elapsed time between receipt of management response to the draft report and the issue of the final report	15 Days	100% of the audits met this target. (Previously measured issue of draft report to the issue of the final report) 2021/22 66% 2020/21 80% 2019/20 74%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2023.	83% of the plan was completed by the end of April 2023 (including grant certification work). 2021/22 87% 2020/21 74% 2019/20 74%
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at April 2023: actions being monitored on the system. • 82% implemented • 8% not yet due • 7% partially implemented • 3%overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2 1 - Good 2 – Satisfactory 3 – Unsatisfactory in some areas 4 – Poor	Average score was 1.2 2021/22 1.1 2020/21 1.06 2019/20 1.17 2018/19 1.07
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. Next review is planned for Summer 2023.

Financial Implications

46. There are no direct financial implications arising from this report.
Comments checked by: Lorna Baxter, Director of Finance
lorna.baxter@oxfordshire.gov.uk

Legal Implications

47. There are not direct legal implications arising from this report.
Comments checked by: Paul Grant, Head of Legal
paul.grant@oxfordshire.gov.uk

Staff Implications

48. There are no direct staff implications arising from this report.

Equality & Inclusion Implications

49. There are no direct equality and inclusion implications arising from this report.

Sustainability Implications

50. There are no direct sustainability implications arising from this report.

Risk Management

51. There are no direct risk management implications arising from this report.

Sarah Cox, Chief Internal Auditor, May 2023.

Annex:	Annex 1: Progress with completion of 2022/23 Internal Audit Plan Annex 2: Annual assurance opinion definitions Annex 3: Executive Summaries of Audits finalised since last report to Audit and Governance Committee.
Background papers:	None.
Contact Officer:	Sarah Cox, Chief Internal Auditor Sarah.cox@oxfordshire.gov.uk

APPENDIX 1 - Overall conclusion and management action implementation status of 2022/23 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 19/04/2023
Childrens				
SEND	Final Report	Amber	6	1 Implemented, 5 Not Due
Childrens Education System – Implementation of New Council IT System: System Testing Training Operational Processes	Final Report	 Amber Green Amber	 4 1 5	3 Implemented, 1 Partially Implemented 1 Implemented
Supported Families	Continuous programme of claim verification throughout year	N/A	-	-
Supported Families – new framework development	Final Report	N/A	-	-
Children we care for / Care Leavers – support with management of finances.	Final Report	Amber	12	12 Not Due
Placements – quality assurance	Deferred to Q1 of 23/24 plan – due to IA resources	-	-	-
YPSA (Young People's Supported Accommodation)	Draft Report	Amber	tbc	tbc
IT application audit – EHCP System	Final Report	Green	2	2 Implemented
Primary school 1 – Audit/Counter Fraud Investigation	Final Report	Red	38	29 Implemented, 9 Not Due

Primary school 2 – audit	Draft Report	Amber	tbc	tbc
Adults				
Direct Payments – Follow Up	Final report	Amber	11	2 Implemented, 1 Not Due, 8 Overdue
Providers – quality assurance	Exit Meeting	Amber	tbc	tbc
Shared Lives	Draft Report	Amber	tbc	tbc
Build back better – Introduction of cap on care costs.	Removed from plan	-	-	-
IT application audit – LAS	Final report	Amber	9	6 Implemented, 3 Partially Implemented
Customers, OD & Resources – HR				
Off contract spend	Final Report	Amber	2	2 Implemented
HR – contract management	Final Report	Green	1	1 Not Due
HR – Employee Relations	Draft Report	Green	tbc	tbc
Payroll	Final Report	Green	0	No Actions to Implement
Corporate and Statutory Complaints	Deferred to 23/24 plan – request of service	-	-	-
Music Service	Final Report	Amber	17	11 Implemented, 3 Partially Implemented, 3 Overdue
Customers, OD & Resources – Finance				
Pensions Administration	Final Report	Amber	3	1 Implemented, 2 Not Due
Customers, OD & Resources – IT				
Virtualised Infrastructure	Final Report	Green	8	8 Implemented
IT Agile Working	Final Report	Green	5	3 Implemented, 2 Partially Implemented
Cyber Security – Ransomware	Final Report	Amber	7	6 Implemented, 1 Overdue
Cloud Services	Final Report	Amber	11	8 Implemented, 1 Partially Implemented, 2 Overdue

CDAI				
Leases	Final Report	Amber	10	10 Not Due
Property / FM – Contract Procurement and Contract Management arrangements	Final report	Amber	13	1 Implemented, 12 Not Due
Legal Case Management	Deferred to 23/24 plan – request of service	-	-	-
Environment & Place				
Capital Programme – Major Infrastructure	Draft Report	Amber	tbc	Tbc
Capital Programme - Highways Asset Management	Final report	Green	1	1 Not Due
Supported Transport	Deferred to 23/24 plan – request of service	-	-	-
S106 – New IT system	Deferred to 23/24 plan – request of service	-	-	-
Climate	Final Report	Amber	17	1 Implemented, 16 Not Due
Street Lighting Contract	Exit meeting	Green	tbc	tbc
IT application audit – GIS	Final Report	Amber	11	5 Implemented, 2 Partially Implemented, 4 Overdue

Grant Certification work completed during 2022/23;

- Disabled Facilities Grant
- Travel Demand Management 2020/21
- Green Homes Grant (LAD1B) 2021
- BDUK 2021/22 Q1-3
- BDUK 2021/22 Q4
- Test and Trace 2020/21
- Contain Outbreak Management Fund 2020/21

- Universal Drug Treatment Grant 2021/22
- Local Transport Capital Block Funding 2021/22 (includes Integrated Transport, Highways Maintenance Block and Pothole fund)
- Local Authority Bus Subsidy (Revenue) Grant 2021/22
- Broadband grants; Business in Rural Oxfordshire Airband, Business in Rural Oxfordshire BT, Better Broadband for Oxfordshire, Top-up Vouchers, Gigahubs

APPENDIX 2

Overall annual opinion – definitions based upon framework recommended by Institute of Internal Auditors.

Substantial

There is a sound framework of control operating effectively to mitigate key risks, which is contributing to the achievement of business objectives.

- no individual audit engagement graded as "red" or significant "amber"
- occasional medium risk rated weaknesses identified in individual audit engagements although mainly only low/efficiency weaknesses
- internal audit has confidence in managements attitude to resolving identified issues.

Satisfactory

The control framework is adequate and controls to mitigate key risks are generally operating effectively, although a number of controls need to improve to ensure business objectives are met.

- medium risk rated weaknesses identified in individual audit engagements
- isolated high risk rated weaknesses identified for isolated issues
- no critical risk rated weaknesses were identified
- internal audit is broadly satisfied with management's approach to resolving identified issues.

Limited

The control framework is not operating effectively to mitigate key risks. A number of key controls are absent or are not being applied to meet business objectives.

- significant number of medium and/or critical risk rated weaknesses identified in individual audit engagements
- isolated critical and/or high risk rated weaknesses identified that are not systemic
- internal audit has concerns about managements approach to resolving identified issues.

No Assurance

A control framework is not in place to mitigate key risks. The organisation is exposed to abuse, significant error or loss and/or misappropriation. Objectives are unlikely to be met.

- serious systemic control weaknesses identified through aggregation of individual audit engagements
- significant number of critical and/or high risk rated weaknesses identified for isolated issues
- internal audit has serious concerns about managements approach to resolving identified issues.

APPENDIX 3

Summary of Completed 2022/23 Audits since last reported to the Audit and Governance Committee - January 2023.

IT application audit LAS 22/23

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
Logical Security	**G**	**0**	**0**
Access Rights	**A**	**0**	**3**
System Administration	**A**	**0**	**3**
Audit Trails	**G**	**0**	**0**
System Support	**G**	**0**	**1**
Backups	**A**	**0**	**2**
		0	**9**

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

The LAS IT system was implemented in 2015 and is the main IT system supporting adult social care. The system is used by social workers, partner agencies, service users and carers to manage referrals, assessments, care commissioning, personal budgets and provider management. The audit has found there are some good controls in place over the authentication of users and the logging of user activity, however, there are risks in other areas, specifically user access rights and system administration. More details on the risks are provided below.

Logical Security:

All users have a unique account to the system, and they are all password protected. The accounts for internal users are synchronised with Active Directory (AD) and they are required to physically enter their AD username and password to access LAS.

Access Rights:

Users are given a 'profile' which determines their level of access within the application. Some users have a read-only profile and others have active profiles, allowing them to make changes to data. We found there is no formal review of access rights to confirm that users have the correct level of access to the system. Incorrect access can lead to unauthorised changes being made to data. We also identified a risk relating to requests for users to be given self-approver rights as our testing found these are not always approved by a Team Manager in accordance with agreed procedures. There are also IT users with access to the underlying database who no longer require it.

System Administration:

System administration is performed by the IT Application and Systems Support team within IT Services. The "ICT Systems Administrator" profile is allocated to 16 users, and all were confirmed to be valid.

The LAS application is exposed to the same risk with the new starter process which was highlighted in the EHCP IT Application review earlier in the year, in terms of access for new users being copied from existing users. This is being addressed by IT Services and hence has not been included as a finding in this report.

All requests for new accounts should be approved by a manager but this is not specified in operational procedures and our testing of six new accounts identified one which had not been approved at this level. There is also no formal approver list for accounts requested by Oxford Health. The procedure for identifying and disabling redundant accounts needs to be strengthened.

Audit Trails:

The application comes with a default audit trail which logs all user activity. There is an audit trail tab on each case record which shows when it was viewed or updated and provides details of any changes made. A Data Access Log report is available which can be searched for the activity of any specific user. The audit log is available from when the system was implemented in 2015.

System Support:

The application is supported and maintained by the supplier but there is no documented contract in place for the provision of this service. The Service Improvement Team within Adult's provide system support to users and anything they cannot deal with is logged with the IT service desk for the IT Application and Systems Support team. A LAS knowledge base is being developed on the service desk system.

Backups: There is a daily backup of the LAS database and the application. All backup jobs are reviewed daily to confirm they completed successfully and to identify and remediate any reported errors. Our testing of a two-week period in October identified that the daily check was not performed on one of the days as all relevant staff were on a training course. An application-level recovery test has also not been performed to confirm that the system can be fully recovered from the backups taken.

GIS IT Application 22/23

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
Logical Security	A	0	2
Access Rights	A	0	2
System Administration	A	0	4
Audit Trails	A	0	1
Data Maintenance	A	0	1
System Support	G	0	0
Backups	G	0	1
		0	11

Opinion: Amber	
Total: 11	Priority 1 = 0 Priority 2 = 11
Current Status:	
Implemented	5
Due not yet actioned	4
Partially complete	2
Not yet Due	0

GIS (Geographic Information System) is a priority 1 system that is used by service areas across the council for mapping and location services, including highways, fire service, planning, social care and school admissions. The main platform is supplied by Esri, and specific applications have been developed within this by the GIS team. GIS is accessible via a desktop tool and also externally through a number of web portals. There are generally good controls over the security and management of GIS, although we have identified risks around password security, management of user access rights, audit logging and updating of maps which should be addressed. As part of the audit, we met with a sample of users from different service teams, and they all made positive comments about their experience of using GIS.

Logical Security:

Internal access to GIS is subject to Single Sign-On, based on network level authentication. For external access to the GIS web portals, a username and password is required, and we found that the current password length does not comply with corporate password standards. This increases the risk of users selecting poor quality passwords. Due to the nature of the

system and the type of information it holds, Multi-Factor Authentication (MFA) is not used for external access. A formal risk assessment should be performed to determine if MFA is required.

Access Rights:

GIS allows different access levels to be defined for users and these are set based on "type" and "role". User access rights were reviewed in 2022 as a one-off exercise but are not reviewed annually to ensure users have the correct level of access to the system. We also found that an IT user's standard account has been given administrator privileges to the underlying SQL database, which means the account is operating with a higher level of access than it requires and poses a security risk.

System Administration:

System administration for GIS is performed by a small, dedicated team within IT Services, who manage all users and their access rights. We found the procedures for managing users, in terms of starters and leavers, are not documented to ensure they are clearly defined, including specific responsibilities. All new accounts have to be authorised by a line manager and our sample testing confirmed that this control is working effectively. The leavers process is less effective, and we identified a number of GIS accounts that have either never been accessed or were last accessed before 2021. System administration accounts are generally limited to members of the GIS team and relevant third parties, although we found one member of the team has an excessive number of administrator accounts on one of the portals. All default administrator accounts on portals have the same password, which poses a security risk.

Audit Trails:

Audit logging is enabled on the portals. There are six levels of auditing, and we found the current level does not log certain security related events, such as changes to user access, or key user activity such as publishing content. Increasing the level of auditing will help manage this risk, although there is a balance to be struck in terms of the number of events logged and the subsequent impact it will have on the size of audit logs. The current audit logs are also only retained for 90 days before they are overwritten, which does not comply with PSN (Public Services Network) requirements.

Data Maintenance

Maps and associated data are updated from trusted sources, such Ordnance Survey, Environment Agency and Natural England. Some of the tools used to perform the updates have built-in validation routines and manual checks are also performed for completeness and accuracy by the GIS team. Whilst this is satisfactory, the procedures for performing the updates are not documented and details of checks and validations are not logged to confirm they are carried out and that any issues are addressed before the changes are made live.

System Support:

GIS is covered by a support and maintenance contract, which was extended in July 2022 for 12 months with an option for a further year beyond this. Our testing confirmed that users are aware to log all support issues with the IT service desk, where there is a specific queue for the GIS team. GIS is being upgraded to a more recent version and we confirmed that software license numbers are not being exceeded.

Backups:

A backup of the main database and portal servers are taken on a daily basis and all copies are safeguarded and protected, including against ransomware attacks. In addition to the overnight backup of the database, log files are backed up every two hours during the day to minimise the loss of data. We have identified a risk in that whilst database level restores are performed from backup media, an application-level recovery has not been tested to confirm that the system can be fully restored within agreed timescales.

School audit 1 22/23

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance	**R**	**0**	**10**
Financial Planning & Monitoring	**R**	**2**	**2**
Procurement	**R**	**0**	**4**
Income	**R**	**1**	**3**
Assets	**A**	**0**	**1**
Staffing/Payroll	**R**	**1**	**13**
Unofficial Funds*	**-**	**0**	**1**
		4	**34**

Opinion: Red	
Total: 38	Priority 1 = 4 Priority 2 = 34
Current Status:	
Implemented	29
Due not yet actioned	0
Partially complete	0
Not yet Due	9

A governance and financial management audit was undertaken at a primary school. The audit highlighted areas of concern in relation to the financial management practices in place. The audit had the overall conclusion of Red, with weaknesses identified in the areas of Governance, Financial Planning & Monitoring, Procurement,

Income, Assets, Staffing & Payroll, and Unofficial Funds. A new Headteacher is now in post, and it is acknowledged that significant progress has been made in addressing the issues raised in the audit ensuring improved governance and financial management processes are in place. There are issues of non-compliance with expected financial procedures and controls which are still under investigation. These will be reported on at a later date.

Supported Families (including January/February/March 2023 claim)

Following new funding invested by the Government in the Supporting Families Programme, the Department for Levelling Up, Housing, and Communities (DLUHC) have developed the programme further, expanding the outcomes framework and updating the funding formula. Oxfordshire County Council have become an early adopter of the new framework, building an automated system, Ohana, to identify claimable families.

The claim consisted of **239 families** identified by the new system; 181 of which are Phase 2 (the old framework, which can be claimed under until July 2023), and the remaining 58 under Phase 3 (the new framework).

Scope of Work

As per the Supporting Families programme guidance, Internal Audit have been working with the Supporting Families Team to agree that evidence used to demonstrate programme eligibility and successful family outcomes is in line with the national Supporting Families Outcome Framework.

The programme guidance also requires that a representative sample should continue to be verified by Internal Audit before each claim is made, to ensure that relevant criteria for both eligibility and sustained progress had been met.

Overall Conclusion

The audit recognises the significant work undertaken by the Supporting Families Team to build and develop the Ohana system, and the substantial increases in efficiency this will have on future claims. The review carried out confirmed consideration had been given to all relevant areas when building the system to ensure evidence used is in line with DLUHC requirements and data outputs are accurate and reliable. As such, no audit findings or management actions are required at this stage and having received satisfactory responses for all queries raised by Internal Audit, the January 2023 claim was signed off for submission.

Leases 22/23

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: Policies & Procedures	**A**	**0**	**4**
B: Business Cases for the Leasing of Surplus Land and Buildings	**A**	**0**	**1**
C: Marketing, Negotiations, and Agreement of Lease	**A**	**0**	**2**
D: Ongoing Management of Lease	**G**	**0**	**0**
E: Management Information and Reporting	**A**	**0**	**2**
F: Lease Portfolio Strategy and Management	**A**	**0**	**1**
		0	**10**

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

The Council has a lease portfolio (including leases out, licenses, sub-leases and so on) of just over 650 agreements that collectively provide annual rental income of £3.5m (in addition to one off premium payments totalling £9.7m). Approximately 50% of leasing agreements are with nil rental values, mostly driven by government policy over the years (e.g., long leases to schools). During 2022/23, the Council entered into 14 leases out agreements (annual rental value of £24k), 3 license agreements (annual value of £3k) and no sub-lease agreements.

The Council does not currently proactively lease out its property, it is reactive i.e., the Council will be approached about one of its vacant properties by an interested party or an existing lease will expire, and a re-negotiation entered into where appropriate. A Property and Assets Strategy was recently approved, and a Disposals policy and process is being drafted (N.B. since the audit fieldwork was completed, the policy has been re-named the Vacant Site Asset Review policy) that will drive a greater strategic approach and formalise decision making in respect of surplus land and buildings, which may include the decision to proactively lease out the land and/or building. In addition, the existing policy for Community Asset Transfers (CATs) is being re-drafted

to reflect current priorities. This audit assessed controls operating during the year whilst taking into account the planned changes. Where draft documents were available, we reviewed and provided feedback.

Policies and Procedures - As noted above, a Disposals policy and process is being drafted which will, in effect, provide a strategic disposals (including leasing) framework, in that all surplus land and buildings will need to be formally declared and approved and a disposals strategy determined before a new lease can be entered into.

The end-to-end leasing process, renewals process and rent reviews process, including roles and responsibilities, is understood, and operated effectively across Estates, Legal and Strategy but it is not documented within a set of procedure notes to aid new joiners and act as a reference point to existing staff.

Business Cases for the Leasing of Surplus Land and Buildings - At present, formal business cases to lease / re-lease surplus land and buildings are not required. However, going forward, the draft Disposals policy includes a requirement for a formal declaration from the Strategic Leadership Team (SLT) and Cabinet as to whether a given property is deemed surplus following a process to assess alternative Council uses. Once deemed surplus, a strategy for disposal will then be required to assess options (e.g. a sale or lease). This will be presented to SLT and Cabinet for approval before going ahead with the chosen option. This proposed process will enhance control in this area. We reviewed the draft process documentation and suggested a handful of enhancements. For example, to include templates for the documentation of the disposal strategy and to develop guidance notes to support the correct operation of the process.

Marketing, Negotiations, and Agreement of Lease - As noted above, properties are not currently proactively marketed for leasing out. When the Disposals process is operational and disposal strategies are approved, where a lease is the preferred option, a lease marketing strategy will form part of the overarching approved strategy.

From the negotiation phase to entering into the lease agreement itself, there is an effectively operated process and set of controls that includes standardised templates to document the proposed transaction, a scheme of delegation for review and approval, and established lines of communication between the Estates, Strategy and Legal teams. Some minor enhancements have been noted in the Supplementary Issues section of this report.
We also reviewed the controls in place to comply with the Community Asset Transfer (CAT) policy where relevant. A couple of control design enhancements have been noted for consideration as part of the re-draft of the policy and process. For example, if business cases from prospective tenants will still be required, developing business case templates would aid the comparability of business cases as part of the assessment process. There is also a lack of documentation of the assessment of the proposal against the principles of the CAT policy.

Ongoing Management of Lease - Once a lease is entered into, copies of lease agreements and any changes to lease terms are sent to relevant stakeholders including the Property Records team for uploading to Concerto and the Property Finance team to process for rent collection. The Operational Manager Property

Management (OMPM) takes ownership over preparing an Annual Work Plan (AWP) where all property management activity, including rent reviews and lease renewals are tracked. The Case Management module in Concerto will soon be implemented to automate the notifications process when trigger events (e.g. lease renewals) are due. Rent reviews are carried out in accordance with the terms of the lease agreement and lease renewals follow the same process as new leases.

Management Information and Reporting - All management information related to a lease is stored within Concerto. There isn't any regular reporting in relation to the leasing portfolio. Instead, reports are run in response to ad hoc queries/ requests. We understand that there are plans to create a dashboard in Concerto for the Head of Estates, Assets and Investment so they can more easily see the management information they require in relation to the lease portfolio when they need it. Consultation with stakeholders should be carried out to understand what information will be helpful to them on a regular basis. For example, Strategy have requested regular reporting on lease expiry dates.

Lease Portfolio Strategy and Management - A Property and Assets Strategy was approved this year of which leased out assets form part. One of the next steps in implementing the strategy is to perform a detailed strategic review and assessment of the portfolio to ensure that the Council continues to obtain the best rate of return and wider community value from its leases. This strategic review should then be completed on a periodic basis.

Childrens finances 22/23

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: Policies & Procedures	**A**	**0**	**6**
B: Children We Care For Finances	**R**	**0**	**5**
C: Care Leavers Finances	**A**	**0**	**1**
		0	**12**

Opinion: Amber	
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 Council has an important role in supporting Children We Care For (CWCF) and care leavers to develop the financial skills they need as they grow and move on to live independently. This audit focused on the adequacy of the support provided and the controls in place to help children and young people save and manage their money effectively.

Although the audit has highlighted weaknesses relating to the recording of financial information, availability of guidance, and consistency and timeliness of processes such as making or transferring savings, it is acknowledged that these issues have already been recognised by the service. Guidance and policies relating to key areas are in the process of being drafted, and work is underway to review how the Council can manage children's finances in a more consistent way.

Policies & Procedures: The audit found that there is currently limited written guidance available to social care staff around the management of children's finances. A "Transition to Adulthood Financial Policy and Guidance" document has recently been drafted for staff supporting care leavers aged between 16-17 and 18-21/25 with their finances, however this is not yet finalised and available to staff. Currently, there is no guidance for social care staff for the management of children's finances for CWCF below 16, or any information around how to manage or access Junior ISAs (JISAs) or Child Trust Funds (CTFs) on behalf of these children. The absence of available guidance in relation to both CWCF and care leavers is acknowledged by the service who have plans in place to address this.

In terms of guidance available to care providers, it was positive to note there is a comprehensive Fostering Handbook designed to provide guidance to OCC Foster Carers around most aspects of children's finances that is reviewed and updated annually. For internal children's residential homes, it was found there is no written guidance relating to the management of children's finances.

Children We Care For Finances: When carrying out sample testing in this area it was positive to note that for the majority of cases it could be evidenced from LCS that savings were being made and pocket money was being issued. However, the amounts being saved were inconsistent varying across placement types, for example one placement (an IFA) was found to be saving £37 per week (the Fostering Handbook suggests £6 per week for a child this age); another (a secure unit) did not offer a saving service. For internally managed placements (i.e. OCC foster carers and children's residential homes) there were variances in the level of savings and pocket money between children of a similar age.

The level of detail and consistency of information held within LCS records varied, with amounts being saved or given as pocket money not always recorded. Internal Audit were unable to confirm from a review of these records that savings accounts had been set up for almost half of the 15 children sampled (acknowledging roles and responsibilities in this area are currently unclear due to the absence of guidance).

It was also noted there is currently no easy way of identifying where a child's savings are held or what the current balance on the account is. This makes it difficult to confirm that savings are being transferred appropriately when a child moves placements or

leaves care or that the account is being managed as expected / that savings are being accumulated as expected. Of the 15 instances reviewed, reference to the value of savings could be found in four cases. This was on an ad hoc basis in case notes.

The audit found there was little evidence on LCS of savings being transferred between placements. This was followed up with the relevant Social Workers who confirmed savings were yet to be handed over in all but one case. There were also examples noted where although savings from the previous placement had been successfully transferred, funds from the placement prior to that had not yet been obtained from the provider. Whilst there was little evidence on LCS of savings being transferred when a child returned home, when queried with the allocated Social Workers, they were able to confirm that savings had been handed over in the majority of cases tested.

In terms of educating CWCF to become financially capable and independent, evidence held on LCS was also found to vary, with approximately half of the children sampled shown to have received some form of information or education in how to manage their finances, although this varied in amount and level of quality.

Children born between 1 September 2002 and 2 January 2011 are eligible for a Child Trust Fund (CTF), and children born after 2 January 2011 are eligible for a Junior ISA, both issued by the Government. Audit testing confirmed that Junior ISA's were in place as expected for the children sampled. The service are in the process of improving recording and monitoring of Junior ISAs with recent work undertaken to enable account details to be recorded within LCS so that they can be tracked / monitored on behalf of the child. It was not possible to confirm CTF details for those sampled who were eligible. It was reported that OCC do not have access to CTF information at present which makes assisting the child / young person in gaining access to their CTF when they reach 18 more difficult.

Care Leavers Finances: The audit reviewed a sample of ten care leavers, finding care leavers allowances to have been set up promptly and accurately in all cases, along with support with their Setting Up Home Allowance (SUHA). LCS records confirmed all of the care leavers sampled received a consistent level of education in relation to financial capability and independence upon leaving care. This included support with applying for relevant benefits as well as education around budgeting.

When reviewing the transfer of savings to care leavers, it was noted that there was no evidence or record on LCS of savings being transferred to the care leaver for 3/10 cases sampled. This was followed up with the care leavers' Social Workers who confirmed that all three care leavers had received their savings. Further inconsistencies were noted in the timeliness of the transfer of savings, and the method for doing so. The care leavers sampled were found to receive their savings between one year before their 18th birthday and 11 months after they turned 18. From review of the circumstances of the cases sampled, although there were examples where the timing of the transfer appeared reasonable, there were also examples where this was unclear or did not appear to be appropriate. A case was also noted in which it could not be evidenced that a care leaver who turned 18 in April 2022 had received savings accumulated from all previous placements, only the most recent. The care leaver's Social Worker reported that this was still in the process of being resolved.

In terms of methods used to transfer savings for the sample tested, examples identified included cash, bank transfer, cheque, access to a previously set up savings account, and access to an ISA. It was not possible to confirm from LCS that the care leavers sampled had been able to access their CTF, although references to these accounts were noted in 3/10 cases.

HR Contract Management 22/23

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
A: Contract Governance	**G**	**0**	**1**
B: Management Information and Performance Reporting	**G**	**0**	**0**
C: Risk Identification and Management	**G**	**0**	**0**
D: Contract Payments	**G**	**0**	**0**
		0	**1**

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

The Council holds a number of contracts relating to HR services, including employee assistance and occupational health, workforce supply chain management, and training. The audit reviewed a sample of five active contracts to provide assurance over the contract management and monitoring activity taking place. These contracts ranged from Bronze to Platinum in terms of the Council's contract classification tool (in which scores are applied to a series of questions relating to the contract and, dependent on the associated risks, complexities, and opportunities, a Bronze/Silver/Gold/Platinum category is applied) and ranged between £250,000 and £44m in lifetime value.

Contract Governance

Overall, the audit found strong systems of contract governance in place. With the exception of one contract, assigned contract managers were found to be in place for each contract reviewed. In the final case, the absence of an overall contract manager and associated contract management and monitoring activity had been previously identified by both HR and the Provision Hub, noting that spend is incurred across the Council by different teams and services. The quality of work is therefore monitored at an individual level by those teams, however there is no high-level oversight of the contract, value for money, or contractor performance. Work is ongoing by the Hub to identify an appropriate contract manager, as well as ensuring the contract meets the needs of all users across the Council.

For the four contracts where contract management activity could be reviewed, meetings with contractors were found to be taking place regularly to monitor performance and finances, with actions recorded and followed up on as necessary. Good working relationships across the Council could also be demonstrated, including with Legal, the Provision Hub, and individual teams/areas using the services provided by the contractors.

Management Information and Performance Reporting

A review of the four contracts found one did not include any Key Performance Indicators (KPIs) or Service Level Agreements (SLAs). This was queried with the contract manager who confirmed that SLAs have now been drafted and are in the process of being finalised and agreed. Internal Audit confirmed that, in the absence of these SLAs and associated targets to measure performance against, the contractor has still been providing detailed performance data which is reviewed at quarterly meetings. It was reported that, once finalised, reporting on performance against the new measures will be clearly demonstrated within the performance data provided by the contractor.

Reporting against the KPIs and SLAs included in the remaining contracts was found to be accurate and timely, with concerns around poor performance being escalated as appropriate, with evidence which demonstrated working with contractors to improve performance.

In terms of internal reporting, data relating to three contracts / service areas was found to be reported to Cabinet, via a quarterly 'Workforce Report and Staffing Data' update. This provides Councillors and senior management with an update on HR activity, including management information and high-level figures on the Employee Assistance Programme, Occupational Health, and agency staff expenditure.

Risk Identification and Management

The risk management activity in place for each contract reviewed was found to be at an appropriate level. Contract managers were able to articulate how risks are managed and demonstrate the business continuity arrangements in place. It was also clear from review contract governance meeting records that issues and concerns are discussed and escalated as appropriate.

Contract Payments

Budget monitoring was found to be taking place effectively, with variances monitored and reported on as appropriate. In terms of payments to contractors, a review of five invoices per contract as part of the audit, confirmed that payments had been made on a timely basis and were subject to the appropriate pre-payment checks carried out by the relevant contract manager. Where recharges to other teams / services were then required (for example to maintained schools who buy into the Employee Assistance Programme and Occupational Health service, or to cost centres paying for agency staff), these could also be evidenced as taking place accurately and on a timely basis.

Climate Change 22/23

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: Strategy and Scope	**A**	**0**	**3**
B: Governance	**A**	**0**	**2**
C: Reporting and Monitoring	**G**	**0**	**0**
D: Business Planning and Performance Monitoring	**A**	**0**	**2**
E: Risk Management	**A**	**0**	**2**
F: Procurement	**A**	**0**	**3**
G: Capital Planning	**A**	**5**	**0**
		5	**12**

Opinion: Amber	
Total: 17	Priority 1 = 5 Priority 2 = 12
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	16

The Council has a key strategic priority to address the climate emergency. Two targets have been set: to reach net zero as a Council by 2030; and, to reach net zero as a County by 2050. A Climate Action Framework has also been developed to inform the Council's approach to climate action. This audit has looked at the Council's processes and controls in place to meet these targets and address climate change risks.

Overall, we found that there has been a significant amount of work to define an indicative path for reducing carbon emissions to meet the 2030 target and there are a number of activities in place to support this pathway. This includes clear actions to update the Council's fleet, retrofit buildings and install high efficiency street lighting. However, there are areas where the Council still has work to do in order to develop its processes and controls further. We have outlined these in more detail below.

Strategy and Scope

The Council has a clear understanding of the scope for its 2030 and County's 2050 targets and overall delivery strategy via the climate action framework.

2030 Council target
A clear plan has been developed for achieving the 2030 target but there is a lack of clarity on the actions to be taken after 2025. This is partially to allow more clarity on the Council's strategy in certain areas beyond this point (e.g. retrofitting Council buildings to use net zero heating) as well as to allow for an agile approach in response to national policy, recognising that technology will change over this period.

2050 Oxfordshire County target
The County is still developing the pathway of emissions reductions needed to achieve its 2050 target. The Council co-commissioned the 'Pathways to a Zero Carbon Oxfordshire' (PAZCO) report with the University of Oxford. The report is intended to support the County in planning and implementing its next steps for reaching net zero. The Council is now working with District Councils to agree joint working areas.

Capital Planning

Council's Estate
Heating of buildings is one of the top sources of emissions for the Council. A key action to meet its 2030 target is to refit Council buildings to make them more energy efficient. The Council has split the refitting of its buildings into two phases. Phase 1 is funded and ready to commence. Phase 2 has not yet had funding formally agreed but it has been added to the capital pipeline for future years. Funding is necessary to ensure that emissions are reduced to meet the 2030 target.

Funding is also a significant factor in being able to reduce emissions from the existing capital pipeline. Funding for the capital pipeline was agreed several years ago, meaning there is limited ability to change these projects due to the cost impacts, or because the funding was subject to a scope for high carbon infrastructure, such as roads. There is a need to better understand the funding requirements and to understand the lifetime emissions from infrastructure currently being built. It is noted that the proposed capital programme 2023/24-2032/33 that was presented to Cabinet

for approval on 24 January 2023 includes reprioritised capital proposals of £24.3M which are specifically targeted at climate action, the largest areas being the 'Fleet Replacement Programme', 'Climate Action including Tree Replacement' and 'Transport Hubs'.

This issue with funding also extends beyond capital planning, in that the Council has detailed understanding of the funding requirements to meet the emissions reductions required of only a third of the corporate property portfolio. The remaining sites will undergo energy audits spread over several years due to available resources. Additionally, there will be cost to offset emissions that cannot be eliminated after 2030. Both these costs are potentially significant, and more work needs to be done to understand them and how the Council will fund them.

Oxfordshire County
At a county level, high level figures on investment needed to meet the 2050 target are set out in the PAZCO report but much of it is not commercially investable yet and there are other considerations, such as the importance of innovation.

Governance

The Council has put in place a governance structure with a series of workstreams covering the Council's response to climate change, for example by putting in extra flood defences on key roads. These workstreams report into a programme board that oversees the programme and provides assurance to management on progress against the strategy, which we found to be effective.

We note that there is a toolkit to support the completion of Climate Impact Assessments within board decision papers to Cabinet and the Senior Leadership Team. However, we noted that a variety of decisions e.g. capital approvals that sit outside the remit of the Climate Change Programme Board are not subject to input by the climate change team and there is a risk that decisions are made that do not properly take into account the objectives of the climate strategy.

Business Planning and Performance Monitoring

Actions on climate change are primarily driven by the central climate change team. There are two working groups in place that report into the Climate Change Programme Board to address different elements of the climate response. They are supported by a small number of core teams, such as property and infrastructure.

Our review of a sample of service plans highlighted variations in the levels of engagement with the Climate Change Strategy. We also noted that not all areas are clearly showing ownership over KPIs relevant to the 2030 target. This poses a risk to targets being met if key actions to reduce emissions are missed.

Risk Management

The Council maintains a central risk register for climate change. We noted that this focuses mainly on the risks to achieving the 2030 target and is not as expansive on the risks to achieving the 2050 target nor the risks the Council faces due to the effects

of climate change. We also noted that as with business planning there is a significant variation in the level of risk from climate change captured in operational risk registers.

Procurement

Actions have been taken to reduce emissions at a contract level where opportunities have been identified by the contract manager or as part of tender submissions in response to the social value procurement framework. Further work is needed to establish the level of emissions that are built into the Council's supply chain and to specify the procurement strategy for emissions reductions needed in upcoming procurements. Management is in the process of developing a process to do this and bringing in the required resources.

Reporting and Monitoring

The Council has a regular set of reports that feed into the Climate Change Programme Board. These reports are submitted by the two working groups that bring together different stakeholders to lead the climate response. They set out key areas of progress and current emissions and are reviewed and challenged at board meetings.

Capital Highways 22/23

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

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

A corporate review of Capital Programme governance carried out in 2022 resulted in a revised approach to areas such as decision making, thresholds, and roles & responsibilities. A Strategic Capital Board was established to oversee the Capital Programme, and a capital hub created to improve oversight, reporting and monitoring. The Board is becoming more embedded with continuous improvements being made to enhance the quality and timeliness of information being reported at Board level. There are four programme boards reporting into the new Strategic Capital Board: Highways Maintenance, Major Infrastructure, Digital and IT, and Property. This audit sought to provide assurance over the new governance arrangements in relation to Highways Asset Management and Improvement Programmes, which, as of March 2023, accounts for £50.6m of 2022/23 capital expenditure / £282.4m for the 10-year programme.

The overall conclusion of this audit is Green. This conclusion is based upon the governance in place at scheme level and the effectiveness of escalation processes and documentation of decision making. Through sample testing of four projects/programmes within the Highways Capital Programme, the audit reviewed the governance arrangements in place to confirm that, at an individual project level, project management and risk management arrangements are operating effectively, and, at senior management level, strategic governance arrangements provide sufficient oversight of the delivery of the Council's capital programme. This included review of how issues, concerns, and information is escalated and/or flows through the governance structure. The audit also reviewed the adequacy of guidance in place for staff in relation to the management of capital projects.

The governance structure in place was found to be operating effectively, providing senior management and Members with sufficient oversight of both delivery of the Highways Capital Programme and, where necessary, awareness of arising issues and concerns, as could be demonstrated during sample testing.

Supporting the Boards is a Highways dashboard, providing oversight of all projects and programmes within the Highways Capital Programme. This includes the assignment of RAG ratings relating to a programme's finance, timeline & delivery, and risk. Each programme can then be drilled into further, providing budget positions, identified risks, and information relating to each individual scheme (which are also assigned RAG rated). The information presented in this dashboard is then used to inform escalation / sharing of arising concerns or potential issues with the Strategic Capital Board. While it was noted some areas of the dashboard were more established than others, it was confirmed during discussion with officers that the dashboard is undergoing further development, to ensure a consistent approach across all programmes and alignment across the different boards and meetings.

Review of Board papers throughout the governance structure confirmed decisions, approvals, and actions are being documented accurately, although it was noted the Terms of Reference for the Highways Operation Board has not been updated to reflect the responsibilities the Board holds in relation to oversight and delivery of the Highways Capital Programme or that the Capital Programme Manager is now an attendee of the Board.

Facilities Management (FM) Follow up 22/23

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

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

As a result of a whistleblowing referral, an investigation was undertaken by the Internal Audit / Counter Fraud team during 2021/22. The investigation reviewed issues surrounding engagement of suppliers and practices within the Facilities Management service and the construction of the Temporary Place of Rest (TPOR). There were multiple strands to the investigation. An action plan was agreed capturing all agreed management actions arising from the investigation and internal audit work. This action plan was owned by the previous CDAI Corporate Director, and progress in implementing the agreed actions was reported to the March 2022 Audit & Governance Committee (as exempt information). Since the completion of the investigation, changes have been implemented within Facilities Management including the re-structuring of Property and the Provision Cycle has been implemented. A follow up audit was agreed as part of the 2022/23 Internal Audit plan.

The audit reviewed the implementation of agreed actions and, where actions had been implemented, confirmed effectiveness of implementation. The action plan covered Facilities Management training, Facilities Management contracts and contract management, work order processes in relation to purchasing card expenditure, Facilities Management overtime, use of fuel cards by Facilities Management, supplier charging, emergency guidance, assets, whistleblowing procedures and training.

The audit noted good progress in the implementation of the agreed investigation action plan with Procurement and the Facilities Management Commercial Team working together to address and implement the improvements. Of 20 actions agreed, 16 have been confirmed as implemented, 1 is not implemented (whistleblowing training and awareness, so the action has been restated), the remaining 3 are partially implemented with a further 11 actions agreed to embed and improve the controls already implemented. These relate to the administration of purchasing cards, overtime and fuel cards.

Key Findings

Works Orders / Purchasing Card Process: Previously there was no process or system in place to enable purchasing card expenditure to be matched to works orders. The service implemented a temporary solution which made some improvement to the process for the review and approval of spend for engineers, but this was not applied to supervisors spend. Since conclusion of audit testing, the works order system has been replaced and it has been reported that the service are now able to upload receipts for expenditure against the works orders within the system, removing the need for the temporary solution. The new processes are now being applied to both engineers and supervisors spend. Guidance on the new processes is being developed. Audit testing of transactions between April – November 2022 identified that 50% of purchasing card transactions by the team had not been approved. Further sample testing undertaken identified issues with VAT not being correctly identified and accounted for.

Overtime: Since October 2022 a new system has been developed within the service, using MS Forms, for the recording of engineer's overtime. This process has not yet been extended to supervisors who claim overtime. Audit testing of a sample of claims identified errors where engineers and supervisors had been incorrectly claiming overtime at x2, rather than the correct rate of x1.5. These errors had also recently been identified within the team. Testing identified that sufficient detail was not always available to support overtime claims made by supervisors within the sample tested.

Our sample testing also identified a duplicate claim, which resulted in an overpayment. Following this issue being highlighted during the audit, immediate action was taken by the Operations Manager who has now introduced a method for highlighting duplicate claims using works order numbers. It has been reported that the new works order system has the functionality to record overtime against works orders, however until system reporting arrangements are finalised, the MS Forms system will continue to be used as a temporary measure.

Fuel Cards: The audit noted that fuel cards within the FM Maintenance Team are assigned to a person (rather than a vehicle) increasing the risk of misuse. It is acknowledged that there is no consistent approach to how fuel cards are assigned across the organisation.

Journeys are not logged by the FM Maintenance Team and whilst trackers are in use in some vehicles, this is not consistent across the team. As a result, there is currently limited information to check fuel invoices back to official journeys if required. This has been recognised by the Operations Manager as an area for improvement.

The service does not maintain a record of all vehicles used by the FM Maintenance Team, including those on short term hire. This means that fuel card spend cannot always easily be confirmed as being for work purposes. In addition, fuel cost invoices are not currently split by the correct cost centres as they are based on historic information, making it more difficult to ensure that costs are correctly allocated.

The FM Maintenance Team have not been provided with any documented guidance or process regarding the use of fuel cards, although it is acknowledged that there is also a lack of corporate guidance in this area.

It was reported during the audit that as part of a recent renewal of expiring cards, new cards were issued for ex-employees. It is acknowledged that there is no corporate approach to the issue of new cards and the cancelling of old ones.

Actions agreed in relation to fuel card use and administration have been agreed corporately as well as with the service. It has been reported that changes being implemented as part of the vehicle fleet strategy One Fleet will include central management of fuel cards, the development of a corporate Fleet and Driver Policy and centralised invoicing of fuel costs.

Supplier Charges: The action in relation to overcharging by suppliers is partly implemented. The matter is subject to an ongoing confidential investigation and is being progressed within Legal.

Whistleblowing: The actions agreed in relation to the policy and procedures have been implemented. There is one outstanding action in relation to the rollout of training and awareness across the organisation. This is in the process of being implemented. A revised target date for implementation has been agreed.

Pensions Administration 22/23

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**	**1**
Scheme Employer & Member Lifecycle	**A**	**0**	**1**
Debtor Management	**A**	**0**	**1**
		0	**3**

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

Regulatory Framework

Overall, audit testing found that controls and processes in relation to Pensions Administration are strong and working well.

There is comprehensive staff guidance is in place for all key team pensions administration processes, however there are some areas which are more specialist and high level (mainly processes carried out by the Pension Services Manager and Technical Manager) which are not currently documented.

From review of team performance against SLA targets, it was noted that whilst the team are not fully meeting targets in all areas, they are now working to the routine SLA targets (following a period during the previous audit where reduced targets were being worked to). Performance is routinely being reported to the Pension Fund Committee. Performance across areas varied from month to month, meeting SLA targets overall between 81% and 93% of the time over the 22/23 financial year reviewed to October 22.

Scheme Employer & Member Lifecycle

The implementation of the Administration to Pay system is ongoing with some progress made since the last audit. Four of six areas have been implemented, with the other two due to be implemented by the end of May 2023. Ongoing progress with the implementation is being reported to the Pension Fund Committee.

Review of pensions administration processes noted that there is an opportunity, with the roll out of Admin to Pay and the establishment of debt recovery processes, to review and rationalise the number of sign off points in the payroll payment process. There is currently

a duplicated benefit administration approval step at the end of the process, which could be removed and would streamline the process.

Although previous technical issues with the running of the "Payjour" report at the end of the pensions payroll run process have been resolved, it was noted that this process is not currently operating effectively, with reporting currently on more members of staff than expected and there being a lack of clear evidence of review and sign off of this step in the process. This will be subject to further Internal Audit review as part of a separate audit of Pensions Admin IT Applications to be completed in 2023/24.

It is positive to note that, with the exception of Oxfordshire County Council which is due to transfer this month, scheme employers have now all moved over to the automated system for providing monthly data returns. This move to automated uploads has improved efficiencies for the team in relation to monthly data checking and review processes.

Debtor Management

Although limited progress was made during the year in review and recovery of pensions debts, it has now been agreed that the corporate Finance Systems & Support Team will take over responsibility for pensions debts shortly with recovery processes to be aligned with corporate processes.

SEND Follow up 22/23

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

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

Following the 2019/20 audit of SEND, with an overall conclusion of "Red", 41 management actions were agreed. This follow up audit has confirmed that 32 management actions have been implemented, 1 has been implemented with a new management action arising, 2 actions have been superseded, 4 actions were found to have been partially implemented and 2 actions have not yet been implemented (1 has been superseded with a new re-worded action agreed within this report and the other remains open on the 4action system).

The audit has noted significant progress has been made in addressing the control weaknesses identified during the previous audit. Policies, procedures and processes have been reviewed across the service, processes have been updated as part of the implementation of the new Education IT System where appropriate, with staff guidance now in place across all key areas. It is noted that guidance is subject to ongoing review and is being updated as new system processes become fully confirmed and embedded (this is particularly the case in relation to some of the new finance processes).

Finance processes have been reviewed and improved with work ongoing to fully implement and embed new processes in the new education IT system. Whilst progress has been slower than anticipated, officers are working hard to identify and resolve anomalies and issues arising as different financial processes fully move over to the new system. Whilst the new financial processes are being embedded, spreadsheets continue to be used to ensure accuracy of outputs and provide effective management control. Work is also ongoing in relation to development and provision of training on financial processes for SEN Casework officers with training needs reviewed and identified and training to be delivered shortly.

There is an action outstanding in relation to the agreement of the policy for split funding. Whilst a draft Funding and Joint Commissioning Protocol has been produced this has not yet been agreed, with funding splits unchanged from when the previous audit took place.

Whilst the situation in relation to the timeliness of completion of EHCPs remains challenging due to issues including increased demand, a backlog of EHCPs which needs to be cleared, staffing challenges and a national shortage of Educational Psychologists and teams in other sectors (for example Health) whose input is required in order to produce individual EHCPs, the Head of SEND is working on robust actions to improve performance and there is regular reporting to senior management, members and the DfE. Reporting includes forecasting of when actions to improve performance will have an impact and when it is anticipated that performance targets will be met.

Processes for ensuring that EHCPs are of the required quality have been reviewed and updated with a quality assurance framework in place covering routine moderation processes at team level as well as deep dive sample checking and feedback by the Multi Agency Quality Assurance (MAQA) Forum.

The process, roles and responsibilities in relation to the completion of annual reviews have been reviewed and confirmed with recording requirements clarified. There have been recent developments in relation to system reporting which should now enable accurate identification of overdue reviews. Testing did identify that further work is required to data cleanse current records, with sample testing identifying cases showing as overdue for review which should actually be closed.

Tribunal processes, roles and responsibilities, including recording requirements have been reviewed and confirmed, however due to issues with system functionality, it is currently necessary to maintain spreadsheet records for reporting on tribunal outcomes. Further consideration should be given to how system functionality can be developed going forward to remove the need for the maintenance of a separate spreadsheet. Although guidance on the tribunals process was updated following the audit, further updates to this guidance were required following additional changes to process as a result of the implementation of the new IT system. A follow-on management action was therefore agreed which has now been implemented.

Performance management and management information requirements have been reviewed and confirmed following the previous audit, as noted previously, there is regular reporting on timeliness of completion of EHCPs to senior management, members and the DfE. Although dashboard reporting (coverage including timeliness of EHCPs, the Annual Review process and tribunals) had to be paused following implementation of the new IT system due to issues with data accuracy, a new dashboard has been developed using PowerBI and is due to be released shortly with one further enhancement in relation to

annual reviews still under development. Team level reporting requirements have been reviewed and confirmed with reporting in place across the key processes expected.

There is now some SEND focussed resource within Commissioning; however, this does not cover all types of provision and it has been reported that further discussion is needed between Commissioning and Education to confirm requirements and expectations in relation to SEND commissioning activity and processes going forward. There is an outstanding action on the production of a SEND commissioning strategy and process which have not progressed as expected with a lack of clarity and agreement over whether separate commissioning strategies are required for the different types of SEND spend.

Although a secondment from SEND to what was then Quality & Contracts was extended in order for existing SEND provision and placements to be identified and documented, it has not been possible to confirm that this piece of work was appropriately concluded, with the seconded officer now having left the Council. Therefore, further is required to review and document current contractual arrangements and confirm that responsibilities for oversight of this are clearly understood going forward with contractual arrangements appropriately recorded. Responsibilities for contract arrangement and management have now been clarified although it is understood that there are ongoing discussions about SEND brokerage and where this function should sit going forward.

Payroll 22/23

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
A: Strategy and Scope	**G**	**0**	**0**
B: Governance	**G**	**0**	**0**
C: Reporting and Monitoring	**G**	**0**	**0**
D: Business Planning and Performance Monitoring	**G**	**0**	**0**
		0	**0**

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

This audit provides assurance over the controls implemented and operated by Oxfordshire County Council (OCC) managers in relation to payroll processes. Separate assurance over Integrated Business Centre (IBC) operated controls and processes is received annually from Hampshire / IBC. This audit has identified that there is a strong system of internal control in place in relation to OCC payroll processes.

Policies & Procedures – It was confirmed that there is appropriate 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 enquiry process and web chat function and a dedicated HR advice email address. It is also noted that a review of all HR policies is in the process of being completed, this will include those relating to payroll.

Starters & Leavers – Sample testing on starters and leavers confirmed that the relevant manager processes are being completed accurately and on a timely basis. Although new starter testing identified 3 cases (all schools staff) where contracts had been issued after the employee start date, it was confirmed that reporting and review processes set up to monitor and address non-compliance in this area are working as intended. Changes to process in relation to school's starters have been made to facilitate compliance with the Good Work Plan (government policy issued in 2018).

Variations, Adjustments, Deductions & Additions to Pay – Since the previous audit, the web-based honorarium form designed to give better visibility of compliance with corporate process has been rolled out, with monitoring and follow up of non-compliance taking place on a quarterly basis. Action has also been taken to review, with the IBC, how temporary contracts which have gone past their anticipated end date without action being taken by the relevant manager to either end or extend the contract, can be identified and followed up. A portal report has been identified which picks up contracts which should have ended the previous month plus any without end dates following issues identified in this area during the previous audit. The first round of review and follow up on this reporting is currently underway.

There were no other findings of note in relation to variations, adjustments, deductions and additions to pay.

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 - There were 11 management actions agreed following the 2020/21 audit of Payroll. All were reported as implemented and where appropriate have been re-tested and implementation has been confirmed.