ITEM 6

AUDIT and GOVERNANCE COMMITTEE
10 JANUARY 2024

INTERNAL AUDIT 2023/24 PROGRESS REPORT

Report by the Executive Director of Resources

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   Note the progress with the 2023/24 Internal Audit Plan and the outcome of the completed audits.

Executive Summary

2. This report provides an update on the Internal Audit Service, including resources, completed and planned audits.

3. The report includes the Executive Summaries from the individual Internal Audit reports finalised since the last report to the September 2023 Committee. Since the last update, there has been one red report issued. There are no other outstanding red reports.

Progress Report:

Resources:

4. A full update on resources was made to the Audit and Governance Committee in May 2023 as part of the Internal Audit Strategy and Plan for 2023/24. Since then we have continued with our efforts to try and recruit to our two Senior Auditor vacancies, which has been unsuccessful. We did appoint a temporary Senior Auditor to assist with the completion of quarter 4 activity, however unfortunately they withdrew two weeks before starting. Also during quarter 3 our Auditor resigned and left. At the start of quarter 4 one of the Principal Auditors commences her maternity leave. This has meant that we have needed to make some amendments to the 2023/24 internal audit plan which are reported on in paragraph 7 and appendix 1 below.

5. Due to the ongoing significant difficulties with recruitment of skilled internal audit staff, the decision has been made to withdraw the provision of internal audit and counter fraud services to Cherwell District Council

from next financial year. Notice was given to Cherwell District Council at the end of October 2023, and it was agreed we would cease to provide these services after the end of April 2024. With the current staffing position we are unable to resource delivery of the audit plans across both Councils. The Audit Working Group were briefed on this decision at the 8 November 2023 meeting and all members of the Audit and Governance Committee were emailed by the Chief Internal Auditor. As a result of ending this service we will lose a Senior Auditor post from our structure from 1 April 2024, however this is currently one of our vacant posts so has no impact on the current staff. There will be no amendment or reduction to the Counter Fraud Team posts.

6. We also have two current apprenticeship posts within the team, one for Counter Fraud and one for Internal Audit. In line with our continued "growing our own" strategy we are planning to start the recruitment for a new Internal Audit Apprentice during February 2024, with the aim of them starting in September 2024.

2023/24 Internal Audit Plan:

7. The 2023/24 Internal Audit Plan, which was agreed at the May 2023 Audit & Governance Committee, is attached as Appendix 1 to this report. This shows current progress with each audit and amendments made to the plan. The plan and plan progress is reviewed quarterly with senior management. There are three audits which we have deferred until the 2024/25 plan, two of which we will undertake in quarter one of 2024/25. There has also been a recent request to undertake a primary school audit which will likely be scheduled for February 2024. These amendments have been agreed with the Executive Director of Resources.

8. There have been four audits concluded since the last update, summaries of findings and current status of management actions are detailed in Appendix 2. The completed audits are as follows:

Final Reports 2023/24:

Directorate	2023/24 Audits	Opinion
CODR	Corporate and Statutory Complaints	Amber
CODR	Cyber Incident Preparedness and Response Review	Green
Children's	Placements Contract Management and Quality Assurance	Amber
CODR	Physical Security Systems	Red

PERFORMANCE

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

Performance Measure	Target	% Performance Achieved for 23/24 audits (as at 18/12/23)	Comments
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc)	71%	Previously reported year-end figures: 2022/23 71% 2021/22 59% 2020/21 50%
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	86%	Previously reported year-end figures: 2022/23 89% 2021/22 86% 2020/21 88%
Elapsed Time between receipt of management responses to draft report and issue of final report.	10 days	100%	Previously reported year-end figures: 2022/23 92% 2021/22 66% 2020/21 80%

The other performance indicators are:

- % of 2023/24 planned audit activity completed by 30 April 2024 - reported at year end.

- % of management actions implemented (as at 18/12/23) – 74.6% of actions have been implemented. Of the remaining 25.4% there are 5.7% of actions that are overdue, 6.8% partially implemented and 12.9% of actions not yet due.

(At September 2023 A&G Committee the figures reported were 73% implemented, 4% overdue, 5% partially implemented and 18% not yet due)

- % of repeat findings/actions (relative to the number of actions raised within the year) – reported at year end.

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

Appendix 3

The table in Appendix 3 lists all audits with outstanding open actions, it does not include audits where full implementation has been reported. It shows the split between Priority 1 and Priority 2 actions implemented.

As at 11/12/23, there were 62 actions that are not yet due for implementation (this includes actions where target dates have been moved by the officers responsible), 35 actions not implemented and overdue and 42 actions where partial implementation is reported.

External Assessment of Internal Audit – November 2023

10. Internal audit within the public sector is governed by the Public Sector Internal Audit Standards (PSIAS). It is a requirement of the standards for each public sector internal audit provision to be subject to an external assessment against those standards every five years. Ours was completed in November 2023 by an assessor from Cipfa (Chartered Institute of Public Finance and Accountancy).

11. The results of the assessment were very positive, with an overall conclusion that Oxfordshire County Council's Internal Audit Service FULLY CONFORMS to the requirements of the standards. There were no areas of either partial or non-conformance with the standards identified and no recommendations arising. The full report was circulated to members of the Audit & Governance Committee on 27 November 2023 and has been included within Appendix 4 of this report.

12. There were six advisory issues included within the assessor's report, five related to matters of good practice and one was a generic issue relating to the future of the standards. All of these advisory issues are already in progress or are now being considered and will be actioned.

Counter-Fraud

13. The next counter fraud update to Audit & Governance Committee is scheduled for March 2024.

Financial Implications

14. There are no direct financial implications arising from this report

Comments checked by:
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Legal Implications

15. There are no direct legal implications arising from this report.

Comments checked by:
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Staff Implications

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

Equality & Inclusion Implications

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

Sustainability Implications

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

Risk Management

19. The are no direct risk management implications arising from this report.

Lorna Baxter, Executive Director of Resources

Annex: Appendix 1: 2023/24 Internal Audit Plan progress report
Appendix 2: Executive Summaries of finalised audits since last report.
Appendix 3: Summary of open management actions.

Appendix 4: External Assessment of Internal Audit – Final Report, November 2023

Background papers: Nil

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January 2024

APPENDIX 1 - 2023/24 INTERNAL AUDIT PLAN - PROGRESS REPORT

Directorate / Service Area	Audit	Planned Qtr Start	Status as at 18/12/23	Conclusion
Cross cutting	Transformation - Programmes & major projects.	Q3	Deferred to 24/25 – see below	n/a
Cross cutting	Business Continuity	Q1	Final Report	Amber
Cross cutting	Strategic Contract Management	Q3	Deferred to 24/25 – see below	n/a
Cross Cutting	Risk Management – directorate / service level	Q3	Fieldwork	
Cross cutting	Joint Internal Audit & Counter Fraud proactive review - Procurement Cards	Q2	Fieldwork	
Cross cutting	Joint Internal Audit & Counter Fraud proactive review - Expenses	Q3	Scoping	
Childrens	Placements – Contract Management / Quality Assurance	Q1	Final Report	Amber
Childrens	Transformation Programme – including Financial Management	Q3	Scoping	
Childrens	Independent Reviewing Officers	Q4	Planned for qtr 4	
Childrens	Supported Families	Ongoing / quarterly	Ongoing	-
Adults	Payments to Providers	Q1/Q2	Fieldwork	
Adults	Health Funded Payments	Q2	Fieldwork	
Adults	Safeguarding	Q4	Scoping	
Adults	Income and Debt Recovery	Q3	Fieldwork	

Customers & Organisational Development – Customer Services	Corporate & Statutory Complaints	Q1	Final Report	Amber
Customers & Organisational Development – Property & FM	Property Health & Safety	Q1/Q2	Draft Report	
Customers & Organisational Development – Property & FM	Property Strategy Implementation	Q4	Deferred to 24/25 – see below	
Customers & Organisational Development – IT	IT Incident Management	Q3/Q4	Draft Report	
Customers & Organisational Development – IT	Cyber – Incident Preparedness and Response	Q2	Final Report	Green
Customers & Organisational Development – IT / Property & FM	Physical Security Systems – Building Access Controls & CCTV System	Q3/Q4	Final Report	Red
Customers & Organisational Development	I-Hub Governance and Project Management	Q3	Scoping	

Finance	Pensions Administration	Q3/Q4	Fieldwork	
Finance	Pensions Administration – IT Application Audit	Q2	Final Report	Amber
Finance	Feeder System Controls	Q2/Q3	Fieldwork	
Legal	Case Management	Q3	Fieldwork	
Public Health / Cross Cutting	Pandemic Preparedness	Q1	Combined with Business Continuity Audit	-
Environment & Place	Supported Transport	Q3	Scoping	
Environment & Place	Parking Contract – Contract Management	Q1	Final Report	Green
Environment & Place	Local Transport Connectivity Plan	Q3/Q4	Fieldwork	
Environment & Place	S106 – New IT System	Q2	Fieldwork	
Grant Certification	• Business in Rural Oxfordshire Airband • Business in Rural Oxfordshire BT • Better Broadband for Oxfordshire • Top-up Vouchers • Gigahubs • Local Authority Bus Subsidy (Revenue) Grant • Disabled Facilities Grant • Local Transport Capital Block Funding (Integrated Transport and Highway Maintenance Blocks) • Local Transport Capital Block Funding (Pothole Fund) • Homes Upgrade Grant, Phase 1	Complete	-	-

Amendments to the 2023/24 Internal Audit Plan:

Directorate / Service Area	Audit	Amendment
Cross Cutting	Transformation Programmes & Major Projects	As part of the new ways of working of delivering the future together, a new portfolio approach is being implemented to manage programmes and major projects. Each portfolio will provide the structure and governance for the transformation activity. A new Data, Insights and Delivery Hub is being established which includes the creation of a new PMO (Project Management Office). Due to the significant work now being undertaken in this area it has been agreed with the Executive Director of Resources that the audit will be deferred and considered for inclusion in the 2024/25 internal audit plan, which would review the effectiveness of the new arrangements and processes implemented.
Customers & Organisational Development – Property & FM	Property Strategy Implementation	Due to being unable to fill the Senior Auditor vacancies, the resignation of the Auditor (left end of November 2023), the temporary Senior Auditor who was due to start December 2023 but withdrew at short notice, and the Principal Auditor being on maternity leave from January 2024, it is necessary to defer this audit for 3 months. Instead of planned completion in quarter 4 of 2023/24, these will instead commence at the start of quarter 1 as part of the 2024/25 internal audit plan.
Cross Cutting	Strategic Contract Management	Due to being unable to fill the Senior Auditor vacancies, the resignation of the Auditor (left end of November 2023), the temporary Senior Auditor who was due to start December 2023 but withdrew at short notice, and the Principal Auditor being on

		maternity leave from January 2024, it is necessary to defer this audit for 3 months. Instead of planned completion in quarter 4 of 2023/24, these will instead commence at the start of quarter 1 as part of the 2024/25 internal audit plan.
School	Primary School Audit	At the request of Childrens, there will be a primary school audit undertaken in February 2024. The addition to the internal audit plan has been agreed with the Executive Director of Resources.

APPENDIX 2 - EXECUTIVE SUMMARIES OF COMPLETED AUDITS

Summary of Completed Audits since last reported to Audit & Governance Committee September 2023.

Corporate & Statutory Complaints 2023/24

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**	**7**
Corporate & Statutory Complaints Process	**A**	**0**	**5**
Management Information	**A**	**0**	**1**
		0	**13**

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

During 2021, as part of the customer service transformation programme, the Voice of the Customer Team took over complaints management across the Council. Following on from this, a complaints recovery plan was introduced to manage the back log of complaints and a review of data management, process, policies and team structure was undertaken. In the second half of 2022 a new staffing structure was introduced along with refreshed processes and the implementation of a complaints management system (Infreemation).

The Customer Feedback Team act as the corporate lead and work with service areas to ensure resolution of new complaints effectively in accordance with the required timescales and have been responsible for working with directorates who investigated and resolved the backlog of complaints (mostly in relation to the children's service and education). There has been significant progress in reducing the backlog of complaints, with work ongoing to improve the quality and timeliness of complaint responses.

Additional funding has recently been agreed to increase team resources, this will enable the team to reduce the use of agency staff and progress additional

areas of development and embed new processes. It has also been reported that the team are participating in a new initiative, an Accountability Performance Improvement and Innovation Clinic, which will involve working with an in-house team to look at the complaints process across the Council in order to identify areas of success or development need and drive further service improvements in these areas. Initial areas to be reviewed include data quality and complaints culture.

Policies & Procedures

A lot of work has been done within the Voice of the Customer and Customer Feedback teams to review and refresh processes in relation to complaints management. However, there is a need to update the documented guidance available for council staff and the public. This is acknowledged by the team, with review and updating of current content underway.

Website information available for the public and intranet guidance for staff in service areas requires updating. Documented guidance is in place for the Customer Feedback Team covering the main processes, however there were some areas where the audit noted that this could be further enhanced (for example, clear guidance on the quality assurance processes now in operation in relation to complaints responses). It is noted that there is training available for council staff, which focusses on dealing with complaints and communicating effectively. However, availability is limited and the content, whilst helpful in promoting effective complaints management, is generic, and doesn't cover Council specific processes or use actual examples of cases to promote best practice. It is noted from the Monitoring Officer's response to the Audit & Governance Committee from September 2022 and September 2023 to the two most recent Local Government & Social Care Ombudsman's (LGSO) Annual Review Reports, that this is an area of continued focus and development for the team.

Corporate & Statutory Complaints Process

Improvements to the complaints management process were noted, following the review and refresh of processes, a quality assurance process was introduced whereby the responses to complaints are reviewed and signed off by the responding manager's manager and by the relevant Customer Feedback Officer / Statutory Social Care Complaints Officer prior to being issued. However, whilst this introduces challenge and should improve the quality of response, the review and sign off process is not currently being documented / evidenced consistently which makes it difficult to confirm that the new process is fully embedded.

Review and testing of the complaints management process identified that whilst the new system introduced at the end of 2022 has enabled the team to move away from old spreadsheet-based systems for the monitoring and co-ordination of the complaints response process, there are some reliability issues with the new system which require resolution. Problems with reliability of system inputs and outputs and presentation issues with complaints related communications have resulted in workarounds, inefficiencies and additional staff effort. There is an ongoing project in place with the service working with the developer and ICT

to log and track these issues and find resolutions. Senior management within the service are aware of these issues and are in the process of sourcing an alternative system. A Management of Unreasonable Customer Behaviour Policy was introduced in 2022. This provides a centralised way of tracking and managing communications with these customers. There is work ongoing to ensure that relevant service areas are informed of customers being managed under this policy in a timely and efficient way so that any communications can be directed to the relevant officer.

Management Information

There is routine monitoring and reporting on the timeliness of response to complaints, with KPI's in place for both corporate and statutory complaints. It is widely acknowledged that the council's corporate performance in this area has not been at the required level, however recent reporting reviewed has shown significant improvements in clearing the backlog of complaints and in responding in a more timely manner to new complaints.

In addition to monthly performance reporting to senior management, currently via CMT, there is also quarterly reporting to Adults and Children's Directorate Leadership Team meetings which provides information on key areas including the level of complaints received, timeliness of response as well as key themes and complaints categories to assist management in being able to identify and remedy the causes of complaints received. An annual report is also produced for these two directorates.

It has been evidenced that the Customer Feedback Team are working closely with key service areas to provide support and have reduced backlogs and improved responses times. The team have focussed on areas where levels of complaints / backlogs have been highest. For example, there have been weekly reports produced and circulated up to Deputy Director level within the Children's directorate to provide ongoing information on the status of outstanding complaints. It is noted that the service have reported that they are expecting a significant increase in stage 2 and 3 statutory complaints.

Testing on the accuracy of performance reporting noted that there were examples where it was not possible to confirm the accuracy of the figures reported. This included manual calculations where evidence of the calculation wasn't retained, examples where figures had been added up incorrectly (these were not material differences) and examples where there had been adjustments which could not be evidenced. It is acknowledged that reporting arrangements and system capabilities are still in the process of being developed.

Cyber Incident Preparedness and Response Review 2023/24

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
Threat Warnings and Notifications	G	0	0
Incident and Breach Detection	A	0	2
Incident Response Team	G	0	0
Response Plan	G	0	0
Post Incident Analysis	G	0	0
Testing	G	0	0
		0	2

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

IT, Innovation and Digital (ITID) have a cyber incident response capability, which includes a documented plan and access to specialist third-party cyber incident response services. The cyber incident response plan has been significantly improved since we last reviewed it 12 months ago. There are systems in place that log security events and alert members of the IT team to any potential threats. Incident detection can be further improved by formalising corporate requirements for logging and monitoring and also centralising log data so that information can be analysed more quickly.

Threat Warnings and Notifications:

ITID subscribe to various reputable information sources for an early warning on any new security threat or vulnerability. This includes the National Cyber Security Centre (NCSC), NHS England and the South East WARP (Warning, Advice and Reporting Point). Threat detection is also available on internal technical security solutions.

Incident and Breach Detection:

Security events are logged and email alerting of events is in place. A review of the email alerts confirmed they are setup to be received by more than one person, ensuring there is no key person dependency. Log files are retained for six months in accordance with PSN requirements. The areas for control improvement include having a formal logging and monitoring policy setting out corporate requirements and centralising log files that are currently retained on source systems. Centralised logging is included in the ITID Strategy 2019-24 but timescales for addressing it are not defined.

Incident Response Team:

An incident response team is identified to manage the response to a cyber incident and includes an incident manager, technical lead and various technical roles. In March 2023, an agreement was put in place with a third-party, who are part of the NCSC assured cyber incident response scheme, to provide specialist incident support services on a call-off basis.

Response Plan:

There is a documented Cyber Incident Response Plan (CIRP), which has playbooks for high-risk cyber threats, such as ransomware, phishing and account compromises. The plan includes a severity matrix to help categorise incidents based on certain criteria and references to other key documents, such as the IT Major Incident Policy and the IT Business Continuity Plan.

Post Incident Analysis:

The requirement for a post incident analysis is included within the CIRP and it has been performed for two incidents that occurred earlier in the year, one of which was found to be a false positive.

Testing:

The two incidents highlighted above served as a real test of the CIRP within the last 12 months. ITID are aware of the need to test the plan annually.

Children's Placements Contract Management and Quality Assurance 2023/24

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 & Oversight	**A**	**0**	**3**
B: Contract Management & Quality Assurance Processes	**A**	**0**	**13**

C: Management Information	**A**	**0**	**0**
		0	**16**

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

The Quality Improvement Team is responsible for working with care providers across all age groups and types of service provision to ensure they are providing good quality services to the residents of Oxfordshire. For Start Well, the focus of this audit (specifically children's social care), this includes monitoring providers, as well as working with other teams and organisations to improve and ensure the quality of care. This audit therefore reviewed the robustness and effectiveness of the quality assurance processes over the providers in this area.

The audit found good evidence of investigations into concerns being carried out promptly and appropriately, engaging with and updating other teams within the Council as necessary. It was also found that for some areas of weakness noted, including team guidance and development of the Provider Directory (a portal used to hold and share information about providers), had already been identified by the service, with action underway to improve such processes.

Other weaknesses identified include the documenting of evidence and outcomes relating to monitoring activity, and the timeliness and recording of pre-placement checks being carried out for new providers.

Governance & Oversight

From review of guidance available to staff it was positive to note that the key high-level guidance documents (the Quality Improvement Protocol (a guidance document available to all staff and external providers, outlining how the Council monitor services) and the Children's Monitoring Protocol (which sets out roles and responsibilities across teams for monitoring children's placements)), have recently been reviewed and updated, covering all expected areas. Work is now underway to document key processes sitting below this.

It was noted that work has been ongoing regarding assignment of roles and responsibilities between the Quality Improvement Team and the Procurement Hub in regard to contract management (an area of weakness identified in previous audits). The services are now reporting the development work has moved to a business-as-usual programme, with both formal and informal

arrangements to work through shared challenges, areas for clarification, and regular contact in general.

The audit looked at the Placement Review Panel, which operates to provide oversight and monitoring of providers and the safety and quality of placements, confirming expected areas are covered, and actions are recorded and followed up. However, while this Panel has recently adapted its focus following developments within HESC, it was highlighted there is a still a gap in terms of information sharing across certain groups within the Council. For example, Health & Safety, Corporate Finance, and HR are not involved in any forum regarding the quality of children's placements, limiting the opportunity to ensure the appropriate flow of information between services, to enable insight into risks, trends, and share best practice.

Contract Management and Quality Assurance Processes

Review of routine monitoring activity carried out by the Quality Improvement Team of providers over the past year acknowledged the risk-based approach taken to contract management, whereby block providers undergo routine contract monitoring, framework providers are monitored by the host authority (Bournemouth, Christchurch and Poole Council), and spot providers (who make up the majority of the volume of placements) are monitored on a more ad-hoc, reactive basis.

For the block providers, while regular meetings and visits carried out by the team could be demonstrated, it was found annual compliance checks, as stated in the contract, have not been carried out consistently, with confirmation of insurance last checked in 2019 and 2021 for the two block providers sampled, and business continuity plans last obtained and reviewed in 2020.

For the spot providers, where the majority of work carried out by the team is reactive, efforts were made at the beginning of the year to have all providers complete a self-assessment around their quality and monitoring practices. Response rates for this were less than 2%, and work is now underway to explore other options to engage with providers in more meaningful way.

All providers should now be included on the Provider Directory, assigned a RAG rating, and detail any pre-placement checks that have been carried out. This allows relevant teams across the Council to access information on the provider, including any restrictions on making placements. Sample testing across the audit identified instances of providers not being included on the directory, not including information around completed checks, and various inconsistencies surrounding RAG ratings (e.g., not being assigned RAG ratings, inconsistent ratings against other information held by the team, and delays in updating assigned ratings).

In terms of reactive work (for example responding to safeguarding concerns or poor Ofsted ratings), sample testing confirmed the team are responding to issues promptly, with visits carried out, reports issued, and actions plans agreed as necessary. From review of the Children's Social Care information system (LCS) it was possible to demonstrate Social Care Teams are being informed

throughout the process. Weaknesses were noted in the recording of some decisions made and action taken, with one provider moving from a Red to Amber RAG rating, with no evidence provided or saved to the provider's file to support the change. Inconsistencies were also noted in documenting files, with different approaches taken dependent on the type of contract, and routine reports such as Ofsted or Reg 44s not always saved to the provider's file.

The audit testing carried out also reviewed whether new providers had undergone appropriate background checks prior to care placements being made, a responsibility of the Quality Improvement Team following requests by Brokerage. This identified several instances in which checks had not been requested, with sample testing also often finding placements had commenced prior to completion of the checks.

For internally run provisions (i.e., OCC children's residential and assessment homes and OCC foster carers), quality monitoring processes in place were found to be operating effectively. A review of processes within the Fostering Service confirmed appropriate assurance is obtained around completion of supervisions, visits, household reviews, and quality assurance audits. For the homes, it was found Reg 44 visits are being routinely commissioned and reported on by an independent party, in line with The Children's Home Regulations 2015.

Management Information

During the 2022/23 Internal Audit of Adults Contract Management & Quality Assurance, it was noted that currently there is no routine performance reporting in place within the Quality Improvement Team. It was reported to Internal Audit that this is a known area for development, and that the team has been working with IT to develop dashboard reporting. An action was therefore agreed as part of that audit for the development of performance dashboards to allow oversight across the Quality Improvement Team's activities, covering all areas of HESC. The agreed date for implementation date for this action is 31 December 2023. Given the risk based / reactive approach taken to monitoring spot providers and resulting reliance on other teams sharing identified concerns with the Quality Improvement Team, the audit also considered the availability of management information within Children's Social Care in terms of compliance with statutory responsibilities, such as Children We Care For Reviews.

This confirmed a variety of reports are run on a routine basis by the Performance Information Team, providing senior management within Children's Social Care with appropriate information to obtain assurance that statutory duties are being met (in turn allowing any concerns to be identified and shared), or, where they are not, sufficient detail to allow escalation of that specific case.

Physical Security Systems 2023/24

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
Corporate Policy	R	0	2
Building Access Security	R	1	3
CCTV Systems	R	0	7
Third-Party Services	A	0	1
		1	13

Opinion: Amber	
Total: 14	Priority 1 = 1 Priority 2 = 13
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	13

Physical security is important for protecting corporate assets and to ensure the safety of staff and visitors at all corporate sites. This review focused on two specific aspects of physical security, namely building access control and the operation of closed circuit television (CCTV). A number of key risks have been identified in both areas, including that corporate CCTV systems are not being operated in compliance with data protection legislation.

Corporate Policy:

There is no formal documented policy on building access security. There is a draft version of a CCTV Policy that was developed in February 2023 however this has not been finalised, as ownership has not been confirmed. Formal policies are required for both areas to ensure minimum security standards and requirements are clearly defined, including roles and responsibilities.

Building Access Security:

An electronic door management system is used to control access at all main sites. Each site has a number of zones and people are given access to one or more zones depending on their requirements. The Facilities Management (FM) team manage access at all managed sites and administrators are nominated at all other sites. The door management system logs all access so that security incidents can be investigated if required.

We have identified risks with the management of the door access system, including how access is granted/revoked and the high number of overall system administrators. There are also risks with the way access is setup at certain sites, including a main office building and an establishment, which could allow unauthorised access to secure/restricted areas.

CCTV Systems:

CCTV is operated at a number of corporate sites. There are no formally documented procedures governing the use of CCTV and overall management responsibility for systems has not been assigned. As CCTV systems capture images that can identify people they are deemed to process personal data and are subject to data protection legislation. Current CCTV systems are not being operated in accordance with the requirements of the Data Protection Act 2018/UK GDPR. For example, a Data Protection Impact Assessment (DPIA) is not performed before new CCTV systems are installed, signs are not clearly displayed where CCTV is being used and a retention period has not been agreed for recordings.

A maintenance contract for CCTV systems was awarded to a new supplier in May 2023 and includes a six monthly check of all systems. The maintenance visits have slipped due to issues with the supplier's performance. This has been raised with the supplier and is being managed by FM and hence no further action is included in the report.

Third-Party Services:

There is a formal contract with a third-party for servicing and maintaining CCTV and intruder alarm systems and it was confirmed they are certified to a recognised electronic security systems scheme. Other security services, such as lock/unlock, man-guarding and retrieving CCTV recordings, are sourced from another supplier. They were confirmed to be SIA (Security Industry Authority) accredited but a copy of the formal contract could not be located at the time of the review and hence we are unable to confirm that one is in place and that it includes defined service levels.

APPENDIX 3 – As at **18/12/2023** - all audits with outstanding open actions (excludes audits where full implementation reported):

	ACTIONS								
	RISK CATEGORY			IMPLEMENTED					
Report Title	1	2	**Total**	1	2	**Total**	Not Due for Implementation	Not Implemented	Partially Implemented
OCC Business Cont 23/24	2	17	**19**	-	5	**5**	12	-	2
OCC Childrens Finances 22/23	0	12	**12**	-	4	**4**	4	1	3
OCC Children's Placements CM & QA 23/24	0	17	**17**	-	-	**-**	17	-	-
OCC Client Charging and Prov Payments 2019/20	0	21	**21**	-	20	**20**	-	-	1
OCC Climate Audit 22/23	5	12	**17**	1	4	**5**	4	5	3
OCC Controcc Payments 19/20	4	18	**22**	4	17	**21**	1	-	-
OCC Controcc Payments 2122	0	9	**9**	-	6	**6**	-	2	1
OCC Corp & Stat Complaints 23/24	0	13	**13**	-	2	**2**	11	-	-
OCC Covid Payments Audit 2020/21 – 85% Transport Payments	0	5	**5**	-	1	**1**	4	-	-
OCC Cyber Prep and Response 23/24	0	2	**2**	-	-	**-**	1	1	-
OCC Cyber Security (Ransomware) 22/23	1	6	**7**	1	5	**6**	-	1	-
OCC Direct Payments 22/23	0	11	**11**	-	5	**5**	-	-	6
OCC Educ IT System – processes 22/23	0	5	**5**	-	3	**3**	-	-	2
OCC Five Acres School 21/22	2	9	**11**	2	8	**10**	-	-	1
OCC Fleet Mgmt Compliance 21/22	0	5	**5**	-	4	**4**	-	-	1
OCC FM Follow up 22/23	0	13	**13**	-	8	**8**	-	5	-
OCC Gartan Payroll 21/22	1	34	**35**	1	29	**30**	3	-	2
OCC GDPR 21/22	1	11	**12**	1	8	**9**	1	2	-
OCC HR Contract Management 22/23	0	1	**1**	-	-	**-**	-	-	1
OCC HR Employee Relations 22/23	0	2	**2**	-	1	**1**	1	-	-
OCC LAS IT Application 22/23	0	9	**9**	-	8	**8**	1	-	-
OCC Leases 22/23	0	10	**10**	-	6	**6**	-	-	4
OCC Longfields School 22/23	2	31	**33**	2	19	**21**	1	10	1
OCC M365 Cloud 22/23	0	11	**11**	-	8	**8**	1	-	2
OCC Music Service Follow Up 22/23	0	17	**17**	-	16	**16**	-	-	1

OCC Payments to Providers 21/22	0	6	**6**	-	5	**5**	-	-	1
OCC Pensions Admin 21/22	0	5	**5**	-	4	**4**	1	-	-
OCC Pensions Admin 22/23	0	3	**3**	-	-	**-**	-	-	3
OCC Pensions Admin IT App 23/24	0	6	**6**	-	2	**2**	1	3	-
OCC Provision Cycle 2021/22	0	19	**19**	-	17	**17**	2	-	-
OCC Risk Management 20/21	0	14	**14**	-	12	**12**	-	-	2
OCC S106 21/22	0	6	**6**	-	1	**1**	4	-	1
OCC SEND 2020/21	14	27	**41**	14	26	**40**	-	-	1
OCC SEND follow up 22/23	1	5	**6**	-	3	**3**	3	-	-
OCC Shared Lives 22/23	0	8	**8**	-	7	**7**	1	-	-
OCC Thomas Reade School 22/23	4	34	**38**	4	32	**36**	-	1	1
OCC YPSA 22/23	1	18	**19**	1	9	**10**	3	4	2
Purchasing (inc Acc Payable) 2017/18	0	2	**2**	-	1	**1**	1	-	-
Samuelson House 2018/19	0	5	**5**	-	4	**4**	1	-	-
TOTAL	**38**	**459**	**497**	**30**	**307**	**337**	**79**	**35**	**42**

APPENDIX 4

External Quality Assessment of Conformance to the Public Sector Internal Audit Standards

Table of contents

1. INTRODUCTION

1.1 Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS), which have been in place since 1st April 2013 (revised 2016 and 2017). All public sector internal audit services are required to measure how well they are conforming to the standards. This can be achieved through undertaking periodic self-assessments, external quality assessments (EQA), or a combination of both methods. However, the standards state that an external reviewer must undertake a full assessment or validate the Internal Audit Service's own self-assessment at least once in a five-year period.

2. Background

2.1 The Internal Audit Service provides the internal audit services to Oxfordshire County Council and around 200 days to Cherwell District Council. The Chief Audit Executive is the Council's Chief Internal Auditor (CIA). Below the CIA post is an Audit Manager, two Principal Auditors, two Senior Auditor posts (both of which were vacant at the time of the EQA), an Auditor and an Assistant Auditor. The Services structure chart shows the CIA post as being 0.7 of a full time equivalent (FTE), the Audit Manager post as being 0.8 of an FTE, and one of the Principal Auditor posts as being 0.6 of an FTE. The rest of the posts all appear to be FTEs. Given the fact that Internal audit is providing services to other local authorities, this appears to be quite a lean structure. However, since we undertook the field work for this EQA, the CIA has advised us that they have secured the services of a temporary Senior Auditor until at least the end of the financial year and have commenced the recruitment processes for the two vacant Senior Auditor posts. We have also been advised that a recruitment process for an audit apprentice will commence early in 2024. The CIA is however aware that there is a dire shortage of experienced and/or qualified internal auditors across the country and as such they may not be successful in filling the vacant posts. With this in mind it would be prudent to develop a mid/long term resourcing strategy for the Service and we have included this as an advisory action in section 8 of the report.

In addition to the in-house team, the Service uses some external partners and has contracts in place with a specialist IT Auditor for the provision of one hundred days of IT audit per annum, and a separate contract with a major accountancy firm for the delivery of specific audit reviews and, when needed, additional general audit resources for the Service to use and manage.

2.2 The CIA is an experienced internal audit professional who is a Chartered Internal Auditor. The Audit Manager is also an experienced internal audit professional and is also a Chartered Internal Auditor. The two Principal Auditors are both experienced and are also Chartered Internal Auditors. The Auditor and Assistant Auditor are both undertaking training for a relevant internal audit qualification.

2.3 From an operational perspective, the Internal Audit Service is part Oxfordshire County Council's Resources Directorate, with the CIA being line managed by the Assistant Director of Finance with direct reporting lines to the Council's Executive Director of Resources (the Section 151 Officer) and to the Chair of the Audit and Governance Committee. The CIA meets regularly with the Executive Director of Resources and the Council's Director of Law and Governance (the Monitoring Officer) and has direct access to the Council's Chief Executive.

2.4 For Cherwell District Council, the CIA reports directly to the Assistant Director of Finance (the Council's Section 151 Officer) and meets regularly with him. The CIA also meets with the Council's Chief Executive Officer, the Monitoring Officer, and the Chair of the Accounts, Audit and Risk Committee. However, we understand from the CIA that since we completed the field work stage of the EQA, the Service has now given notice to Cherwell District Council that they intend to end the arrangement with them at the end of the 2023/24 year.

2.5 The Internal Audit Service has been operating under PSIAS since its launch in 2013, and this is the second external quality assessment (EQA) that they have commissioned, the previous one being in 2018 and was also undertaken by CIPFA.

2.6 Internal Audit has an audit manual that provides the auditors with a comprehensive guide to all aspects of performing an internal audit or consultancy assignment and is cross referenced to the PSIAS and the LGAN. The Service uses standard templates for all terms of reference, engagement working papers, testing schedules, and audit reports, with completed documents retained in the Service's dedicated network drive. Supervision of the engagements takes place at every stage of the process and is recorded on the appropriate documentation.

2.7 There is a quality assurance process in place that includes internal and external quality assessments of the Service, reviews of live engagements, a post-audit client feedback survey, and final clearance of all completed reports by either the CIA or the Audit Manager, all of which feed into the Internal Audit Service's Quality Assurance and Improvement Programme (QAIP).

3. Validation Process

3.1 This validation of the Service's self-assessment comprised a combination of a review of the evidence provided by Internal Audit; a review of a sample of completed internal audits; a survey that was sent to and completed by a range of stakeholders; and interviews with key stakeholders, using MS Teams. The interviews focussed on determining the strengths and weaknesses of Internal Audit and assessed the Service against the four broad themes of Purpose and Positioning; Structure and Resources; Audit Execution; and Impact.

3.2 The Internal Audit Service provided a comprehensive range of documents that they used as evidence to support their self-assessment,

and these were available for examination prior to and during this validation review. These documents included the:

- self-assessment against the standards;
- quality assurance and improvement plan (QAIP);
- evidence file to support the self-assessment;
- the audit charter;
- the annual report and opinions
- the audit plan and strategy;
- audit procedures manual;
- a range of documents and records relating to the team members;
- progress and other reports to the Governance Committee.

All the above documents were examined during this EQA.

3.3 The main phase of the validation process was carried out during the week commencing 9 October 2023, with further work undertaken during the following weeks. This phase of the EQA involved a review of a sample of audit files and interviews with a sample of key stakeholders from Oxfordshire County Council and from Cherwell District Council. Overall, the feedback from the interviewees was positive with clients valuing the professional, knowledgeable, and objective way the Internal Audit Service delivered their services.

3.4 The assessor reviewed examples of completed audits from both organisations to confirm his understanding of the audit process used at the Council, and to determine how Internal Audit has applied the PSIAS and LGAN in practice.

4. Opinion

It is our opinion that the self-assessment for the Oxfordshire County Council's Internal Audit Service is accurate, and we therefore conclude that the Internal Audit Service FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.

4.1 The table below shows the Internal Audit Service's level of conformance to the individual standards assessed during this external quality assessment:

Standard / Area Assessed	Level of Conformance
Mission Statement	**Fully Conforms**
Core principles	**Fully Conforms**
Code of ethics	**Fully Conforms**
Attribute standard 1000 – Purpose, Authority and Responsibility	**Fully Conforms**
Attribute standard 1100 – Independence and Objectivity	**Fully Conforms**
Attribute standard 1200 – Proficiency and Due Professional Care	**Fully Conforms**
Attribute standard 1300 – Quality Assurance and Improvement Programmes	**Fully Conforms**
Performance standard 2000 – Managing the Internal Audit Activity	**Fully Conforms**
Performance standard 2100 – Nature of Work	**Fully Conforms**
Performance standard 2200 – Engagement Planning	**Fully Conforms**
Performance standard 2300 – Performing the Engagement	**Fully Conforms**
Performance standard 2400 – Communicating Results	**Fully Conforms**
Performance standard 2500 – Monitoring Progress	**Fully Conforms**
Performance standard 2600 – Communicating the Acceptance of Risk	**Fully Conforms**

5. Areas of full conformance with the Public Sector Internal Audit Standards

5.1 **Mission Statement and Definition of Internal Audit**

The mission statement and definition of internal audit from the PSIAS are included in the audit charter.

5.2 **Core Principles for the Professional Practice of Internal Auditing**

The Core Principles, taken as a whole, articulate an Internal Audit function's effectiveness, and provide a basis for considering the organisation's level of conformance with the Attribute and Performance standards of the PSIAS.

The clear indication from this EQA is that the Core Principles are embedded in Internal Audit's procedures and working methodologies and Internal Audit are a competent, experienced, and professional Service that conforms to all ten elements of the Core Principles.

5.3 **Code of Ethics**

The purpose of the Institute of Internal Auditors' Code of Ethics is to promote an ethical culture in the profession of internal auditing, and is necessary and appropriate for the profession, founded as it is on the trust placed in its objective assurance about risk management, control, and governance. The Code of Ethics provides guidance to internal auditors and in essence, it sets out the rules of conduct that describe behavioural norms expected of internal auditors and are intended to guide their ethical conduct. The Code of Ethics applies to both individuals and the entities that provide internal auditing services.

The clear indication from this EQA is that the Internal Audit Service conforms to the Code of Ethics, and this is embedded in their procedures, and their audit methodologies. The code of ethics is part of their overarching culture and underpins the way the Service operates.

5.4 **Attribute Standard 1000 – Purpose, Authority and Responsibility**

The purpose, authority and responsibility of the Internal Audit activity must be formally defined in an internal audit charter, consistent with the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards, and the Definition of Internal Auditing). The internal audit charter must be reviewed regularly and presented to senior management and the audit panel for approval.

There are separate audit charters in place for each authority, and these are reviewed on an annual basis. We reviewed these documents and found them to be comprehensive and well written and contain all the elements that the PSIAS expects to be included in an audit charter. We are satisfied that the Internal Audit Service conforms to attribute standard 1000 and the LGAN.

5.5 **Attribute Standard 1100 – Independence and Objectivity**

Standard 1100 states that the Internal Audit activity must be independent, and internal auditors must be objective in performing their work.

The need for independence and objectivity is an integral part of any Internal Audit Service's culture. The CIA reports in her own name directly to the Senior Management Teams at each authority, and to the Audit and Governance Committee at Oxfordshire County Council and the Accounts, Audit and Risk Committee at Cherwell District Council. All employees declare any potential impairment to their independence or objectivity on recruitment to the Service and again on an annual basis.

We have reviewed the Internal Audit Service's procedures and their standard documentation; their quality assurance and improvement plan; and a small sample of completed audits. We have also reviewed their reporting lines and their positioning within both authorities. In addition to internal audit, the CIA has responsibilities for the County Council's counter fraud function and the provision of counter fraud services to Cherwell District Council as part of their internal audit contract with that Council. Whilst it is common for CIA's to be responsible for counter fraud alongside internal audit, the PSIAS does not regard it as being part of the mainstream internal audit function, and as such it should be subjected to periodic review by internal audit. It would therefore be prudent to include a review of the counter fraud function in future audit plans, and to maintain a sound level of independence and objectivity, to use the Internal Audit Service's external partner to do the review, rather than the in-house team. We have therefore included an advisory action in section 8 of this report to this extent.

Notwithstanding the above observation, we are satisfied that the Internal Audit Service conforms with attribute standard 1100 and the LGAN.

5.6 **Attribute Standard 1200 – Proficiency and Due Professional Care**

Attribute standard 1200 requires the Internal Audit Services' engagements are performed with proficiency and due professional care, having regard to the skills and qualifications of the staff, and how they apply their knowledge in practice.

As mentioned above, the CIA is an experienced internal audit professional who is a Chartered Internal Auditor. The Audit Manager is also an experienced internal audit professional and is also a Chartered Internal Auditor. The two Principal Auditors are both experienced and are also Chartered Internal Auditors, and one of which has also gained an IT audit qualification. The Auditor and Assistant Auditor are both undertaking training for a relevant internal audit qualification. The team members have sufficient knowledge of the operation of high-level IT controls, and they can incorporate these in their testing for the audits they undertake. The more detailed and complex ICT reviews are undertaken by an external specialist ICT auditor who has a rolling contract with internal audit.

The Standards require internal audit services to consider the use of data analytics when performing their audit reviews. The Service has produced a data analytics strategy and has started to develop this function jointly with the Council's counter fraud function. The primary tools currently used for data analytics are Excel and Business Objectives, although

Power BI is now starting to be used within the Council. The team members also make use of the data analytics functionality built into some of the Council's core applications. The Service does not currently have a licence for any specialist data analytics software although they have done in the past (the IDEA data analytics software) and are considering purchasing a new licence for this product. As the functionality of IDEA, and indeed that of other applications such as ACL and Arbutus to name just two, have improved and expanded considerably during the past few years, it is our view that obtaining such a product would enhance the Service's data analytics functionality. We have therefore included this as an advisory action in section 8 of this report. Notwithstanding the above, we feel there are further opportunities to broaden the use of data analytics by making use of external sources of data for benchmarking purposes, such as the local authority data held in the CIPFA statistics and 'Nearest Neighbour Model' applications, which the Councils should already have access to, or the data held by the Local Government Association in their LG Inform application. These are useful sources of data for benchmarking that should not be overlooked, particularly when auditors are undertaking research and preparing the terms of reference for audits as benchmarking can highlight areas where there may be scope to add value to the Council's operations, or at least challenge the current thinking. We have included this as an advisory action for management to consider in section 8 of this report.

Standard 1200 expects internal auditors to maintain and enhance their knowledge and this is usually achieved through undertaking relevant training. When a team member has completed relevant training, it is recorded on a central record for the service. However, internal auditors also enhance their knowledge and understanding through other means, such as reading technical journals and undertaking research prior to commencing audits. This is an important and valid element of an internal auditor's learning and development, and although this is recognised as good practice, most of the team do not tend to formally record this on the learning and development records. The team members that are studying for professional qualifications do, however, record it in their training logs. We have therefore included an advisory action in section 8 of this report.

It is evident from this review that the Internal Audit Service's employees are experienced and well qualified and perform their duties with due professional care. We are therefore satisfied that the Internal Audit Service complies with attribute standard 1200 and the LGAN.

5.7 **Attribute Standard 1300 – Quality Assurance and Improvement Programmes**

This standard requires the Head of Audit to develop and maintain a quality assurance and improvement programme that covers all aspects of the Internal Audit activity.

The Internal Audit Service has developed an effective quality assurance process which feeds into their quality assurance and improvement programme that ensures engagements are performed to a high standard. Supervision of audit engagements is carried out at all stages

of the audit and is recorded throughout the audit process. The Service uses post audit client satisfaction surveys for the audits they undertake, and in addition to the quinquennial EQA, carry out annual self-assessments of their conformance to the Standards and the LGAN. In addition, the County Council's Monitoring Officer carries out an annual survey of managers to assess the effectiveness of the Internal Audit Service. All these feed into the Service's quality assurance and improvement plan (QAIP). Updates on completing the actions in the QAIP are made to the Governance Committee.

We have examined the supporting evidence provided by the Internal Audit Service during this EQA and, we are satisfied that they conform to attribute standard 1300 and the LGAN.

5.8 **Performance Standard 2000 – Managing the Internal Audit Activity**

The remit of this standard is wide and requires the Chief Audit Executive to manage the Internal Audit activity effectively to ensure it adds value to its clients. Value is added to a client and its stakeholders when Internal Audit considers their strategies, objectives, and risks; strives to offer ways to enhance their governance, risk management, and control processes; and objectively provides relevant assurance to them. To achieve this, the Chief Audit Executive must produce an audit plan and communicate this and the Service's resource requirements, including the impact of resource limitations, to senior management and the Governance and Ethics Committee for their review and approval. The Chief Audit Executive must ensure that Internal Audit's resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.

The standard also requires the Chief Audit Executive to establish policies and procedures to guide the Internal Audit activity, and to share information, co-ordinate activities and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimise duplication of efforts.

Last, but by no means least, the standard requires the Chief Audit Executive to report periodically to senior management and the Governance Committee on Internal Audit's activities, purpose, authority, responsibility, and performance relative to its plan, and on its conformance with the Code of Ethics and the Standards. Reporting must also include significant risk and control issues, including fraud risks, governance issues and other matters that require the attention of senior management and/or the audit committee.

The Internal Audit Service has a comprehensive audit manual in place that covers all aspects of the Internal Audit Service. They have developed comprehensive planning processes that take into consideration the Council's risks and objectives; the risk management and governance frameworks; the Council's objectives and priorities; any other relevant and reliable sources of assurance that are available; key issues identified by managers during planning meetings; the Service's own risk and audit needs assessments; and any emerging risks

identified through horizon scanning and networking with other organisations and regional audit groups. For each authority, the Service produces a risk-based audit plan that is aligned to the relevant Council's objectives and is designed to provide each Council with relevant assurance on their governance, risk management and control frameworks. The audit plans are reviewed and approved by the respective Senior Management Teams and Audit Committees.

Details of the completed audits, together with regular updates on the progress being made on delivering the audit plans and the performance of the Internal Audit Service, are reported regularly to the respective Senior Management Teams and the Audit Committees. An annual report and opinion is produced for each authority at the end of the year and presented to the respective Senior Management Team and Audit Committee.

The clear indication from this EQA is that the Internal Audit Service is managed effectively and conforms to standard 2000 and the LGAN.

5.9 **Performance Standard 2100 – Nature of Work**

Standard 2100 covers the way the Internal Audit activity evaluates and contributes to the improvement of the organisation's risk management and governance framework and internal control processes, using a systematic, disciplined and risk-based approach.

This is the approach adopted by the Internal Audit Service and is embedded in their working methodologies. During this EQA, we reviewed a small sample of completed audits and examined them to see if they conformed to standard 2100, the LGAN and Internal Audit's own methodologies. We found that all the sample audits examined during the EQA complied with all three.

The clear indication from this EQA is that the Internal Audit Service conforms to performance standard 2100 and the LGAN.

5.10 **Performance Standard 2200 – Engagement Planning**

Performance standard 2200 requires Internal Auditors to develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. The plan must consider the organisation's strategies, objectives, and risks relevant to the engagement.

As mentioned above, the Service has an audit manual and robust supervision processes in place, that include engagement planning, and meets the requirements of the PSIAS. From the sample of audits that we examined during the EQA, we found that they all conformed to standard 2200, the LGAN, and the Service's own audit procedures, and we therefore conclude that Internal Audit conforms to performance standard 2200 and the LGAN.

5.11 **Performance Standard 2300 – Performing the Engagement**

Performance standard 2300 seeks to confirm that Internal Auditors analyse, evaluate and document sufficient, reliable, relevant, and useful

information to support the engagement results and conclusions, and that all engagements are properly supervised.

The Internal Audit Service has an audit manual, sound supervision arrangements, and quality assurance processes in place that meet the requirements of the standards. We reviewed the evidence provided in support of the Service's self-assessment, together with a sample of audits to see if they conformed to the standards, and Internal Audit's own working methodologies. We found that all the evidence we examined conformed to the standards and Internal Audit's own procedures and methodologies. We therefore conclude that Internal Audit conforms to performance standard 2300 and the LGAN.

5.12 **Performance Standard 2400 – Communicating Results**

This standard requires Internal Auditors to communicate the results of engagements to clients and sets out what should be included in each audit report, as well as the annual report and opinion. When an overall opinion is issued, it must take into account the strategies, objectives and risks of the clients and the expectations of their senior management, the audit committee and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant, and useful information. Where an internal audit function is deemed to conform to the PSIAS, reports should indicate this by including the phrase "conducted in conformance with the International Standards for the Professional Practice of Internal Auditing".

The Service's procedures and supervision processes cover the communication of results of individual audits and meet the requirements of the PSIAS. During the EQA we reviewed the evidence provided in support of the Service's self-assessment and the audit reports issued for a sample of audits to establish if they conformed to the standards. We found that all the evidence we examined conformed to the standards and Internal Audit's own procedures and methodologies.

We also reviewed the progress and annual reports presented to the respective Audit Committees and found that these also conformed to the standards and the Service's own internal procedures.

We therefore conclude that the Internal Audit Service conforms to performance standard 2400 and the LGAN.

5.13 **Performance Standard 2500 – Monitoring Progress**

There is a comprehensive follow-up process in place, the objective of which is to monitor the client's progress towards the implementation of agreed actions. The results of the follow-up reviews are reported to the respective Audit Committee. From this EQA, it is evident that the Internal Audit Service conforms to performance standard 2500 and the LGAN.

5.14 **Performance Standard 2600 – Communicating the Acceptance of Risk**

Standard 2600 considers the arrangements which should apply if the CIA has concluded that managers have accepted a level of risk that may

be unacceptable to the organisation. Situations of this kind are expected to be rare, consequently, we did not see any examples of this during this review. From this EQA, it is evident that the Internal Audit Service conforms to performance standard 2600 and the LGAN.

6. Areas of partial conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

6.1 There are no areas of partial conformance with the Public Sector Internal Audit Standards or the CIPFA Local Government Application Note.

7. Areas of non-conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

7.1 There are no areas of non-conformance with the Public Sector Internal Audit Standards or the CIPFA Local Government Application Note.

8. Issues for management action

8.1 From our review of the Service's self-assessment we have six advisory issues that management should consider. Five relate to matters of good practice linked to the operation of the Service and not the Service's conformance to the standards, and one is a generic issue relating to the future of the PSIAS for the CIA to consider. These are all set out in the table below:

Issues for management action	**Priority**
Consideration should be given to developing a mid/long term recruitment and retention strategy for the Internal Audit service.	**Advisory**
Whilst it is common for CIA's to be responsible for counter fraud alongside internal audit, the PSIAS does not regard it as being part of the mainstream internal audit function. It would therefore be prudent to include a review of the counter fraud function in future audit plans, and to maintain a sound level of independence and objectivity, to use the Internal Audit Service's external partner to do the review.	**Advisory**
To enhance the Service's data analytics functionality, consideration should be given to obtaining specialist	**Advisory**

Issues for management action	Priority
data analytics software, such as IDEA, ACL, Arbutus etc, to supplement the standard applications (Excel and Power BI) used by the Service.	
The Service's use of data analytics can be enhanced further by making use of external sources of data for benchmarking purposes. Suitable sources of external sources of data are the local authority data held in the CIPFA statistics and 'Nearest Neighbour Model' applications, which the Councils should already have access to, and the benchmarking data held by the Local Government Association in their LG Inform application.	**Advisory**
Research for audits and reading technical journals and other publications forms part of an internal auditor's continuous learning and development, however undertaking these activities are not routinely recorded on the central learning and development record for the Service. As this is an important, significant, and valid element of an internal auditor's learning and development, consideration should be given to adding this to the central training records.	**Advisory**
Management should be mindful of the fact that a consultation on revising the Institute of Internal Auditors Global IPPF which is incorporated into the PSIAS, has recently taken place and any changes to the Standards arising from the consultation may affect the Service's future conformance to the Standards. It is, therefore, suggested that the Audit Manager keeps a watching brief on the developments to the Standards and how this may impact the Service in the medium term.	**Advisory**

The co-operation of the Chief Internal Auditor in providing the information requested for the EQA, is greatly appreciated. Our thanks also go to the Chairs of the Audit Committees and the key stakeholders that made themselves available for interview during the EQA.

Ray Gard, CPFA, FCCA, FCIIA, DMS

23 November 2023

10. Definitions

Level of Conformity	Description
Fully Conforms	The Internal Audit Service complies with the standards with only minor deviations. The relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the individual Standard, the element of the Code of Ethics, and the Local Government Application Note in all material respects. This means that there is general conformance to a majority of the individual Standards, elements of the Code of Ethics, or the Local Government Application note, and at
Partially Conforms	The Internal Audit Service is endeavouring to deliver an effective service however, they are falling short of achieving some of their objectives and/or generally conforming to a majority of the individual Standards, elements of the Code of Ethics, or the Local Government Application note and at least partial conformance to the others. There will usually be significant opportunities to improve the delivery of effective internal audit, and enhance conformance to the Standards, elements of the Code of Ethics, and/or the Local Government Application Note. The Internal Audit Service may be aware of some of these opportunities and the areas they need to develop. Some identified deficiencies may be beyond the control of Internal Audit and may result in actions for Senior Management or the Board of the organisation to
Does Not Conform	The Internal Audit Service is not aware of; not making efforts to comply with; or is failing to achieve many/all of the individual Standards, elements of the Code of Ethics, or the Local Government Application Note. These deficiencies will usually have a significant adverse impact on Internal Audit's effectiveness and its potential to add value and are likely to represent significant opportunities for improvement to Internal Audit. Some identified deficiencies may be beyond the control of Internal Audit and may result in recommendations to Senior Management or the

Action Priorities	Criteria
High priority	The Internal Audit Service needs to rectify a significant issue of non-conformance with the standards. Remedial action to resolve the issue should be taken urgently.
Medium priority	The Internal Audit Service needs to rectify a moderate issue of conformance with the standards. Remedial action to resolve the issue should be taken, ideally within a reasonable time scale, for example six months.

Low priority	The Internal Audit Service should consider rectifying a minor issue of conformance with the standards. Remedial action to resolve the issue should be considered but the issue is not urgent.
Advisory	These are issues identified during the course of the EQA that do not adversely impact the service's conformance with the standards. Typically, they include areas of enhancement to existing operations and the adoption of best practice.

11. Disclaimer

This report has been prepared by CIPFA at the request of Oxfordshire County Council, and the terms for the preparation and scope of the report have been agreed with them. The matters raised are only those that came to our attention during our work. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, we have only been able to base findings on the information and documentation provided to us. Consequently, no complete guarantee can be given that this report is necessarily a comprehensive statement of all the issues that exist with their conformance to the Public Sector Internal Audit Standards that exist, or of all the improvements that may be required.

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