Southern Internal Audit Partnership

Assurance through excellence and innovation

HAMPSHIRE COUNTY COUNCIL

Annual Internal Audit Report & Opinion 2022-2023

Prepared by: Neil Pitman, Head of Partnership

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Contents

1. Role of Internal Audit

The Council is required by the Accounts and Audit (England) Regulations 2015, to

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

In fulfilling this requirement, the Council should have regard to the Public Sector Internal Audit Standards (PSIAS), as the internal audit standards set for local government. In addition, the Statement on the Role of the Head of Internal Audit in Public Service Organisations issued by CIPFA sets out best practice and should be used to assess arrangements to drive up audit quality and governance arrangements.

The role of internal audit is best summarised through its definition within the Standards, as an:

***'Independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'*.**

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

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

2. Internal Audit Approach

To enable effective outcomes, internal audit provides a combination of assurance and consulting activities. Assurance work involves assessing how well the systems and processes are designed and working, with consulting activities available to help to improve those systems and processes where necessary. A full range of internal audit services is provided in forming the annual opinion.

As the Chief Internal Auditor, I review the approach to each audit, considering the following key points:

- Level of assurance required.
- Significance of the objectives under review to the organisations' success.
- Risks inherent in the achievement of objectives.
- Level of confidence required that controls are well designed and operating as intended.

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

The Southern Internal Audit Partnership (SIAP) maintain an agile approach to audit, seeking to maximise efficiencies and effectiveness in balancing the time and resource commitments of our clients, with the necessity to provide comprehensive, compliant and value adding assurance.

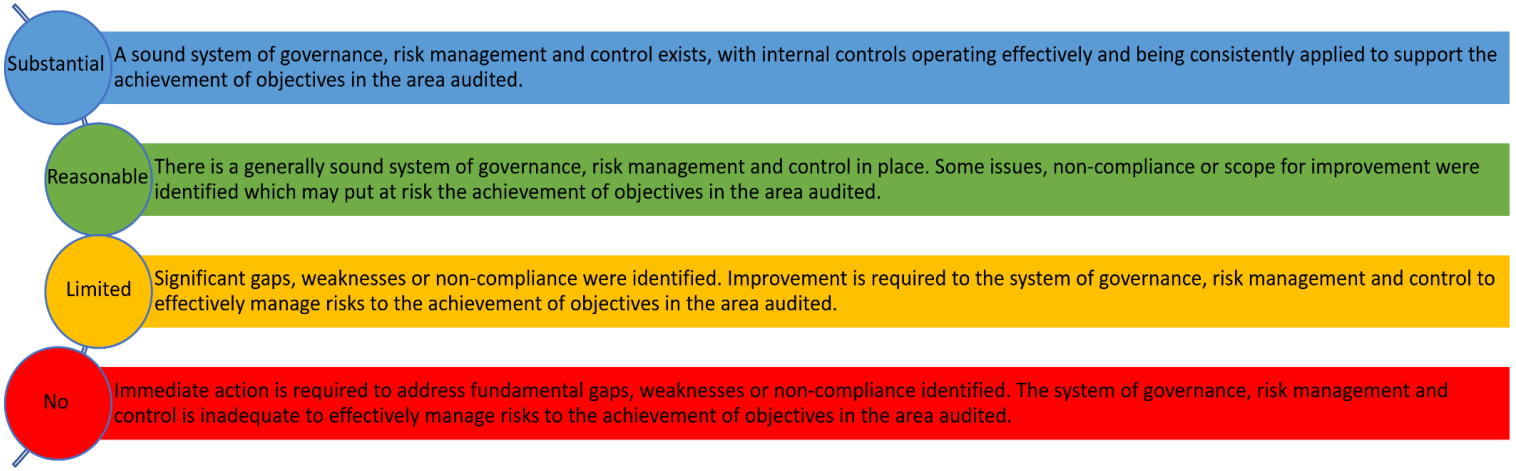
Working practices have been reviewed, modified and agreed with all partners and we have sought to optimise the use of virtual technologies to communicate with key contacts and in completion of our fieldwork. However, the need for site visits to complete elements of testing continues to be assessed and agreed on a case-by-case basis.

3. Internal Audit Coverage

The annual internal audit plan was prepared to take account of the characteristics and relative risks of the Council activities and to support the preparation of the Annual Governance Statement. Work has been planned and performed to obtain sufficient evidence to provide reasonable assurance that the internal control system is operating effectively.

The 2022-23 internal audit plan was considered by the Audit Committee at its meeting in September 2022. The plan was informed by internal audit's own assessment of risk and materiality in addition to consultation with management to ensure it aligned to key risks facing the organisation. The plan has remained fluid throughout the year to maintain an effective focus and ensure that it continues to provide assurance, as required, over new or emerging challenges and risks that management need to consider, manage, and mitigate.

Internal audit reviews culminate in an opinion on the assurance that can be placed on the effectiveness of the framework of risk management, control and governance designed to support the achievement of management objectives of the service area under review. The assurance opinions are categorised as follows:



4. Internal Audit Opinion

As Chief Internal Auditor, I am responsible for the delivery of an annual audit opinion and report that can be used by the Council to inform their annual governance statement. The annual opinion concludes on the overall adequacy and effectiveness of the organisations' framework of governance, risk management and control.

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

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

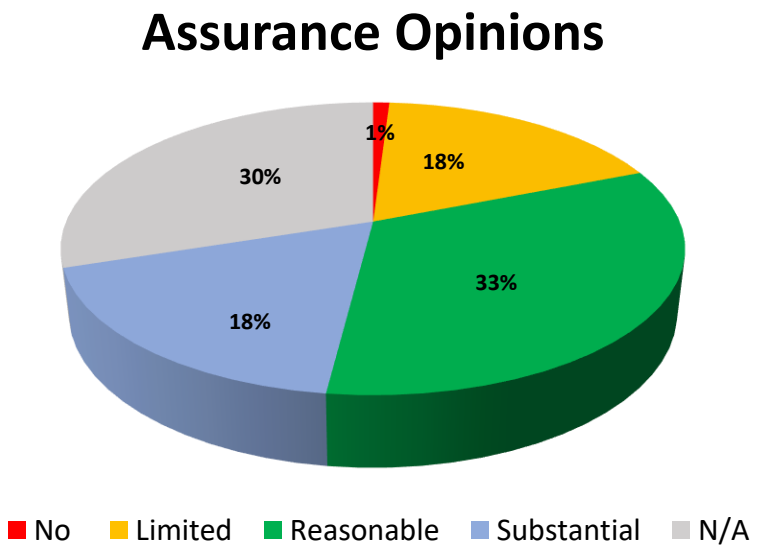
We enjoy an open and honest working relationship with the Council. Our planning discussions and risk-based approach to internal audit ensure that the internal audit plan includes areas of significance raised by management to ensure that ongoing organisational improvements can be achieved. I feel that the maturity of this relationship and the Council's effective use of internal audit has assisted in identifying and putting in place action to mitigate weaknesses impacting on organisational governance, risk, and control over the 2022-23 financial year.

Annual Internal Audit Opinion 2022-23
I am satisfied that sufficient assurance work has been carried out to allow me to form a conclusion on the adequacy and effectiveness of the internal control environment. In my opinion frameworks of governance, risk management and management control are **reasonable** and audit testing has demonstrated controls to be working in practice. Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective actions and a timescale for improvement.

5. Governance, Risk Management & Control – Overview & Key Observations

Assurance opinions for 2022-23 reviews

Significant findings from our reviews have been reported to the Audit Committee throughout the year and a summary of the assurance opinions is outlined below.



**N/A relates to mandatory reviews such as grant certifications and those areas were outcomes resulted in a Position Statement*

Governance

Governance arrangements are considered during the planning and scoping of each review and in most cases, the scope of our work includes overview of:

- the governance structure in place, including respective roles, responsibilities, and reporting arrangements.
- relevant policies and procedures to ensure that they are in line with requirements, regularly reviewed, approved, and appropriately publicised and accessible to officers and staff.

In addition, during 2022-23 we undertook reviews of the Annual Governance Statement and Equality Impact Assessments each of which concluded in a reasonable assurance opinion.

The review of the Annual Governance Statement concluded that the overall framework for the preparation of the AGS (facilitated by the Head of Legal Services), is sufficiently robust to ensure its accuracy, currency and timely completion. The AGS had been prepared in collaboration with Directors and key officers across all areas of the Council and the comments received through the completion of Statements of Assurance, updates on the governance framework and previous action plans were reflected in the draft AGS.

Based on the work completed during the year and observations through our attendance at a variety of management and governance meetings, in our opinion the governance frameworks in place across the Council are robust, fit for purpose and subject to regular review. There is also appropriate reporting to the Audit Committee to provide the opportunity for independent consideration and challenge including the in-year update and review of the Annual Governance Statement.

Risk management

We last reviewed risk management arrangements in the Council in 2021/22 which resulted in a reasonable assurance opinion. The evidence obtained during the review demonstrated that risk management arrangements were sound, documented and embedded within the Council.

In accordance with the constitution, the Audit Committee play a key role 'to consider the effect of the County Council's risk management arrangements'. This has been supported through the Committees overview of the Risk Management Update report (December 2022).

The risk register is a key document that is taken into account during the development of our risk based internal audit plan. The information in the risk register is taken into account when scoping each review in detail to ensure that our work is appropriately focussed.

Control

In general, internal audit work found there to be a sound control environment in place across the majority of review areas included in the 2022-23 plan that were working effectively to support the delivery of corporate objectives.

We generally found officers and staff to be aware of the importance of effective control frameworks, and open to our suggestion for improvements or enhancements where needed. Management actions agreed as a result of each review are monitored to completion to ensure that the identified risks and issues are addressed. The key areas of challenge identified or confirmed through our work are outlined below:

Care Charging - No

Hampshire County Council maintain their own suite of residential and nursing homes which complement and add to market provision. Funding for these beds can be through HCC, Self-funding, NHS or Other Local Authorities (OLA). This audit was requested to provide assurance that beds within HCC Care which should be funded by the NHS or another Local Authority, are in fact being charged for and at the correct rate.

The review found there to be no documented process or procedure in place for the provision of HCC Care beds to an OLA or NHS funded client or how these would be invoiced for.

There was no central list of OLA or NHS funded clients maintained for HCC Care homes. HCC Care homes themselves were also unable to provide accurate details of who within their care is/should be funded by the NHS or OLA. Additionally, there was no reconciliation carried out to confirm that income was being received for every client within each HCC Care home.

Consequently, we could provide no assurance that income due for care provision that should be funded by the NHS or Other Local Authority was known and collected by HCC.

A wider ranging care charging audit has been included in the audit plan for 2023/24 which will include those who are funded by other means.

Independent Non-Maintained Special Schools - Limited

INMSS account for 750+ cases where children have Educational Health Care Plans (EHCPs) and where their needs are accommodated for in the independent sector equating to overall annual costs on INMSS in the region of £55m (excluding travel costs). The focus of the audit was to review a sample of placements to assess whether the Authority were attaining value for money in the placement of children into specialist school provision.

Whilst it remains a statutory duty of HCC, the responsibility for reviewing individual EHCPs is currently delegated to individual schools. The INMSS team's task is to monitor EHCPs, identify those coming up for review, track that the review takes place, and that changes relating to the needs of the Children & Young People (CYP) are accounted for as appropriate and to ensure this process is carried out in line with legislation. However, rather than an annual review of all INMSS EHCPs, the teams EHCP reviews, led by SEN, are completed using a risk-based approach. Information around the number of EHCPs reviewed on this risk assessed basis is not freely available and therefore the service is unable to determine, out of all the EHCPs which are in place, whether the interventions in place remain appropriate to meet the needs of the CYP and the potential cost impact around those not assessed on a fuller basis.

Individual Placement Agreements (IPA) detailing the agreed provision were incomplete, with approx. 50% of those tested only available as draft, or unsigned. Of all IPAs tested, clarity of information in terms of costing was limited.

Positively a temporary resource was put in place at the time of the audit to ensure that costing detail accounted for within INMSS package approvals remained appropriate as per the requirements of CYP, aligns with EHCPs and identifies instances where cost avoidance by suppliers might be present. Cost avoidance identified by this post at the time of the audit totalled approx. £1.3m. At their meeting on 14th December 2022, Schools Forum agreed to the continuation of, and increased investment, to support the quality assurance of INMSS places and alternative provision.

Contingency Planning (Adults) - Limited

Contingency Plans are developed to ensure that appropriate arrangements are in place for clients continued care in an emergency. The Authority has a statutory duty to consider Contingency Plans under the Care Act (2014).

The directorates Social Care Practice Manual (SCPM) was found to detail the expectations relating to contingency planning and contained links to other relevant guidance. This manual was available to all staff on the intranet.

From our review of an AIS report covering the period between 1 January 2021 and 6 December 2021 we found a total of 30,578 clients. Of these, 22,262 (72.8%) did not have a contingency plan recorded within their care and support plan on AIS in line with the SCPM to enable ease of access should there be a requirement to enact the plan. It should be highlighted however, that for a sample examined in greater detail, the care and support plan was later located elsewhere in AIS.

Further to this, detailed analysis provided from the Practice Excellence Manager as part of the Quality Assurance Framework (QAF) confirmed that contingency plans were inconsistently recorded in AIS. For 355 clients' records reviewed as part of the QAF, for the 12 months up until 19th April 2022, it was found that 173 clients had a contingency plan in their assessment only, and for 66 clients there was no contingency plan in their support plan or assessment.

Review of 20 contingency plans recorded within client care and support plans and/or assessments found that the level of detail recorded varied and some sections, as defined within the Social Care Practice Manual, had not been completed.

Management of Legionella - Limited

The Health and Safety Corporate Procedure for Legionella (December 2022) were found to provide clarity on how risks associated with Legionella in Hampshire County Council properties are managed and intranet / SharePoint pages provided comprehensive and accessible training and guidance materials. Additionally, the biennial reports issued by the Head of Profession, to Departmental Management Teams, include an update on issues relating to the management of Legionella.

A monthly report is produced listing all maintenance checks that have failed or have not been completed and are therefore overdue. Each failure on the list is allocated to an officer within Property Services for review, investigation and rectification. The expectation is that all failures will be reviewed within the reporting month, however, discussions with officers allocated with these failures confirmed that target timeframes are not being met. There are informal mechanisms in place for reviewing delays, however, outcomes and the extent of backlogs are not being formally reported on. We were advised that it is not currently possible to report on the total number of outstanding failed or overdue checks.

The Health and Safety Corporate Procedures for Legionella (dated December 2022) state that the training should be completed annually. There are two online e-learning training courses available to those involved in the management of legionella which are accessible via Learning Zone (Part 1: Introduction Course and Part: 2 Specific Roles and Responsibilities). It was evident from the audit that not all relevant officers had completed both e-learning courses and there was inconsistency in refresher training occurring on an annual basis.

School Thematic(s) – Government Grants / Procurement & CSO / Income Generation - Limited

Government Grants

This review focused on the allocation and payment of the DWP Winter and Household Support Grants made to schools to provide food vouchers to support eligible families.

Testing found that 17 of 20 schools sampled distributed funding to children and families identified as needing additional support, in addition to those receiving Free School Meals (FSMs). Of those, four used the EDDIE system as per the guidance within the school communication at the start of the scheme. 13 schools used alternative means, increasing the risk that not all children listed on the EDDIE system would have been identified and provided / offered the appropriate support. For the remaining three schools, we were advised that food vouchers were not offered to families identified as needing additional support.

Reconciliation of grant funding received was not routinely carried out by all schools in our sample. This has the potential to create difficulty for schools in terms of their assurance that funds received were sufficient for the intended purpose, or that it covered their obligations.

Procurement & CSO (DRAFT)

The purpose of this audit was to carry out a review on procurement processes, compliance with Contract Standing Orders (CSOs), and recording of Related Party Transactions (RPTs).

We found that finance/administrative staff were not always aware of the CSOs and the process to be followed. Further to this, we found that schools were not routinely obtaining three written quotations for procurements in accordance with CSO guidelines.

34% of sampled purchase orders tested across schools were found to be raised after the date of invoice and therefore some goods had already been received prior to raising the order and approval of spend.

Income Generation (DRAF FINAL)

For the 15 schools reviewed, decisions regarding entering into a new activity were made either via the Headteacher or the Governing Body, however, 33% of schools sampled did not have any supporting guidance or policies around the decision-making process for income generating activities, such as what type of activity could be considered, who should approve it and what due diligence is required. It was further found that a majority of the schools sampled did not submit business cases to the school governors for approval when putting forward the discussions for a new income generating activity.

A majority of schools sampled were found to use third parties to provide activities on the premises, however, only three were found to have appropriate contracts or agreements in place.

Swanwick Lodge - Limited

Swanwick Lodge is a secure residential care unit providing specialist services to young people aged between 10 and 17. The purpose of the audit was to review the effectiveness of the processes in place at Swanwick Lodge around the recruitment and retention of staff, use of agency staff and the current charging model.

Review of expenditure on agency staff highlighted significant spend with one supplier that was not part of a framework nor supported by a contractual agreement.

Whilst there was no evidence through testing to suggest any breaches had occurred, records retained did not clearly identify total hours worked (including overtime) to ensure working time directives were not exceeded.

Audit testing found that a small sample of invoices to other local authorities contained a level of detail falling outside of requirements of the Data Protection Regulations.

Positively, a new operating model for Swanwick Lodge, approved by CSDMT in April 2022, has been produced based on a review of costs and income which enables the recovery of all costs associated with caring for residents and provides a clearer process for managing occupancy safely and appropriately.

Direct Payments – Adults (DRAFT) - Limited

As at May 2023 there were 2,312 Direct Payment (DP) provisions. Detailed examination of 10 DP clients' records and found:

- one agreement could not be found
- five agreements were dated after the start of the DP.
- evidence of approval (by RAG, SPOG or Team Manager) for three clients could not be located prior to the commencement of the DP.
- reviews were not routinely being undertaken in line with the SCPM. For those that had reviews there was not always evidence on the client's file recording whether the DP was discussed and whether it was meeting the client's needs.

The SCPM requires DPs in excess of 14 hours a week to be paid into a dedicated bank account. The bank account form has a section to confirm if the bank account is a dedicated account or not, however for our sample we were not routinely able to locate this form or that the relevant section(s) had been completed.

Testing was undertaken to ensure client records showed evidence of mental capacity and if not, that an authorised person had been identified. We found that there was not always adequate supporting documentation for clients where mental health or physical health concerns had been identified.

DPs are central government's preferred method for clients to meet their assessed care and support needs. We examined the records of six clients not in receipt of DPs to ensure that their records contained evidence of DP discussions and why the client was not in receipt of a DP. There was no record of DP discussions on any of the six client records examined.

Training Attendance - Limited

AHC Learning and Development hold Learning Pathways for Practice and Provider Services roles, detailing the induction and essential, recommended and refresher training requirements for each role.

The audit confirmed that training pathways are all easily available on the AHC intranet, and staff are reminded to undertake training via monthly training flyers and weekly Team Briefs and there are also separate Managers Briefs to remind Managers of their role for staff training.

However, whilst we were informed the training pathways are up to date, testing has highlighted the training pathways contain courses that could not be found on the Learning Zone, as they are no longer run (albeit we were advised that the content is covered within other courses).

The Training Team do not routinely monitor and report on individual staff members' outstanding training, so there are no overall section or departmental completion percentage rates providing assurance to management that staff have completed all required induction and essential courses, along with recommended courses. Audit testing of a sample of staff highlighted that only 65% of the induction courses had been completed, 54.7% of essential courses had been completed and 12.6% of recommended courses had been completed.

A Training Dashboard was developed by the Performance Improvement Team, to enable managers to be able to monitor their own staff's training; however, at the time of this review, was not a reliable source of information and does not work as intended.

Out of Area Placements (DRAFT) - Limited

The Care Act 2014 sets out clear expectations of a local authority to ensure that all individuals receiving care and support plans have the opportunity to reflect on what is and what is not working well. The Act requires Local Authorities to ensure care plans are kept under general review; and there is a suggested minimum requirement of an annual review.

The directorate have raised concern that Out of Area Placements may be at greater risk of not receiving regular review of their care support plans, however, whilst a holistic analysis could be undertaken of all clients from AIS, which currently shows 58% of reviews being completed within the required timelines (against a target of 85%), there is no ability to report solely on Out of Area Placements to effectively monitor such cases if they are deemed at higher risk of omission.

In the absence of a standard report from AIS, a data extraction was requested based on provider post code that highlighted a best estimate of 757 Out of County Placements. Analytical review showed that of those only 52% had an in date review. We examined the records of 10 clients with overdue reviews and found that reasoning for a delayed review was not routinely recorded.

Carer Assessments - Limited

The audit sought to provide assurance that the processes in place for the provision of Carers' Assessments (including respite care) were being completed appropriately in the older adults' client group, including whether respite care has been offered.

It was not possible to report on the number of carers and those which had had a carers assessment. Although Annual Statutory Short and Long Term (SALT) returns are made, which include statistics on carer support provided during the year, the return relies on information being accurately recorded in AIS, which may not always be the case.

Our testing of records on AIS found that Carers are not consistently identified, and carer provision is not routinely recorded between the carer and cared for persons' record. Additionally, there is no specific template for Carers Assessments, instead the client care assessment document is used, which may not be sufficiently detailed for all situations. Furthermore, review dates for carers assessments was not consistently set in AIS.

TUPE - Limited

The purpose of the audit was to attain assurance that the processes in place provide a smooth transition for employees being transferred into partner organisations. Since August 2021, 22 TUPEs have been completed involving 217 individuals.

Although testing of five TUPEs completed within the last year found that the employees had been transferred in on time with the correct positions set up, there were a variety of issues and delays with every project, particularly when the OM and eStore Manager was not available. This highlighted an over reliance on the OM and eStore Manager and need for further training and awareness within the wider team and more detailed documentation of the process.

Discussions highlighted that there is currently no reporting to senior management to highlight and escalate issues and delays within ongoing TUPE projects, to facilitate prompt escalation and resolution.

Additionally, there is no analysis carried out for completed TUPEs to monitor and report on the performance of projects. As a result, any delays and issues caused by partners or the IBC are unknown and trends cannot be identified or analysed to help improve the process.

Minibuses Adults -Thematic – Limited

The purpose of the audit was to ensure that an overarching strategy for Day Services vehicles management is in place, and that vehicles are only driven by staff with the relevant licence categories and after MiDAS training. This review also included ensuring checklists have been completed and that vehicle checks are appropriately carried out.

Positively, the Corporate Health & Safety Procedure – Transport – Driving for Work sets out a consistent way of managing the risks associated with driving for work and covers the driver's suitability to operate the vehicle (competence, licencing and fitness), different types of vehicles and the management, planning and scheduling of journeys (route, timing, duration and weather).

The Corporate Health & Safety – Transport – Driving for Work states that each time a vehicle is used the driver is responsible for ensuring the vehicle is road legal and safe. MiDAS training and HTM minibus documentation details the pre-journey checks that should be undertaken prior to driving a minibus. Testing found inconsistencies in the completion of these checks and two of the six day centres did not undertake any pre-journey vehicle checks if a different driver drove the vehicle on the same day.
The audit found that for two out of the 33 drivers tested across the centres, we were not able to obtain evidence if the drivers were MIDAS trained. Furthermore, no other training was evidenced for these drivers.

Whilst we found that the suitability for drivers to use vehicles was evidenced at all sites by DBS checks as part of the recruitment process and we were also advised that drivers with repeat workplace accidents are reassessed, we found that four of the six day centres visited (equating to 25 of the 70 day service drivers) do not have their driving licences checked on an annual basis.

County Highways Laboratory - Limited

This review sought to provide assurance over the efficiency and effectiveness of controls to offer a good customer service to all HCC and Private Sector clients. As part of this audit, we looked at the customer journey, from the customer's first contact with the laboratory to the efficiency of testing and results being reported to the client.

There was found to be a 1-year business plan in place for 2022/23, however we could find no evidence that progress on delivering the business plan is being monitored and reported to management. A plan has also been drafted for 2023/24.

The Quality Management Procedure Document states 'Non-HCC Client approval should be sought before carrying out subcontracting work, and should be recorded on the sub-contractor register.' This approval is not being sought, however, customers were kept informed where sub-contractors had been used.

Customers had reported through the customer survey in 2021/22 that they were unhappy with the length of time sub-contractors would take to send reports back to them, however, we were advised that there were no specified timescales within the contracts with sub-contractors and therefore no monitoring was in place to ensure that testing results are reported within a reasonable time period.

Although risk assessments for site visits are kept in physical folders in the office, there is no evidence to confirm that technicians are looking at these before they carry out a site visit.

HTM H&S compliance – Limited

Hampshire Transport Management (HTM) is Hampshire County Council's (HCC) in-house supplier of vehicles and provider of servicing and maintenance.

HTM has developed its own sets of safety policies and as part of this should carry out a biannual management inspection to confirm compliance with health and safety requirements or rectify any issues identified. However, these checks were suspended due to Covid-19 and had not resumed at the time of the audit.

We also found that there was an expectation for a yearly planner to be completed to prompt checks by the workshop managers throughout the year, however, at the time of the visit in October 2022, this had yet to be published for 2022/23. Tasks should be crossed off as completed, however, this does not provide evidence of who completed the check and when, or the outcome and any action taken. It is therefore unclear how health and safety compliance is currently being monitored by the HTM management team.

HTM's own health and safety manual has not been updated in recent years, consequently, recent changes to HTM's structure, personnel and requirements are not accurately reflected in it. Additionally, the existing risk assessment procedure is not sufficiently robust to ensure they remain up-to-date and properly approved.

Sufficient measures have not been implemented to ensure staff members are properly trained on the relevant health and safety procedures.

Registration Services - Booking System (marriages) - Limited

The General Registration Office (GRO) is the government department who hold records of marriages and civil partnerships for England and Wales and GDPR compliance forms part of their audits. Positively, the latest inspection report demonstrates no issues were raised.

The CERCO manual which contains the key processes/procedures for the registration team to follow has not been updated since May 2021 and is missing key procedural information (e.g., venue licensing).

Approved venue data was found not to match between the three systems currently in use, these being the roster database (utilised to book ceremonies); venue licensing database (utilised to track venue licenses) and mini manuals (regional prints of venues which administrators use to book ceremonies). A new booking system to replace the existing roster database is planned for implementation in the near future.

Fees quoted to customers are logged in the roster database and payment is taken via card machines which is automatically posted to SAP. The planned monthly reconciliation between the roster database and SAP had not been completed during 2022/23.

The Registration team should check payment has been received before a venue license is issued. However, our sample testing of eleven venues identified four where payment had not been verified.

International Standards on Assurance Engagements (ISAE 3402)

ISAE 3402 provides an international assurance standard allowing public bodies to issue a report for use by user organisations and their auditors (user auditors) on the controls at a service organisation that are likely to impact or be a part of the user organisation's system of internal control over financial reporting enabling them to inform both their annual governance statement and the annual audit opinion.

In 2022/23 Hampshire County Council commissioned a Service Organisation Controls (SOC) Type 2 Report under International Standard on Assurance Engagement (ISAE) 3402. Assurance against the international standard was provided by Ernst & Young.

The scope of the review incorporated coverage of General Ledger, Order to Cash, Purchase to Pay, Cash & Bank, HR and Payroll, IT General Controls. In forming their 'Opinion' the auditors (Ernst & Young) concluded:

'In our opinion, in all material respects:

a. *The Description fairly presents the finance, HR and IT shared services system as designed and implemented throughout the period 1 April 2022 to 31 December 2022.*

b. *The controls related to the Control Objectives stated in the Description were suitably designed throughout the period from 1 April 2022 to 31 December 2022 to provide reasonable assurance that the Control Objectives would be achieved if the controls operated effectively throughout the period 1 April 2022 to 31 December 2022 and if subservice organisations and user entities applied the complementary controls assumed in the design of Integrated Business Centre's controls throughout the period 1 April 2022 to 31 December 2022; and*

c. *The controls tested, which were those necessary to provide reasonable assurance that the Control Objectives stated in the Description were achieved, operated effectively throughout the period 1 April 2022 to 31 December 2022 if complementary subservice organisation and user entity controls assumed in the design of Integrated Business Centre's controls operated effectively throughout the period 1 April 2022 to 31 December 2022.'*

To compliment the ISAE 3402 Type 2 report a further letter of assurance was provided by the Director of Corporate Operations to confirm for the period 1 January 2023 to 31 March 2023:

- There have been no significant changes to the processes and controls set out in the report.
- There have been no instances in which the design of existing controls was not effective due to changes to the environment in which the System operates, data, personnel, or other factors.
- There have been no instances in which controls did not operate as designed due to changes in the environment, data, personnel, availability of resources or other factors.
- There have been no instances in which the Company has failed to achieve the related control objectives; and
- There are no reasons why we believe the Management Statement would not still be valid.

Internal audit continue to review areas of the Shared Services falling outside the scope of the ISAE2302 engagement as appropriate, through a shared internal audit plan with Hampshire County Council and Hampshire and IoW Police. The results of this work are reflected in this opinion.

Management actions

Where our work identified risks that we considered fell outside the parameters acceptable to the Council, we agreed appropriate corrective actions and a timescale for improvement with the responsible managers.

Progress is reported to the Audit Committee throughout the year through the quarterly internal audit progress reports.

6. Anti-Fraud and anti-corruption

The County Council is committed to the highest possible standards of openness, probity and accountability and recognises that the electorate need to have confidence in those that are responsible for the delivery of services. A fraudulent or corrupt act can impact on public confidence in the County Council and damage both its reputation and image.

The Council maintains a suite of strategies and policies to support the effective management of the prevention, detection and investigation of fraud and corruption (Anti-Fraud & Corruption Strategy and Response Plan; Whistleblowing Policy and Anti Bribery Policy).

Counter-fraud activity during the year has delivered a programme of proactive and reactive work to complement the internal audit strategy and annual plan focusing resource against assessed fraud risks in addition to new and emerging threats.

Reactive Fraud / Irregularity Activity - The Southern Internal Audit Partnership work with Hampshire County Council in the effective review and investigation of any reported incidents of fraud and irregularity. All such reviews are undertaken by professionally accredited (CIPFA CCIP) staff, in accordance with the Council's Anti-Fraud & Corruption Strategy & Response Plan. During the year there were no material fraud investigations undertaken.

National Fraud Initiative (NFI) - The NFI is a statutory exercise facilitated by the Cabinet Office that matches electronic data within and between public and private sector bodies to prevent and detect fraud.

Data was uploaded in October 2022 and match reports across pensions, payroll, blue badges, concessionary travel, creditors, VAT, and Companies House were released from January 2023 onwards. All high priority matches have been risk assessed and action taken to commence investigation where appropriate.

Proactive Approach - Whilst our reactive fraud work assists the Council in responding to notified incidents or suspicions of fraud and irregularity, it is equally important to ensure proactive initiatives are appropriately explored to understand, prevent and detect fraud risks across the organisation.

Initiatives and subsequent outcomes during the year included:

- Advice and guidance were provided across approx. 60 enquiries. The common themes continue to relate to email scams (mandate fraud, malware, impersonation and spoof emails), with schools being particularly targeted.
- We have issued a number of fraud awareness bulletins during the course of the year. Key themes covered have included mandate fraud, social engineering and procurement cards.
- Two themed proactive review were undertaken during the year in relation to procurement cards and payroll expenses. The results of each review are collated into summary reports identifying any potential exposure to fraud risks. The procurement card report has been issued and the payroll expenses report is being prepared.

7. Quality Assurance and Improvement

The Standards require the Head of the Southern Internal Audit Partnership to develop and maintain a Quality Assurance and Improvement Programme (QAIP) to enable the internal audit service to be assessed against the Standards and the Local Government Application Note (LGAN) for conformance.

The QAIP must include provision for both internal and external assessments: internal assessments are both on-going and periodical and external assessment must be undertaken at least once every five years. In addition to evaluating compliance with the Standards, the QAIP also assesses the efficiency and effectiveness of the internal audit activity, identifying areas for improvement.

An 'External Quality Assessment' of the Southern Internal Audit Partnership was undertaken by the Institute of Internal Auditors (IIA) in September 2020. In considering all sources of evidence the external assessment team concluded:

'The mandatory elements of the IPPF include the Definition of Internal Auditing, Code of Ethics, Core Principles and International Standards. There are 64 fundamental principles to achieve with 118 points of recommended practice. We assess against the principles. It is our view that the Southern Internal Audit Partnership conforms to all 64 of these principles. We have also reviewed SIAP conformance with the Public Sector Internal Audit Standards (PSIAS) and Local Government Application Note (LGAN). We are pleased to report that SIAP conform with all relevant, associated elements.'

8. Disclosure of Non-Conformance

There are no disclosures of Non-Conformance to report. In accordance with Public Sector Internal Audit Standard 1312 [External Assessments], I can confirm through endorsement from the Institute of Internal Auditors that:

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

9. Quality Control

Our aim is to provide a service that remains responsive to the needs of the Council and maintains consistently high standards. In complementing the QAIP this was achieved in 2022-23 through the following internal processes:

- On-going liaison with management to ascertain the risk management, control and governance arrangements, key to corporate success.
- On-going development of a constructive working relationship with the External Auditors to maintain a cooperative assurance approach.
- A tailored audit approach using a defined methodology and assignment control documentation.
- Review and quality control of all internal audit work by professional qualified senior staff members.
- An internal quality assessment against the IPPF, PSIAS & LGAN to support the 2020 independent external assessment.

10. Internal Audit Performance

The following performance indicators are maintained to monitor effective service delivery:

Performance Indicator	Target	Actual
Percentage of internal audit plan delivered *(to draft report)*	95%	95%
Positive customer survey response		
- Hampshire County Council	90%	99%
- SIAP – all Partners	90%	99%
Public Sector Internal Audit Standards	Compliant	Compliant

Customer satisfaction is an assessment of responses to questionnaires issued to a wide range of stakeholders including members, senior officers and key contacts involved in the audit process (survey date April 2023).

11. Acknowledgement

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

Neil Pitman
Head of Southern Internal Audit Partnership

Summary of Assurance Reviews Completed 2022-23

Annex 1

Substantial A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.

- Cloud Applications– Adult Services – TCES
- Strategic Financial Planning & Monitoring
- Major Incident Management
- IT Contract Management
- O365 Platform Management
- Budget Monitoring – AHC
- Vulnerability Management (Compliance)
- CART/MASH Information Sharing
- Afghan Bridging Hotel Work
- Street Works (Permitting System)
- Flood Risk Coastal Defence Programme
- HWRC Contract Management
- Procurement-YA Supported Accommodation
- Banking
- Treasury Management
- Budget Planning

Reasonable There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.

- Compliance with DBS/NPPV checks (Draft)
- Sickness Management (Draft)
- Cloud Applications – Children's Services - FTT Aspire
- Cloud Applications – Children's Services – SchoolPod
- Cloud Applications– Adult Services – Nourish
- Annual Governance Statement
- Ransomware Defence and Response
- HPSN3
- School Thematic – Payroll
- Provider Failure
- Client Affairs (Draft)
- Holiday activity fund
- Education Psychology (Draft)
- Minor works framework (Property)
- Emergency Planning
- Climate Change - Strategy & Framework
- Developers Contributions
- Equalities Impact Assessments (Draft)
- Ukraine Payments
- Discharge to Assess – Customer Journey
- COVID-19 Grants
- Use of agency workers
- County Supplies Transport & Distribution
- Buildings Health and Safety
- Tree management
- Highways Service contract
- Pay Review and Award Process
- Asset Investment Strategy
- Road Adoption Process (Draft)

Limited Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.

- Independent Non-Maintained Special Schools
- Contingency Planning
- School Thematic–Government Grants
- Management of Legionella
- School Thematic - Income Generation (Draft)
- Swanwick Lodge
- Direct Payments (Draft)
- Training Attendance
- AHC thematic review – Minibus usage
- County Highways Laboratory
- Out of Area Placement Reviews (Draft)
- Carers Assessments
- HTM H&S compliance
- Registration Service-Ceremony Booking
- TUPE
- School Thematic – Procurement (Draft)

No Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

HCC Care Charging

*Two reviews (Education Other Than Schools and Continuing Health Care & Recharging) have been drafted; however, we are awaiting factual accuracy prior to reporting. Both will be reported as part of the next progress report to the Audit Committee. The status of these reviews has not inhibited my ability to provide an overall opinion on the County Council's framework of governance, risk and control.