CLACKMANNANSHIRE COUNCIL

THIS PAPER RELATES TO ITEM 12
ON THE AGENDA

Report to: Audit and Scrutiny Committee

Date of Meeting: 13 June 2024

Subject: Internal Audit Annual Assurance Report 2023/24

Report by: Internal Audit Manager

1.0 Purpose

1.1 This report provides an overall assurance on the Council's arrangements for risk management, governance, and control, based on Internal Audit work undertaken during 2023/24. It also sets out how Internal Audit operates in compliance with the Public Sector Internal Audit Standards and provides an update on performance via key Performance Indicators.

2.0 Recommendations

2.1 The Committee is asked to note that:

- sufficient Internal Audit work was undertaken to support a balanced assurance;
- Internal Audit can provide **LIMITED** assurance on the Council's arrangements for risk management, governance, and control for the year to 31 March 2024;
- In providing this opinion, Internal Audit operated in compliance with the Public Sector Internal Audit Standards with no impairments or restrictions to scope or independence. PSIAS require a five yearly independent external quality assessment of compliance. This has been undertaken by the Chief Internal Auditor at Argyll and Bute Council, who has concluded that Clackmannanshire Council Internal Audit section fully conforms with the Standards; and
- Internal Audit met, and exceeded, each of its Key Performance Indicators.

3.0 Compliance With Public Sector Internal Audit Standards

3.1 Internal Audit seeks to undertake all work in compliance with the Public Sector Internal Audit Standards 2017 (PSIAS or the Standards). These Standards have four objectives:

- to define the nature of Internal Auditing within the UK public sector;
- to set basic principles for carrying out Internal Audit in the UK public sector;

- to establish a framework for providing Internal Audit services, which add value to the organisation, leading to improved organisational processes and operations; and

- to establish the basis for the evaluation of Internal Audit performance and to drive improvement planning.

3.2 The Standards define internal auditing 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".

3.3 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. There has not been any real or apparent impairment to scope and / or independence or objectivity relating to audit work in 2023/24.

3.4 As a prerequisite to providing an assurance opinion on the overall adequacy and effectiveness of the Council's arrangements for risk management, governance, and control, the Internal Audit Manager is required to confirm the effectiveness of the Internal Audit service and its ability to carry out the work that informs the annual assurance opinion. The Standards, therefore, require the Internal Audit Manager to establish a Quality Assurance and Improvement Programme (QAIP) to allow evaluation of compliance with the Standards. This comprises an annual self assessment and a five yearly external assessment. Part of this annual assessment includes the Internal Audit Manager confirming the organisational independence of the internal audit activity and to confirm that they report to a level within the organisation that allows the internal audit activity to fulfil its responsibilities. This requirement is further defined in the PSIAS as being met when the Internal Audit Manager reports functionally to Audit Committee.

3.6 The external quality assessment element of the Standards seeks to provide independent assurance on the level of compliance. To satisfy the requirement for five yearly external assessment, Clackmannanshire Council participates in a national review process established by the Scottish Local Authorities Chief Internal Auditors' Group. This allows Clackmannanshire Council to act as assessor, and to be assessed at no financial cost to any participants.

3.7 Internal Audit services are provided on the basis of a Joint Working Agreement with Falkirk Council. The Internal Audit Manager undertook a detailed self assessment against the Standards in March 2023. This confirmed continuing compliance with the Standards, and has now been subject to independent, external validation as part of a national review process established by the Scottish Local Authorities Chief Internal Auditors' Group.

3.8 A previous independent, external assessment was undertaken (in conjunction with Falkirk Council's Internal Audit service) by the Scottish Prison Service's (SPS) Head of Audit and Assurance, who concluded that the Council's Internal Audit section was broadly compliant with PSIAS (this is equivalent to 'Substantial Assurance'). While there were a number of recommendations raised in the report, these were designed to support continuous improvement rather than address any material non-compliance.

3.9 In line with the requirement, a further review was undertaken from November 2023 to January 2024 by the Chief Internal Auditor at Argyll and Bute Council.

3.10 The Standards comprise of 14 separate sections, which are detailed within the report. The reviewer has stated that the team fully conforms with 12 sections and generally conforms with 2 sections. As well as providing assurance on compliance with the Standards, the external quality assessment process helps drive continuous improvement. 10 recommendations have been made in the report to improve or add additional supportive processes to promote the Standards. There are three main areas for improvement highlighted in the report and a further seven areas for consideration / implementation which have been graded as 'routine'.

3.11 The report concludes, therefore, that Clackmannanshire Council's Internal Audit team fully conforms with the Standards. This is a positive outcome and provides the Audit and Scrutiny Committee with independent assurance in line with the requirements of the Scheme of Delegation.

4.0 Overall Adequacy of the Council's Control Environment and Summary of Internal Audit Work Undertaken during 2023/24

4.1 Financial Regulations are clear that it is senior managers' responsibility to establish and maintain effective and proportionate risk management, governance, and control arrangements. Internal Audit is not an extension of, or substitute for, operational management.

4.2 The 2017 Public Sector Internal Audit Standards (the Standards) require the Internal Audit Manager to prepare an Annual Assurance Report. This report should include:

- a statement on the overall adequacy of the Council's control environment;
- a summary of Internal Audit work undertaken during the year; and
- a statement on the Internal Audit Section's conformance with the Standards.

4.3 This report has been prepared to meet those requirements.

4.4 Internal Audit's Plan for 2023/24 was agreed by Audit Committee on 20 April 2023. It set out 16 assignment areas to be completed by the team during the year (it does not include those assignments or reports undertaken and issued to the Clackmannanshire and Stirling Integration Joint Board and the Central Scotland Valuation Joint Board). Of these 16 assignments, 11 required an audit report to be issued to Clackmannanshire Council, again it does not include those assignments or reports undertaken and issued to the Clackmannanshire and Stirling Integration Joint Board and the Central Scotland Valuation Joint Board, or include the Public Sector Internal Audit Standards: External Assessment.

4.5 Members will recall when approving the Internal Audit Plan it was recognised that it had to be flexible, given that priorities, resource, and Directorate capacity could, and continue to, fluctuate and change.

4.6 Seven audit reports (completed to final report stage and issued to Clackmannanshire Council's senior management) have been reported to this Committee this year. These include:

- Climate Change Act Public Body Duties Audit;
- Purchase Order Arrangements at Clackmannanshire for Adult Social Care;
- Leisure Income Follow Up Review;
- Freedom of Information Requests;
- Care Home Residents Monies;
- Use of Purchase Cards; and
- Overtime Arrangements.

4.7 At the April 2024 meeting, this Committee noted that four audit reviews had not been undertaken and would most likely be deferred into the 2024/25 Internal Audit Plan. Three of these reviews have been deferred as follows:

- IT and Information Security Governance;
- School Admissions Policy; and
- Community Benefits.

One remaining review relating to the Energy Bills Support Scheme (EBSS) is no longer required as the Scheme has closed and, therefore, it no longer poses a risk to the control environment.

4.8 Of the seven audit reports finalised:

- One review had no overall assurance level as it was a follow up review (Leisure Income Follow Up Review);
- One was a split assurance review (both substantial assurance and limited assurance aspects in Freedom of Information Requests);
- Three were limited assurance (Climate Change Act Public Body Duties Audit, Care Home Residents Monies, and Use of Purchase Cards); and
- Two were provided with no assurance (Purchase Order Arrangements and Overtime Arrangements).

Internal Audit use a set of Assurance Categories. A summary of these is set out at **Appendix 1**.

4.9 A summary of all work completed over the course of the year is set out at **Appendix 2** with the scope of, and findings arising from, each finalised assignment set out at **Appendix 3**.

4.10 The table below provides the number and type of assurance opinions provided in Internal Audit reviews in 2023/24, with comparator data from 2022/23 and 2021/22:

Assurance Levels across completed Internal Audit reviews	2023/24	2022/23	2021/22
Substantial Assurance: Largely satisfactory risk, control, and governance systems are in place. There is, however, some scope for improvement as current arrangements could undermine the achievement of objectives or leave them vulnerable to error or abuse.	**-**	**3 (43%)**	**8 (80%)**
Limited Assurance: Risk, control, and governance systems have some satisfactory aspects. There are, however, some significant weaknesses likely to undermine the achievement of objectives and leave them vulnerable to an unacceptable risk of error or abuse.	**3 (43%)**	**4 (57%)**	**-**
No Assurance: The systems for risk, control, and governance are ineffectively designed and operated. Objectives are not being achieved and the risk of serious error or abuse is unacceptable. Significant improvements are required.	**2 (29%)**	**-**	**-**
Split Assurance: **Substantial / Limited**	**1 (14%)**	**-**	**1 (10%)**
No Assurance Level Applicable: Follow up Review	**1 (14%)**	**-**	**1 (10%)**
Total	**7 (100%)**	**7 (100%)**	**10 (100%)**

This reflects the decreasing number of substantial assurance reports, and increasing limited and no assurance opinions within Internal Audit reviews.

4.11 Internal Audit use a classification grading system for recommendations made. A summary of these is also set out at **Appendix 1**.

4.12 This year, Internal Audit made a total of 64 recommendations in relation to seven finalised audit reports. 63 of 64 (98%) recommendations were accepted by management, with Agreed Management Actions, Responsible Owners, and Action Due Dates included within agreed Management Action Plans.

4.13 Fewer recommendations have been made in 2023/24, however, the priority grading of the recommendations (rated Grade 1 and Grade 2) has been relatively consistent since grading introduction in 2022/23 as follows:

Classification of Recommendations[1]	2023/24	2022/23[2]
Grade 1: Management needs to address and seek resolution urgently.	**20 (31%)**	**27 (32%)**
Grade 2: Require prompt, but not immediate action by management.	**32 (50%)**	**47 (55%)**
Grade 3: Merit attention, but do not require to be prioritised by management.	**12 (19%)**	**11 (13%)**
Total	**64 (100%)**	**85 (100%)**

[1] Linked to data held on the Pentana performance management system.

[2] Only 2022/23 comparator data is available as this was the first year of the recommendations grading classification.

This means that there is over 30% of recommendations that management need to address and seek resolution urgently.

4.14 As part of the Annual Assurance Report last year, the Internal Audit Manager highlighted that Internal Audit had made 81 recommendations in relation to six finalised audit reports[3]. Given the number of recommendations arising from those six finalised audit reports, and given the number of reports where the level of assurance had fallen below substantial assurance, Members noted that it was imperative that remedial action was taken on these recommendations as a matter of priority.

4.15 At the same meeting of this Committee in August 2023 the Strategic Director of Partnership and Performance provided Members with progress on current outstanding Internal Audit actions; systematic updates on outstanding Internal Audit actions had not been provided to Committee since the pandemic response began and that given the reprioritisation of service provision and staff abstractions over a period of nearly 3 years, it was inevitable that backlogs and overruns in progressing actions would occur to some extent.

4.16 Committee noted that extensive efforts were being made to ensure all Internal Audit actions were progressed and added to the Pentana system. To ensure that any significant weaknesses likely to undermine the achievement of objectives and leave the Council vulnerable to an unacceptable risk of error or abuse were addressed, the Strategic Director of Partnership and Performance confirmed that they would provide any status changes to the Audit and Scrutiny Committee as part of a six monthly update report.

4.17 Our review of Pentana highlights that there are several outstanding recommendations from 2022/23 (mainly Grade 1 or 2). It is unclear, however, the exact number outstanding due to the method of upload of data, for example, our Internal Audit reports might state one recommendation with multiple strands which has been uploaded to Pentana as multiple recommendations. Pentana uploads have, however, improved within 2023/24 reflecting the correct number of recommendations as stated in Internal Audit reports.

4.18 The Internal Audit Manager agrees that significant organisational change, the pandemic response, increasing demand on services, and reduction in resources as a result of budget constraints have impacted on the progression of input to Pentana, and the subsequent monitoring and implementation of the recommendations. It is imperative, therefore, going forward that Internal Audit recommendations are timeously and correctly uploaded to Pentana so that Officers can monitor what recommendations need to be implemented and when (within the agreed Action Due Dates).

4.19 In last year's Annual Assurance Report, Members noted that should the trend away from substantial assurance continue, there was a risk that, in future years, the Internal Audit Manager may not be able to reach an overall conclusion of substantial assurance in relation to arrangements for risk management, governance, and control. This would be a significant departure from previous years.

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[3] There was one Internal Audit review outstanding at the August 2023 meeting date which has now been added into the figures, providing the total of seven audits and 85 recommendations as per paragraph 4.10.

4.20 Sufficient Internal Audit work has been undertaken in 2023/24 to support a balanced opinion on the overall adequacy of the Council's control environment. On the basis of the work undertaken during the course of the year, Internal Audit can provide **LIMITED** assurance in relation to the Council's arrangements for risk management, governance, and control for the year to 31 March 2024.

4.21 This opinion reflects the fact that 92%[4] of audits undertaken had a limited or no assurance during 2023/24. Our audit findings have highlighted weaknesses, which have identified significant risks to the Council. In addition, the difficulties faced in the uploading of recommendations to Pentana and the progress made with implementation (and monitoring) of the recommendations presents a greater challenge when there is an increase in higher graded recommendations being made (Grade 1 and Grade 2 rated recommendations). There is a significant risk to the control environment if more urgent weaknesses and gaps are not being addressed. It is acknowledged that Clackmannanshire Council has many priorities and challenges, however, there are significant further improvements required to strengthen the control environment.

4.22 In previous years it has been difficult to get timely replies and engagement with some of our reviews, however, in the last two years it has been challenging in most of our audit work undertaken. In continuing to provide ongoing, robust assurance Internal Audit need the Senior Leadership Group's support to ensure that reviews are undertaken as planned, and management responses are prompt and appropriate.

4.23 Internal Audit measures performance against the following Key Performance Indicators overleaf.

Key Performance Indicator	2023/24	2022/23	2021/22	2020/21	2019/20
Complete **85%** of main audit programme	**100%**	**92%**	**88%**	**89%**	**94%**
Have **90%** of recommendations accepted	**98%**	**100%**	**100%**	**100%**	**100%**
Issue **75%** of draft reports within 3 weeks of completion of fieldwork	**92%**	**83%**	**100%**	**78%**	**100%**

4.24 Actual performance exceeded target for all three indicators, increasing from last year in two indicators, however, performance dropped slightly in one of the indicators (due to one recommendation out of 64 not being accepted).

4.25 Internal Audit are continuing to experience delays in confirming audit findings with auditees / Directorates which has meant it has proven difficult to clear audit reports within agreed timeframes. The Senior Leadership Group has undertaken to monitor these issues to ensure improvement.

4.26 In overall terms, the programme of work was broadly completed within the agreed time allocation, but it is recognised that there are issues outwith the Internal Audit team's control which impact on the ability to meet or exceed performance.

[4] Refer to paragraph 4.10: This discounts the review with 'No Assurance Level Applicable'. Of the remaining reviews 5.5 out of 6 were assigned a limited assurance or a no assurance.

5.0 Conclusions

5.1 Sufficient Internal Audit work was undertaken to support a balanced opinion on the overall adequacy of the Council's control environment. Given the number of recommendations arising from the seven finalised audit reports above, and the number of reports where the level of assurance has fallen below substantial assurance, it is imperative that remedial action is taken on these recommendations as a matter of priority.

5.2 On the basis of work undertaken, and given the split of assurances across the reports issued, Internal Audit can provide **LIMITED** assurance in relation to the Council's arrangements for risk management, governance, and control for the year to 31 March 2024 which is a significant departure from previous years.

5.3 In providing this opinion, Internal Audit operated in compliance with the Public Sector Internal Audit Standards with no impairments or restrictions to independence. PSIAS require a five yearly independent external quality assessment of compliance. This has been undertaken by the Chief Internal Auditor at Argyll and Bute Council, who has concluded that Clackmannanshire Council Internal Audit section fully conforms with the Standards.

6.0 Sustainability Implications

6.1 None Noted.

7.0 Resource Implications

Financial Details

7.1 The full financial implications of the recommendations are set out in the report. This includes a reference to full life cycle costs where appropriate. Yes ☐

7.2 Finance have been consulted and have agreed the financial implications as set out in the report. Yes ☐

Staffing

7.3 No implications other than those set out in the report.

8.0 Exempt Reports

8.1 Is this report exempt? Yes ☐ (please detail the reasons for exemption below) No ☐

9.0 Declarations

9.1 The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

Clackmannanshire will be attractive to businesses & people and ensure fair opportunities for all ☐

Our families; children and young people will have the best possible

start in life ☐
Women and girls will be confident and aspirational, and achieve their full potential ☐
Our communities will be resilient and empowered so that they can thrive and flourish ☐

(2) **Council Policies** (Please detail)

10.0 Equalities Impact

10.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations?
Yes ☐ No ☐

11.0 Legality

11.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes ☐

12.0 Appendices

12.1 Please list any appendices attached to this report. If there are no appendices, please state "none".

- **Appendix 1**: Definition of Internal Audit Assurance Categories.
- **Appendix 2**: Summary of 2023/24 Internal Audit Programme.
- **Appendix 3**: Details of 2023/24 Internal Audit Programme.

13.0 Background Papers

13.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)
Yes ☐ (please list the documents below) No ☐

Author(s)

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Approved by

NAME	DESIGNATION	SIGNATURE
Chris Alliston	Strategic Director Partnership and Performance	

Appendix 1

Definition of Internal Audit Assurance Categories

Level of Assurance	Definition
Substantial assurance	Largely satisfactory risk, control, and governance systems are in place. There is, however, some scope for improvement as current arrangements could undermine the achievement of objectives or leave them vulnerable to error or abuse.
Limited assurance	Risk, control, and governance systems have some satisfactory aspects. There are, however, some significant weaknesses likely to undermine the achievement of objectives and leave them vulnerable to an unacceptable risk of error or abuse.
No assurance	The systems for risk, control, and governance are ineffectively designed and operated. Objectives are not being achieved and the risk of serious error or abuse is unacceptable. Significant improvements are required.

Classification of Recommendations

Classification of Recommendations		
Grade 1: Key risks and / or significant deficiencies which are critical to the achievement of strategic objectives. Consequently, management needs to address and seek resolution urgently.	**Grade 2**: Risks or potential weaknesses which impact on individual objectives, or impact the operation of a single process, and so require prompt, but not immediate action by management.	**Grade 3**: Less significant issues and / or areas for improvement which we consider merit attention, but do not require to be prioritised by management.

Appendix 2

Summary of 2023/24 Internal Audit Programme

	Directorate	Assignment	Level of Assurance
Other Client Work			
1.	Central Scotland Valuation Joint Board	The Internal Audit Plan for 2023/24 was presented to the Central Scotland Valuation Joint Board on 30 June 2023.	**Will be reported to the Board on 28 June 2024**
2.	Clackmannanshire and Stirling IJB	The Internal Audit Plan for 2023/24 was presented to the IJB Audit and Risk Committee on 28 June 2023.	**Will be reported to the Audit and Risk Committee on 26 June 2024**
Annually Recurring Assignments			
3.	All Directorates	National Fraud Initiative	**Ongoing Assurance**
4.	All Directorates	Continuous Auditing	**Ongoing Assurance**
5.	Place	Climate Change Act Public Body Duties Audit	**Final Report Issued Limited Assurance**
6.	All Directorates	Consultancy Work	**Ongoing Assurance**
7.	All Directorates	Work on Recommendations Outstanding	**Ongoing Assurance**
8.	Internal Audit	Public Sector Internal Audit Standards: External Assessment	**Final Report Issued ‘Fully Conforms’ Assurance**
Committed Assignments			
9.	Partnership and Performance / All Directorates	IT and Information Security Governance	**Included in the 2024/25 Internal Audit Plan**
10.	People / All Directorates	Purchase Order Arrangements at Clackmannanshire for Adult Social Care	**Final Report Issued No Assurance**
11.	Partnership and Performance / People	Leisure Income Follow Up Review	**Final Report Issued No Assurance Level Applicable**
12.	Partnership and Performance / All Directorates	Freedom of Information Requests	**Final Report Issued Substantial / Limited Assurance**

Appendix 2

	Directorate	Assignment	Level of Assurance
Other Client Work			
13.	Partnership and Performance / All Directorates	Care Home Residents Monies	**Final Report Issued Limited Assurance**
14.	Partnership and Performance / All Directorates	Overtime Arrangements	**Final Report Issued No Assurance**
15.	Place / Partnership and Performance	Energy Bills Support Scheme (EBSS)	**No Longer Applicable**
16.	People	School Admissions Policy	**Included in the 2024/25 Internal Audit Plan**
17.	Partnership and Performance / All Directorates	Use of Purchase Cards	**Final Report Issued Limited Assurance**
18.	Partnership and Performance / All Directorates	Community Benefits	**Included in the 2024/25 Internal Audit Plan**

Appendix 3

Details of 2023/24 Internal Audit Programme

Assignment	Directorate	Assurance
National Fraud Initiative	All Directorates	**Ongoing Assurance**
Scope	**Final Report Executive Summary**	
The purpose of the NFI exercise is to review and investigate the outcomes of data matching undertaken by Audit Scotland on behalf of the Cabinet Office. Matches cover areas such as Payroll, Pensions, Housing / Council Tax Benefit, Council Tax Single Person Discount, and Creditors. The Internal Audit Manager acts as Key Contact for NFI, with responsibility for co-ordinating the process of ensuring that relevant matches are followed-up.	The 2022/23 NFI exercise is now complete. The 'high risk' matches have been risk assessed and followed up as appropriate. No instances of fraud or error have been identified. In addition to the core NFI exercise, Clackmannanshire Council participates in a related exercise designed to detect wrongly claimed Council Tax Single Person Discount. As a result of participation in this exercise (which matches Council Tax and Electoral Roll data), 893 cases were reviewed, with 742 cases identified as being correct and since cleared. 151 cases of wrongly claimed discount have resulted in the correct discount being applied now. This has led to estimated saving of £120k and potential recovery of £152k. Revised Council Tax demand notices will be issued and recovery action progressed if appropriate. Recovery action would be taken via adjustments to future Council Tax bills.	

Assignment	Directorate	Assurance
Continuous Auditing	All Directorates	**Ongoing Assurance**
Scope	**Final Report Executive Summary**	
This involves analysing Creditors payment data (payments to suppliers) to identify potential duplicate payments. We use audit interrogation software to identify matches on invoice date, amount, and number. We then check our initial results on Integra to identify any cancelled payments; payments made to different suppliers; and duplicate payments already identified (and either cancelled or monies recovered).	For the period April 2023 to March 2024, we identified 164 potential duplicate payments with a value of c£1.14m. After further investigation approximately 12 potential duplicate payments with a value of c£26k have been passed to the Corporate Accountancy Team for further investigation and appropriate recovery action. Additional work was undertaken this year on analysing the supplier database to identify any duplicates and suppliers with the same details as employees. This was to ensure there was no unnecessary duplication of supplier records which can increase the risk of duplicate payments, potentially leading to financial loss. We found that there is scope for deactivating several suppliers, and details of our analysis has been passed to the Corporate Accountancy Team Leader and Procurement Manager for appropriate action. As part of this work, we also analysed employee data to indicate if the Council is buying goods and services from a supplier owned or run by a member of staff. This check could also identify where any supplier payments have been fraudulently changed to those of an employee. We found that, on two occasions, the same bank details were recorded for two different employee names and addresses. Details of our analysis were passed to the Payroll and Systems Manager for investigation and appropriate action. The Payroll and Systems Manager confirmed that, in relation to our findings, no payments were made to incorrect bank details. In addition, monthly validation reports on bank details will be generated by the Corporate Accountancy Team to identify any future similar errors.	

Appendix 3

<table>
<tr><th>Review</th><th>Directorate</th><th>Assurance</th></tr>
<tr><td>Climate Change Act Public Body Duties Audit</td><td>Place</td><td>Limited Assurance</td></tr>
<tr><th>Scope</th><th colspan="2">Final Report Executive Summary</th></tr>
<tr><td>We undertook validation work on the Council’s 2022/23 Annual Report.

The Climate Change (Scotland) Act 2009 (the Act) introduced the requirement for public bodies to report on their climate change duties.

In line with the timescales from the Act, the Council’s annual report had to be submitted to the Sustainable Scotland Network (SSN) by the end of November 2023.

Our work focused on reviewing the reporting arrangements and the accuracy of the information in the report.</td><td colspan="2">To ensure consistency of returns across public bodies, the Annual Report format is a standard template split into five areas:

• Profile of Reporting Body;
• Governance, Management, and Strategy;
• Corporate Emissions, Targets, and Project Data;
• Adaption; and
• Procurement.

The return is made up of the completion of a checklist, which confirms that the information has been validated by the organisation’s Internal Audit section. Our work, therefore, focused on reviewing the reporting arrangements and the accuracy of the information included in the report. Due to delays in Internal Audit receiving the final report and supporting information from responsible Officers this review took place after the 2022/23 report was submitted to the SSN. This resulted in the final report noting that it was pending Internal Audit validation. It is anticipated that the Energy and Sustainability Strategy Officer will report on Climate Change Duties to the Council on 16 May 2024, with recommendations based upon the findings from this audit.

Validation work was further delayed as supporting documentation for figures was not readily available to Internal Audit. We recommend, therefore, that a more systematic gathering of the information required is undertaken to allow for the report to be submitted to Internal Audit a month before its due date. This would ensure full validation of the data (and assurance that the data was accurate) was taken prior to submission, meeting SSN requirements. We also recommend as part of the report data compilation process that a record is kept of what Officers provided the information, along with relevant supporting documentation.

In conclusion, the previous year’s Internal Audit recommendations have been implemented. It was regrettable, however, that Internal Audit were unable to validate the report prior to submission and upon review were further delayed due to identified anomalies and typographical errors. Some of the information could not be reconciled to supporting documentation. This has resulted in Clackmannanshire Council’s non-compliance with an independent verification process / SSN requirement prior to submission, and subsequently reporting inaccurate climate change figures which could be reflected in national statistics providing inconsistent results.

We, therefore, were able to provide Limited Assurance on the Council’s reporting arrangements and the accuracy of the information set out in each section of the Annual Report.</td></tr>
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Appendix 3

<table>
<tr><th>Review</th><th>Directorate</th><th>Assurance</th></tr>
<tr><td>Leisure Income Follow Up Review</td><td>Partnership and Performance / People</td><td>No Assurance Level Applicable[5]</td></tr>
<tr><th>Scope</th><th colspan="2">Final Report Executive Summary</th></tr>
<tr><td colspan="3">Considered under Item 17 on the agenda</td></tr>
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[5] There was no overall assurance level assigned to this piece of work since it was a follow-up review checking progress with the implementation of previous Internal Audit recommendations.

<table>
<tr><th>Review</th><th>Directorate</th><th>Assurance</th></tr>
<tr><td>Care Home Residents Monies</td><td>Partnership and Performance / All Directorates</td><td>Limited Assurance</td></tr>
<tr><th>Scope</th><th colspan="2">Final Report Executive Summary</th></tr>
<tr><td>Residents in Care Homes require access to their personal funds to pay for small items while in residence, for example, haircuts, chiropodist appointments, toiletries, and newspapers. These payments are managed by the Care Home staff on behalf of the residents. Individual bank accounts are not managed by the Council and there are no appointeeships[6] for their residents.

The Care Home staff receive money from family or Solicitors to top up the individual resident's suspense account. It is, therefore, important to keep proper and accurate records for each resident detailing income and expenditure.

All monies received are deposited in the Council's own bank account. Cash payments on behalf of residents for items they require are paid from the Care Home's £2,000 imprest. The imprest is reimbursed from the Council's bank account as per the Council's Imprest Policy.

The main focus of this high level review has been to evaluate and report on the policies and procedures, roles and responsibilities, and security of residents cash and valuables.</td><td colspan="2">There are two Care Homes that are run and maintained by the Council: Menstrie House and Ludgate House. The latter now being for short stays with no monies or valuables held for residents. From a total of 20 residents at Menstrie House, a random sample of 5 was chosen and checked to confirm all income and expenditure was supported by receipts from 1 April to 16 November 2023. We were content that:

• all residents valuables are securely stored in a safe and individually identifiable;
• there is an accurate record held of income and expenditure per resident;
• there is documentation to support all expenditure;
• there are appropriate written policies in place to cover residents' accounts; and
• roles and responsibilities are clearly understood.

We did identify areas where there is scope for further improvement. There is no segregation of duties as the Business Support Administrator performs all the tasks (distributing funds, issuing receipts, updating the spreadsheet, and reconciling the spreadsheet) unless the Senior Care Officer is available to distribute funds. There is a risk of monies being misplaced and records not being accurately updated.

After examining all 94 receipts, totalling £1,895.69, (from 1 April to 16 November 2023) for the random sample of 5 residents (from a total of 20 residents) we found that 12 (13%) income transactions totalling £500 (26% of the total value) were not issued with a written receipt. The amounts received were written on the envelope and stored in the main safe. This creates a risk of money being misplaced and banking being understated, with relatives having no supporting receipts to confirm transactions and Officers being unable to reconcile transactions. We have made the following recommendations:

• Location of the imprest tin should not be disclosed in the Procedures;
• A written policy be created for withdrawing monies by residents or relatives for personal use;
• A different person distributes the cash from that who updates and reconciles the master spreadsheet;
• Training should be introduced to cover the banking requirements, and specifically cash / valuable security;
• The Business Support Administrator role profile to be reviewed and updated;
• Items held in the valuables safe should be witnessed and signed for by a relative or Solicitor;
• All income received should be receipted in the receipt book; and
• A second independent person should undertake the banking along with ad hoc management checks.</td></tr>
</table>

[6] Appointeeship is when a relative or the Council take full responsibility for managing the making and maintaining any benefit claim, and managing the spending of the benefit.

<table>
<tr><th>Review</th><th>Directorate</th><th>Assurance</th></tr>
<tr><td>Adult Social Care Purchase Order Arrangements</td><td>People / All Directorates</td><td>No Assurance</td></tr>
<tr><th>Scope</th><th colspan="2">Final Report Executive Summary</th></tr>
<tr><td>The review focussed on the Purchase Order and contract arrangements for older people and physical disability assessment and care management payments processed through Techone in 2022/23.

This audit assessed the robustness of the Adult Social Care payments internal control framework (in relation to Clackmannanshire Council's Policies and Procedures. It considered the extent to which the Financial Regulations are being consistently applied in practice. A sample of 50 Adult Social Care payments with a total value of c£183k were chosen. Testing was to ensure that the following key requirements from the Financial Regulations and Contract Standing Orders are being consistently applied:

• Official authorised Purchase Orders in line with delegated authorities must be issued and raised on Techone;
• The authorising officer must be satisfied that there is sufficient budget and best value has been achieved; and
• Purchase Order values can be reconciled to a contract / written agreement.

The focus of this review was to ensure payments had appropriately authorised Purchase Orders and related Adult Social Care providers had contracts in place (with the rates paid matching</td><td colspan="2">The Clackmannanshire and Stirling Health and Social Care Partnership (HSCP) brings together integrated health and social care services; it is the delivery vehicle for the delegated functions from across Clackmannanshire Council, Stirling Council, and NHS Forth Valley. The Clackmannanshire element of the HSCP Partnership annual budget for 2022/23 was c£25.1m and for 2023/24 it is c£26.2m.

The Council's Financial Regulations aim to ensure the highest standards of probity in dealing with public money and to assist and protect staff in such dealings, and are reviewed by the Chief Finance Officer (Section 95 Officer) on an annual basis. The most recent version was updated in June 2023, and includes:

• Section 11 (Purchasing of Goods and Services) to reflect the electronic Purchase Order process operated within Techone; and
• Section 12 (Payments for Goods and Services) to set out the process for goods receipting and checking of invoices in line with procedures and controls within Techone.

The Contract Standing Orders set out the rules for the procurement of works, goods, or services for the Council. The Contract Standing Orders ensure that the Council is fair and accountable in its dealings with contractors and suppliers and ensure that value for money is obtained.

We found significant weaknesses in relation to the Adult Social Care Payments internal control framework in relation to Purchase Orders not being raised in advance of payments and non-contract expenditure. We reviewed a sample of 50 Adult Social Care transactions (with a value of £182,646), and concluded that for 6 (12%) of these, with a value of £30,665, Purchase Order and invoice matching arrangements were appropriate (and in compliance with the Financial Regulations and Contract Standing Orders). We, therefore, found non compliance with Financial Regulations and Contract Standing Orders in the remaining 44 transactions (88%) with a value of £151,981 where there was not a Purchase Order raised on Techone or an invoice received.

The Adult Social Care Team in conjunction with the Health and Social Care Partnership Business Support Team arrange for adult care provision out with the Techone system. The Social Care System holds care provision information and related costs. This involves an approval process where individual care plans are compiled by the Social Worker and approved by an Adult Care Manager, before being uploaded onto Techone for approval and payment. This applied to 42 transactions in the sample where a care plan was found to be in place with a projected total yearly value of c£1.4m. We found a number of weaknesses in the care plan approval and payment process including:

• 1 transaction where no care plan was available;
• 7 care plans did not include details of specific manager approval;
• 2 care plans were approved by a manager who did not have sufficient delegated authority for the projected annual cost of care; and
• Care plans include a projected annual cost to assist with effective budget monitoring. They can be in place for an undetermined length of time, however, we were advised by the Adult Care Team Manager that although care provision is reviewed there was no evidence of further financial approval of the ongoing care costs.

We were content that there was sufficient Adult Social Care monitoring</td></tr>
</table>

contract rates).	of actual spend against budget and this consisted of: detailed monthly management budget reports detailing costs and related care provision, monthly management budget meetings, and quarterly projected budget outturn reports. We found no evidence, however, that budgets are being monitored to ensure they are sufficient prior to individual care financial commitments being approved. The sample was also checked to ensure that where care provider expenditure thresholds were met in line with the Contract Standing Orders that contracts were in place and the rates charged reconciled to agreed contract rates. We were content that 32 transactions (64%) had contracts in place, 3 related to direct payments to client and had related agreements in place, 1 was for emergency short term care that was approved by care management, but for the remaining 14 (28%) transactions there was no evidence provided that they were part of a current contract. From our review of the Care and Support Contract Standing Orders Exception Report (agreed by the Council in February 2021) we found no evidence of monitoring of compliance with the exception report conditions. We have made recommendations that contracts are agreed for care providers that meet Contract Standing Order expenditure thresholds, and that a review should be undertaken to ensure compliance with the Contract Standing Orders exception report. For the 32 transactions that had a contract in place. We found that 10 care rates charged reconciled to contracted rates. For the remaining 22 of the 32 we found that rates being paid were less than the contracted rates.

Appendix 3

Review	Directorate	Assurance
Freedom of Information Requests	Partnership and Performance / All Directorates	**Substantial / Limited Assurance**

Scope	Final Report Executive Summary
The Freedom of Information (FOI) (Scotland) Act 2002 (the Act) gives the public a right of access to recorded information of any age held by Scottish public authorities. Any person who requests information is entitled to receive it within 20 working days. Certain types of information may, however, be regarded as exempt from disclosure, and a refusal of request issued instead to the applicant. This includes: • Personal data; • Commercially sensitive information; • Legal documents and court proceeding records; and • Information which may endanger the health and safety of an individual if disclosed. For a request to be valid under the Act, it must: • be submitted in writing (e.g. letter, email, or online form) or in another permanent form which is capable of being used for subsequent reference (e.g. voice mail message – providing the message is retained); • state the name of the applicant and an address for correspondence; and • clearly describe the information requested. The Act details what enforcements are available to the Scottish Information Commissioner (SIC) if there are any breaches in the Act. The first stage is an 'information notice' where the SIC may give notice in writing requiring information to confirm compliance with the Act. If at this point the SIC is satisfied that the Authority has failed to comply the SIC issue an 'enforcement notice' requiring the Authority to take	Applicants do not have to specifically mention the Act or direct their request to a designated member of staff. All FOI requests are logged onto a database which was designed and built in-house. This system documents the date, time the request was logged, and responses given. There are templates stored in the database which are used depending on the response required. The database also calculates the response deadline and issues reminder emails to the assigned Monitoring Officer. FOI Monitoring Officers are allocated at Service level within each Directorate, who are responsible for opening and closing FOIs on the in-house database system. They also manage the generic mailbox. Investigating Officers are members of staff who have access to the information requested, and are delegated by the Monitoring Officers to provide the appropriate information to them in order to answer the request. The Governance Team consists of two Governance Officers, reporting to the Senior Governance Officer. They provide advice and support to the Services for all FOI matters and also administer the database. All staff consulted during the review were clear about their roles and responsibilities which is reflected in Governance team role profiles, however, there is scope to further improve the role profiles of the Monitoring Officers. From the review of the in-house database and the information generated / recorded once FOI requests are received, we are content that there are robust controls in place to receipt and monitor FOIs. During the period April 2022 to November 2023 the Council received 1,985 FOI requests. Responses to these requests generated an additional 50 reviews of the way in which the request was handled and / or review of the response provided, and 16 appeals to the SIC. There are adequate guidance documents from Scottish Executive, and the Council's own 'Basic Guidance' document to manage the FOI process. We found that staff are complying with the guidance, however, there are no Council specific FOI policies in place; there is sufficient information on FOI requests and how they are treated, however, a lack of Operating Procedures detailing how the Monitoring Officers and Governance team work together, specifically, around the follow up of delayed / unanswered responses. Although staff are complying with the guidance, it was found that there are no procedures detailing actions and responsibilities for following up on outstanding requests. A sample of 48 FOI requests were reviewed to assess compliance with the relevant guidance. All were found to be correctly logged on the database and allocated to the appropriate Monitoring Officer in a timely manner. There is a full audit trail for each request on the system noting time and date of each interaction. There were, however, significant issues highlighted with response times. The testing found 46% of requests were not answered within the statutory time frames. If the number of unanswered requests and reviews are not addressed the Council could receive an enforcement notice from the SIC. We recommend action is taken to improve the number of FOI request and reviews answered within the statutory timeframe of 20 working days to ensure no requests remain unanswered. This could be achieved through additional scrutiny of outstanding requests / reviews on the database, as well as additional reporting by the Governance team to the Senior Leadership Group. The Governance Officer updates the Pentana performance management system with monthly figures on a range of areas, including the number of FOI requests received, and the number of FOI requests for which a response was made on time. Pentana does not have a separate column showing the number of requests not answered with the time frame, however, a simple subtraction of the numbers

steps as specified in the 'enforcement notice' for complying. Failure to comply with both notices mentioned above could result in the SIC writing to the Court of Session resulting in possible financial fines. There have been no decision notices issued for the Council.	received and numbers answered on time does give this figure. No separate reports are issued to the Senior Leadership Group for discussion. We recommend that the monthly figures are distributed and discussed at the Senior Leadership Group, with action taken where required in relation to delayed and no responses. Inconsistencies were also found when reporting quarterly performance to the Scottish Information Commissioner (SIC) for publication on their website, compared to what was recorded on the database. Training is available to staff, albeit this is not mandatory for staff with only 15 employees completing the eLearning module in the year to March 2023. We also recommend that FOI training is made mandatory to all staff.

Appendix 3

<table>
<tr><th>Review</th><th>Directorate</th><th>Assurance</th></tr>
<tr><td>Use of Purchase Cards</td><td>Partnership and Performance / All Directorates</td><td>Limited Assurance</td></tr>
<tr><th>Scope</th><th colspan="2">Final Report Executive Summary</th></tr>
<tr><td>Purchase cards represent another payment method that is available to reimburse the Council’s suppliers. As such, there must be compliance with the Council’s Standing Orders, Financial Regulations, and Procurement Policy.

They can be used as an alternative to petty cash, for online purchases, and for urgent expenditure that needs to be incurred outwith normal office hours. Barclays Bank (Barclaycard) provide Clackmannanshire Council’s purchase cards under a UK wide Crown Commercial Service agreement. The expenditure that is incurred from using the purchase cards is recorded and monitored on the Barclaycard Centre Suite system that is administered by Barclays Bank. A monthly statement is also received from Barclaycard.

Barclaycard statements are issued to all purchase cardholders who have incurred transactions during the statement period. These transactions are then authorised by the cardholder’s line manager by matching the statements to a transaction log. This enables the monitoring and review of the purchase card transactions that have been incurred by those who do not have access to the Barclaycard Centre Suite system.

Responsibility for managing / administering the Council’s purchase cards is delegated to the Procurement Manager within the Partnership and Performance Directorate. Budget holders are responsible for managing expenditure.</td><td colspan="2">We were content that:
• all involved are aware of their responsibilities regarding purchase cards;
• procedures and guidance have been developed in relation to the purchase cards;
• purchase cards have been issued on an individual basis instead of on a team basis;
• the Procurement Manager maintains the list of purchase cardholders. Any required updates (for example, as a result of cardholders leaving the Council) are informed via: a monthly ‘starters’ and ‘leavers’ report that is provided by the Human Resources section (HR) to the Procurement Manager; completed Change of Information forms; notification from IT; and / or direct contact from cardholders;
• reports are generated each month that show when the purchase cards were last used (to identify any that are not being used and could be deactivated);
• the single transaction limit for each purchase card does not exceed the purchase order limit for that cardholder; and
• arrangements are in place for paying the monthly statement balance to Barclaycard and for ensuring that cardholders provide a ledger code for each transaction to enable their upload to TechOne and subsequent payment.

We identified many significant weaknesses in the existing framework of control. We have, therefore, made the following recommendations:
• Contingency arrangements should be established to provide business continuity in the absence of the Procurement Manager.
• The Purchase Card Policy and Procedures Guide should provide clarity on who can approve purchase card applications.
• The authorisation limits for each cardholder should be reviewed on a quarterly basis to ensure that they remain appropriate.
• To prevent any unauthorised expenditure, checks should be made to ensure that the authorisation limits revert to their normal amounts after any temporary change.
• To prevent the circumvention of any controls that are in place, line managers should be informed of any changes to authorisation limits.
• To ensure compliance with the Purchase Card Policy and Procedures Guide:
➢ Three occasions where a cardholder’s single transaction limit has been exceeded should be investigated.
➢ All cardholders should be reminded each month of the requirement for them to promptly provide supporting documentation for their purchase card transactions (with consideration given to blocking cards until this documentation is provided).
➢ Travel and subsistence expenses should be challenged by line managers.
➢ Purchase card payments to prohibited suppliers should be investigated.
• To prevent inappropriate use of the purchase cards, consideration should be given to creating a list of approved suppliers for purchase card transactions.
• To ensure that expenditure has been accurately recorded, reconciliations between the ledger and the bank account for transactions should be conducted each month.
• To ensure that accurate transactions data is available and is being reported, the discrepancies between the data provided by the Procurement Manager and what has been reported on the Council’s website should be investigated.
• To ensure that the correct rebate amounts are being received from Barclaycard, the following points relating to purchase card rebates should be addressed:
➢ The reasons for discrepancies in the rebate amounts should be determined.
➢ The rebate % for annual expenditure above £250k should be ascertained.
➢ The reasons for not qualifying for a rebate in 2019/20 should be determined.
➢ Maintain records of all expected and actual rebates received for each year.
➢ The 2021/22 purchase card rebate should be confirmed with Barclaycard.
➢ Evidence (in the form of transaction reports) to be provided confirming that the rebate income for each year has been correctly coded to the ledger.</td></tr>
</table>

Appendix 3

Review	Directorate	Assurance
Overtime Arrangements	Partnership and Performance / All Directorates	**No Assurance**

Scope

Over a 12 month period from 1 December 2022 to 30 November 2023 overtime[7] payments with a total value of £1,609,993 were paid through iTrent.[8] The overtime cost over the same period per Directorate is detailed at **Table 1** below. For context basic pay paid over the period totalled c£72m.

Table 1: Overtime Costs per Directorate

Directorate / Service	Payments	Cost (£)
Place	3,507	1,237,430
Health and Social Care Partnership	910	169,962
People	753	166,236
Partnership and Performance	149	36,365
Total	**5,319**	**£1,609,993**

The Council's Overtime Authorisation, Policy, Principles, and Protocols (known as the OT Protocols) was developed in 2016 and last updated in 2018. These Protocols set out the Council's approach to approved overtime working and provides guidance to managers responsible for authorising overtime, payments, and time off in lieu (TOIL) entitlements.

There are two methods of processing overtime claims on iTrent. Direct approval of claims by a Reporting Manager on iTrent; and Payroll Section input of an overtime claims spreadsheet provided by Services. The main reason for Payroll Section input of overtime claims is that some employees do not have access to iTrent.

We selected a sample of 58 employees and 122 related overtime payments made between 1 December 2022 and 30 November 2023. Our sample included employees from all Directorates and was proportionally representative to overall payments per Directorate over the period. For example, the Place Directorate had the highest number and value of overtime payments and so had the highest number of employees and related payments in the sample for review.

The sample of overtime payments was reviewed to ensure compliance with the requirements of the

Final Report Executive Summary

At corporate level we found overtime Policies[9] were in place with ad hoc training provided to overtime approving managers. At the time of the review, high level management information was provided to Senior Management detailing costs of overtime per Directorate, however, we identified weaknesses and made recommendations in relation to the following:

- Overtime Policies have not been reviewed in over 4 years.
- There was no specific training or operational guidance for overtime approving managers.
- Overtime paid figures per Directorate are not regularly reported to the Extended Senior Leadership Group for review to ensure overtime levels are appropriate and cost effective.

Through testing a sample of overtime payments across all Directorates we identified non compliance with overtime related policies. These issues are summarised in **Table 2** below.

Table 2: Directorate Significant Issues

Directorate / Service	Manager Approval	Audit Trail	Claim Errors	Over Payments
Place	**No**	**No**	**Yes**	**Yes**
Health and Social Care Partnership	**No**	**No**	**Yes**	**Yes**
People	**No**	**No**	**Yes**	**Yes**
Partnership and Performance	**No**	**No**	**N/A**	**N/A**

We were unable to identify any instances within our sample of the Health and Social Care Partnership, or the Place and People Directorates overtime payments that were fully compliant with the Financial Regulations and the OT Protocols. The Overtime Policies are not being applied and overtime arrangements are not being effectively managed.

The following significant issues which require to be investigated were identified within the Health and Social Care Partnership, and the Place and People Directorates:

- There was no evidence that overtime was approved in advance.
- Lack of an audit trail evidencing specific overtime hours worked and related duties undertaken.
- Approving managers did not have sufficient delegated authority to approve overtime claims.
- No evidence of monitoring of overtime levels and compliance with Working Time Regulations Guidance including employee "opt outs"[10].

[7] Overtime Transaction Types: Additional Hours (plain time), Overtime Hours (time and a half), and Overtime Hours (double time).

[8] iTrent is the Council's Payroll and Employee Management self service system.

[9] The Financial Regulations (s13), Overtime, Authorisation, Policy Principles and OT Protocols, and Working Time Regulations Guidance.

[10] Employees (and workers) can agree to work more than the 48 hours weekly maximum by submitting a signed "Opt-out agreement".

OT Protocols including:

- overtime should only be authorised when it is necessary to provide or continue to provide a statutory service or where an identified risk to the public or staff must be managed;
- where appropriate overtime is approved in advance and any associated claims are approved in line with the Council's delegated authorities;
- there is a record of actual overtime hours and work undertaken and there are management checks to ensure the time and work is appropriate;
- management have ensured that Working Time Regulations apply to employees claiming overtime. For example, employees should not work more than 48 hours per week; and
- overtime claims are accurately recorded and processed. For example, plain time is paid for additional hours up to 37 hours per week.

This audit assessed the robustness of the overtime arrangements internal control framework across the Council including related roles and responsibilities and policies and procedures, and considered the extent to which these are consistently applied in practice.

- Errors identified in our sample of overtime claims resulted in potential overpayments which need to be investigated. The total potential overpayments identified for one month per employee in the sample, per Directorate is detailed at **Table 3** below:

Table 3: Sample of Potential Overpayments

Directorate / Service	Employees	Payments	Over Payments Value (£)	% Sample Value
Place	35	73	1,673	2.4
Health and Social Care Partnership	13	30	618	5.3
People	7	15	217	1.4
Partnership and Performance	3	4	-	-
Total	**58**	**122**	**2,508**	**2.5**

The sample of Place overpayment claims contained continuous hours in excess of 6 hours with no breaks (numerous examples across the sample in excess of 12 daily hours claimed, with the highest claim in the sample having 19 daily continuous hours). The approving managers advised that this practice is common in Property and Building Maintenance.

Given the high number of overtime hours being claimed on a daily basis there is a potential risk of fraud, as it is not possible for individuals to work this amount of hours in one day. This also breaches Financial Regulations (Section 13.4 and Section 3.14): claims are not excessive, and payment conforms with approved terms and conditions for the employee and has implications for non-compliance with Working Time Regulations. For example: a 30 minute break should be taken for every 6 hours of work, a daily rest period of 11 consecutive, uninterrupted hours, and working no more than 48 hours in each working week.

Sample testing also confirmed that overtime related policies had not been fully applied within the Partnership and Performance Directorate, including:

- Not all payments had evidence that overtime was approved in advance.
- Lack of an audit trail evidencing specific overtime hours worked and related duties undertaken.
- No evidence of monitoring of overtime levels and compliance with Working Time Regulations Guidance including employee "opt outs".

Through sample testing we also identified instances where overtime is ongoing (within the Health and Social Care Partnership, as well as Place and People Directorates) and in these cases, we recommend that section management should review employee resources to ensure they are sufficient in order to minimise the level of overtime required.

In the areas where the Policy and Procedures are breached, there is a significant risk that overtime is not being effectively managed, potentially resulting in significantly greater costs.