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DATE: 6 November 2018

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Wednesday 14 November 2018

QUESTIONS ON THE INFORMATION BRIEFING

The Briefing comprises:

- 1 REVIEW OF ADULT SAFEGUARDING--2017-2018 (Pages 3 - 12)**
- 2 REVIEW OF CONTRACT FOR ADULT MENTAL HEALTH (Pages 13 - 40)**
- 3 REVIEW OF CREDITORS FOR 2017-2018 (Pages 41 - 52)**
- 4 REVIEW OF EDGEBURY PRIMARY SCHOOL AUDIT FOR 2018-2019 (Pages 53 - 62)**
- 5 REVIEW OF HOME TUITION FOR 2017-2018 (Pages 63 - 104)**
- 6 REVIEW OF IT PROJECT MANAGEMENT FOR 2017-2018 (Pages 105 - 120)**
- 7 PCNS AUDIT FOR 2017-2018 (Pages 121 - 136)**
- 8 FOLLOW UP INTERNAL AUDIT REVIEW OF REABLEMENT FOR 2017-2018 (Pages 137 - 160)**
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- 10 REVIEW OF VEHICLE CROSSOVERS AUDIT FOR 2017-2018 (Pages 177 - 198)**
- 11 REVIEW OF CONTINUING HEALTH CARE FUNDING FOR 2017-2018 (Pages 199 - 218)**
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- 16 REVIEW OF LEAVING CARE AUDIT FOR 2017-2018 (Pages 295 - 322)
- 17 REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-2017 (Pages 323 - 356)
- 18 REVIEW OF ST OLAVE'S SCHOOL AUDIT FOR 2017-2018 (Pages 357 - 392)
- 19 INTERNAL AUDIT REVIEW OF THE TROUBLED FAMILIES CLAIM FOR THE PERIOD 1ST APRIL 2018 TO 30TH SEPTEMBER 2018 (Pages 393 - 394)
- 20 REVIEW OF WINTER MAINTENANCE SERVICE AUDIT FOR 2018-2019 (Pages 395 - 404)

Members and Co-opted Members have been provided with advanced copies of the briefing via email. The briefing is also available on the Council website at the following link:

<http://cds.bromley.gov.uk/ieListMeetings.aspx?CId=559&Year=0>

Printed copies of the briefing are available upon request by contacting Steve Wood on 020 8313 4316 or by e-mail at stephen.wood@bromley.gov.uk.

Copies of the documents referred to above can be obtained from
www.bromley.gov.uk/meetings

FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF ADULT'S SAFEGUARDING FOR 2017-18

Issued to: Stephen John, Director Adult Social Care
Tricia Wennell, Head of Service Assessment and Care Management

Cc: Ade Adetosoye, Deputy Chief Executive, Executive Director, ECHS (final only)
David Bradshaw, Head of Finance ECHS
Naheed Chaudhry, Assistant Director Strategy Performance and Business Support
Dirk Holzhausen, Consultant Lead Practitioner for Safeguarding ECHS
Doreen Williams, Quality Assurance Officer ECHS

Prepared by: Senior Internal Auditor (Mazars LLP)

Date of Issue: 27th June 2018

Report No.: ECHS/06/2017/AU

REVIEW OF ADULT'S SAFEGUARDING FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Adult's Safeguarding for 2017/18. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 22 February 2018.
4. A process is in place for Adult's Safeguarding. Between 1st April 2016 and 1st January 2018 there have been 339 Adult's Safeguarding cases opened from which we selected our sample for audit testing.

AUDIT SCOPE

5. The scope of the audit is detailed in the Terms of Reference.

AUDIT OPINION

6. Overall, the conclusion of this audit was that substantial assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

7. Controls noted to be in place and working well based on audit work conducted included:
 - Policies and procedures were in place and available to staff;
 - Staff completed regular training sessions related to Adult's Safeguarding;
 - Referrals were received and recorded on the case management system in a timely manner;
 - Strategy discussions and enquiries were completed and recorded on the case management system in a complete manner;
 - Case conferences/plans and review meetings were completed and, where required, a protection plan is developed;

REVIEW OF ADULT'S SAFEGUARDING FOR 2017-18

- Regular review meetings took place to monitor the Adult Safeguarding Cases;
 - The safeguarding process was closed and approved appropriately where the safeguarding concern had been removed; and
 - Management information was produced and reviewed on a weekly basis.
8. However, we would like to bring to management attention the following issues:
- Staff were not all following the same practices with regards to use of the case management system.
 - Strategy discussions were not completed within five working days of receiving the referral for four of the sample of 10 cases tested; plan and review meetings/case conferences did not take place within the required 20 days for two of the sample of 10 cases tested.
 - The safeguarding cases were not being closed in a timely manner, i.e. in line with the procedural guidance.

SIGNIFICANT FINDINGS (PRIORITY 1)

9. There were no priority one recommendations raised as part of this audit.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

10. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

11. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1	<p><u>Use of the Case Management System</u></p> <p>Whilst undertaking testing of a sample of 10 Adults Safeguarding cases, it was identified that staff members were using inconsistent document names. In addition, documentation relating to Adult Safeguarding cases was stored in inconsistent locations on the case management system.</p> <p>As a result, locating the documentation for testing took more time, however, all the required documentation was located.</p>	<p>Where staff members store documentation and information in inconsistent locations and use inconsistent document names, there is a risk that this information will not be easily accessible if required. This could result in duplication of work or work not being completed.</p>	<p>Staff should be reminded and, if appropriate, further training provided to ensure that staff use consistent document names and locations to save documentation.</p> <p>The database system should also be reviewed to ensure that it is effectively maintained and any old forms which should not be used anymore, are removed from the system</p> <p>(Priority 3)</p>

REVIEW OF ADULT’S SAFEGUARDING FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
2	<p><u>Timeliness of Strategy Discussions and Plan and Review Meetings</u></p> <p>In accordance with the PAN London Procedures and Bromley Local Procedures, a strategy discussion should be completed within five working days of receiving the referral.</p> <p>For the sample of 10 referrals selected, it was identified that in four cases the strategy discussion did not take place within this target. The longest delay in time was 49 days for one case. No rationale was provided as to the reason for the delays.</p> <p>As a result of the safeguarding enquiry, a plan and review meeting/case conference will be completed to discuss the enquiry and the safeguarding case. The plan and review meeting/case conference should be completed within 20 days of the enquiry report, according to the PAN London Procedures and the Bromley Local Procedures.</p> <p>For a sample of 10 referrals, we identified two cases where the plan and review meetings were not completed within 20 working days of the enquiry report. For one of these cases the delay was due to it being police led and therefore accepted as outside of the control of Bromley officers.</p> <p>However for the other case the Enquiry Report was completed on 23/03/2017 and the plan and review meeting took place on the 08/06/2017.</p>	<p>Where strategy discussions and/or plan and review meetings do not take place in a timely manner, there is a risk that staff are not being compliant with local procedures. There is also a risk that the safeguarding concern may escalate which could lead to reputational damage for the Council.</p>	<p>Staff should be reminded within supervision or team meetings to complete strategy discussions and/or plan and review meetings in line with the procedures and timeframes.</p> <p>The Department should consider sample checking cases to ensure that the required timescales are adhered to.</p> <p>Where timeframes cannot be met, the reasoning should be documented on the case management system.</p> <p>(Priority 2)</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
3	<p><u>Timeliness of Safeguarding Closure</u></p> <p>In accordance with the PAN London procedures, it is suggested that closure of Safeguarding cases should be undertaken immediately following the removal of risks. This has been adapted at the London Borough of Bromley, with the local procedures detailing that the review and closure should be within 30 days of any final actions.</p> <p>For a sample of 10 safeguarding cases tested, it was identified that five had not been closed within the 30 days of final actions target.</p>	<p>Where safeguarding cases are not closed in a timely manner, there is a risk that performance figures will be inaccurate and unnecessary resources may be expended on cases that should be closed.</p>	<p>Staff should be reminded to close safeguarding cases on the case management system in a timely manner and where this cannot be done, the reasoning should be documented on the case management system.</p> <p>Management should consider reviewing cases that are due for closure to confirm that these are closed in a timely manner.</p> <p>(Priority 2)</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>Staff should be reminded and, if appropriate, further training provided to ensure that staff use consistent document names and locations to save documentation.</p> <p>The database system should also be reviewed to ensure that it is effectively maintained and any old forms which should not be used anymore are removed from the system</p>	3	<p>All staff to receive annual training and refresher training.</p> <p>Meeting with the IT provider to discuss the database system has been diarised.</p>	<p>Head of Service Assessment and Care Management /Consultant Lead Practitioner for Safeguarding ECHS</p> <p>Director of Adult Social Care</p>	<p>Ongoing</p> <p>June 2019</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p>Staff should be reminded within supervision or team meetings to complete strategy discussions and/or plan and review meetings in line with the procedures and timeframes.</p> <p>The Department should consider sample checking cases to ensure that the required timescales are adhered to.</p> <p>Where timeframes cannot be met, the reasoning should be documented on the case management system.</p>	2	<p>Staff reminded through 1:1 meetings, CSMG of the supervision and case management responsibilities.</p> <p>Quality Assurance sample and quality assure through these checks.</p>	<p>Director of Adult Social Care</p> <p>Quality Assurance Officer ECHS</p>	<p>July 2018</p> <p>July 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p>Staff should be reminded to close safeguarding cases on the case management system in a timely manner and where this cannot be done, the reasoning should be documented on the case management system.</p> <p>Management should consider reviewing cases that are due for closure, to confirm that these are closed in a timely manner.</p>	2	Simple cases closed as soon as possible following referral. Some protracted cases are routinely reviewed.	<p>Director of Adult Social Care</p> <p>Head of Service, Assessment and Care Management</p>	<p>July 2018</p> <p>July 2018</p>

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

Issued to: Stephen John - Director of Adult Social Care
Paul Feven – Interim Director Programmes
Laurence Downes – Strategic Commissioning Manager ECHS
David Bradshaw - Head of Finance ECHS
Naheed Chaudhry - Assistant Director Strategy Performance and Business Support
Ade Adetosoye - Deputy Chief Executive, Executive Director ECHS (final only)

Prepared by: Senior Internal Audit Manager
Principal Auditor

Date of Issue: 29th May 2018

Report No.: ECHS/08/2017/AU

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based review of the arrangements in place for monitoring the agreement with the Trust for the provision of care management for Mental Health for 2017/18.
2. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
3. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
4. The original scope of the audit was outlined in the Terms of Reference issued on 3 January 2018. This audit is concerned with the contract management and monitoring of the Section 31 Agreement with the Trust.
5. The Council and the Trust have a 20 year Section 31 Agreement for Mental Health functions that started in 2004. For 2017-18 £1,407,910 was paid to the pooled fund for the cost of care management. The pooled fund is managed by the Trust. This payment represents approximately 20% of expenditure for the Mental Health budget, the majority of the budget represents commissioned services for Mental Health clients and is paid directly by Bromley. The value of the services commissioned via the Section 31 Agreement are £5m, offset by approximately £600k of client contributions and contributions from Health.

AUDIT SCOPE

6. The scope of the audit is detailed in the Terms of Reference.

AUDIT OPINION

7. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls for the management and monitoring of the section 31 agreement with the Trust. Definitions of the audit opinions can be found in Appendix C.

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

MANAGEMENT SUMMARY

8. The audit considered the role of two divisions of the Department, namely Adult Social Care and Programmes. At the start of the audit it was difficult to engage with a key officer assigned to manage or monitor the agreement. The first meeting was held with the Strategic Commissioner, who had historically been involved with the Mental Health agreement and was able to explain the changes of personnel since 2004 and give an update on the current roles and responsibilities. It was established that the Mental Health and Substance Misuse (MH&SM) Commissioner was a full time post, part funded with CCG, up to July 2015 when the officer elected to reduce to 18 hours per week. The MH&SM Commissioner left the Authority in May 2016 and the post was filled by an agency worker on a part time basis until June 2017. The establishment list for November 2017 shows that the MH&SM Commissioner post (post number 3275) was to be deleted. The MH&SM Commissioner role has not been effectively filled and the management and monitoring of the agreement lapsed. It is acknowledged that there has been a significant change in personnel, restructures and vacancies in this area that has contributed to this position. For 2016/17 Mental Health was part of the Commissioning Division and the Lead Officer was the designated budget holder. The budget transferred to the Director of Adult Social Care for 2017-18. It was also noted that the Interim Director of Programmes joined the Authority in August 2017 and the previous Director, who had had responsibility for Mental Health, left in June 2017.
9. At a meeting with the Directors of Adult Social Care and Programmes and Internal Audit on the 29 January 2018 it was agreed that the Section 31 agreement with the Trust was in urgent need of revision and update. The Interim Head of Programme Design had recently been appointed and the Director of Programmes had identified the Mental Health agreement as a priority. The Director of Adult Social Care confirmed that a review was underway to consider resources; the need for a permanent Business Support role, the transfer of funding to appoint a Head of Service role employed by Bromley to be the client officer and to restructure and combine Learning Disabilities and Mental Health.
10. For the Section 31 Agreement with the provider, controls noted to be in place included:
 - The agreement between the Council and the Trust for the exercise of mental health functions was signed by the Council's Head of Legal and Electoral Services;
 - The agreement details the requirement to comply with all statutory requirements;
 - The functions of the Council and the provider are stated in the agreement;
 - The agreement details the requirement for confidentiality and compliance with the Data Protection Act 1998;
 - The financial arrangements for the pooled fund are defined in the agreement between the Council and the Trust; and
 - The agreement details the procedure for dealing with overspends and underspends.

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

11. However, examination of the Section 31 agreement has identified the following issues that need to be addressed by management:-
 - The agreement between the Council and the Trust has not been reviewed or varied since commencement 14 years ago;
 - The Department could not evidence monitoring of the effectiveness of the agreement in line with performance measures.
 - Roles and responsibilities that relate to the agreement have not been clearly defined or formally assigned; Oversight responsibility for the overall leadership for Mental Health services in Bromley, including overseeing the S.31 agreement is not clearly defined or assigned;
 - Service agreement reviews had not been completed within agreed timescales.
 - The Department could not evidence quarterly performance management reports as detailed in the agreement.
 - Budget monitoring reports for the pooled fund are not produced nor submitted as stated in the agreement;
12. As defined in the Terms of Reference, this audit only considered the Section 31 agreement. However, during the course of the audit there have been issues identified that impact on the processes and financial management of the commissioned services and should be considered by management. Reference has been made to specific examples in the relevant sections and relate to roles and responsibilities and placement reviews. It should be noted that no detailed audit testing of client data and service agreements has been undertaken at present.
13. It is acknowledged that there have been several changes of personnel and the Department are again considering a restructure; however, the procedure to authorise, upload care packages to the authority's case management system, reconcile information to the care management system used by the Trust and review of service agreements requires urgent attention and ownership.

SIGNIFICANT FINDINGS (PRIORITY 1)

14. There are 5 significant findings relating to:-
 - Variation/s to contract**
15. The Council has a Section 31 of the Health Act 1999 agreement in place with the Trust, which commenced 1 April 2004 for a period of 20 years. Section 42 of the agreement details the conditions for variation. The agreement had been in place for 14 years without any evidence of review or variation to ensure it is relevant and fit for purpose. There was no evidence of any change control documents issued for the agreement. The agreement refers to the Data Protection Act 1998 with regard to

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

personal data held about seconded staff but does not detail how personal client data will be handled. A data sharing agreement was not evidenced.

Performance Measures and Monitoring

16. The Section 31 agreement requires the parties to continually monitor the effectiveness of the arrangements in line with the performance measures. At the time of the audit it was established that the performance measures specified in the agreement were obsolete and out of date and there were no defined monitoring arrangements in place.
17. The agreement requires monthly performance meetings to be held between the Trust and the Council to monitor service volumes, service quality and financial performance. It was established that monthly performance monitoring meetings were not being held between the Trust and the Council.
18. Schedule 15 of the agreement requires the parties to establish a Mental Health Board to provide the overall leadership for mental health services in Bromley, including overseeing the S31 agreement. It was established that there is presently no Mental Health Board in place.
19. The Council is required to perform annual reviews no later than three months after the end of each financial year of the operation of the agreement however there was no evidence that these reviews had been performed. Not less than every three years a full review of the arrangements taking into account the Council's obligations in respect of the best value duty and monitoring arrangements should be undertaken and reported formally. No formal report of the review or outcome was evidenced.
20. Section 14.6 of the agreement requires the Trust to agree performance management and a supervisory framework for all staff with the Council in relation to the arrangements. This was not clearly defined or evidenced as agreed with the Trust.

Roles and Responsibilities

21. The role of the Council's Authorised Officer (CAO) who is empowered to act on behalf of the Council in relation to the Agreement is not formally assigned. The operational responsibility for the Agreement is not defined or formally assigned.
22. The Business Support Officer (BSO) is a key officer in this process and is the link between the Trust care management and Bromley. The BSO receives all panel decisions and uploads care packages to the Authority's case management system to

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

create the service agreement and thus payment. As there is no connection between the Trust's cases management system and Bromley's, all supporting documentation and communication is via e-mail. At the time of the audit the BSO had no line management.

23. In an interview with the Service Accountant concerns were raised over the upload of service agreements to the Authority's case management system, ending services in a timely manner, accuracy of information and possible lack of reviews and changes. In an interview with the Strategic Commissioner the need to reconcile the two case management systems was discussed and agreed that this function is not currently undertaken. The BSO evidenced two recent examples whereby the Authority were invoiced for services in respect of clients with no current service agreement for Mental Health. With no reconciliation the role of the BSO is critical.
24. The BSO is a temporary appointment through the Authority's contracted agency provider. The funding for this post expired on 31 March 2018 and there were no plans to replace this officer. As at the 20th March there were no arrangements in place for the handover of the BSO role and responsibilities.

Service Agreement Reviews

25. Following Mental Health Services Practice Review Group procedures, all clients where decisions have been made to provide services are required to be reviewed within 3 and 6 months.
26. At the audit meeting on the 20/3/18 the BSO stated that there were approximately 200 Mental Health clients spread across 4 teams (3 Mental Health Teams and 1 Older persons team) but that the service agreement reviews for these were not being conducted, with some up to 4 years overdue. Examination of the 'Mental Health PRG Funding Agreement 2016 to 2017' spreadsheet provided confirmed that service reviews from July 2016 were outstanding and overdue.
27. The BSO confirmed that the Strategic Commissioner had engaged 2 temporary care managers in December 2017 to review all cases and identify any potential savings. At the end of audit meeting on the 18/4/18 the Director suggested that all outstanding reviews had now been completed.
28. At a meeting with the BSO and the Strategic Commissioner on the 24/4/18 the current position for reviews was discussed and evidenced. From the summary sheet started in week commencing 7/3/18 and regularly updated from panel information and decision sheets, the outstanding reviews are as follows:-

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

Mental Health Team	Review outstanding > 12 months	Review outstanding for between 6 and 12months	Review completed within 3-6 months	Total
Bromley East	27	2	13	42
Bromley West	48	17	34	99
Older People	18	5	8	31
CMHRES	2	2	1	5
Total	95	26	56	177

The thirty cases with a weekly care package exceeding £900 initially identified for review are not included in the table above. To achieve a rapid turn round and maximise potential savings, cases with no potential to reduce or change were abandoned and not fully reviewed by the temporary care managers engaged by Bromley. Excluding the >£900 p.w. cases, the Authority's case management system is showing an overdue review exceeding 12 months for 53% of clients.

Management Reporting

29. The agreement requires the Trust to submit a quarterly performance management report to the Bromley Joint Mental Health Board. This should include a:
- The Trust's Quality Governance Report (QGR);
 - The Trust's Bromley Management Report (BOMR);
 - Service and Financial Framework Report (SaFFR);
 - Referrals, Assessments and Packages of care (RAP);
 - Performance Assessment Framework (PAF);
 - Trust Start ratings;

REVIEW OF CONTRACT MANAGEMENT - ADULT MENTAL HEALTH FOR 2017-18

- Performance Improvement Plan; and
- Delivery Improvement Statement (DIS).

30. At the time of the audit, Internal Audit noted that a Quarterly Performance Management Report was not being prepared as required.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

31. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

32. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1	<p><u>Variation to Contract</u></p> <p>The Council has a Section 31 of the Health Act 1999 agreement in place with the Trust, which commenced 1 April 2004 for a period of 20 years. Section 42 of the agreement details the conditions for variation.</p> <p>Internal Audit noted that at the time of the audit, the agreement had been in place for 14 years without any evidence of review or variation to ensure it is relevant and fit for purpose. There was no evidence of any change control documents issued for the agreement.</p> <p>Examination of the agreement also identified that, while this details that both the Council and the Trust shall deal with any personal data held about Seconded Staff in accordance with the Data Protection Act 1998, this does not detail how personal client data will be dealt with. A data sharing agreement was not evidenced.</p>	<p>Where the Council does not review its agreements and agreements regularly, there is a risk that terms and conditions are obsolete, out of date and do not reflect current legislation.</p>	<p>The Council should critically review its agreement with the Trust for the exercise of Mental Health functions.</p> <p>Any significant variation to agreement must be supported by a change control document.</p> <p>Priority 1</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
2	<p><u>Performance Measures and Monitoring</u></p> <p>The Section 31 agreement requires the parties to continually monitor the effectiveness of the arrangements in line with the performance measures.</p> <p>At the time of the audit, it was established that:</p> <ul style="list-style-type: none"> the performance measures specified in the agreement between the Council and the Trust were obsolete and out of date. there were no defined monitoring arrangements in place <p>The agreement requires monthly performance meetings to be held between the Trust and the Council to monitor service volumes, service quality and financial performance. It was established that monthly performance monitoring meetings were not being held between the Trust and the Council. It is acknowledged that a representative from the Trust attends monthly service meetings at the Council; however, operational issues are discussed at these meetings and not performance.</p> <p>Schedule 15 of the agreement requires the parties to establish a Mental Health Board to provide the overall leadership for mental health services in Bromley, including overseeing the S31 agreement. It was established that there is presently no Mental Health Board in place.</p>	<p>Where performance measures are not clearly defined, monitored or reported, there is a risk that the Council is unaware of the agreement performance leading to a failure of the Council to provide an effective service.</p> <p>Where reviews are not performed as required, there is a risk that the Council is unaware of relevant issues, which then in turn cannot be corrected promptly.</p> <p>Poor performance may not be identified, recorded or monitored resulting in failure of the service.</p>	<p>The performance measures for the arrangement should be clearly defined and agreed by the parties. These should be regularly reported on and monitored.</p> <p>Any substitution for performance meetings should be formally recognised as such and the minutes evidence attendance of the Trust’s representatives and discussion of issues arising from delivering the agreement.</p> <p>Similarly any replacement to the Mental Health Board should be formally agreed to meet the terms of the Section 31 agreement.</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
2. Cont	<p>The Council is required to perform annual reviews no later than three months after the end of each financial year of the operation of the agreement including in relation to the arrangements:</p> <ul style="list-style-type: none"> • An evaluation of performance against agreed performance measures targets and priorities; • A review of the targets and priorities for the forthcoming year; • A review of the quality of service delivery; • A report of service changes proposed including staff resources; • A report of shared learning and opportunities for joint training; • An evaluation of any statistics or information required to be kept by the Department of Health from time to time; and • A review of the statutory functions of each Party which have been carried out by the other Party using the flexibilities in Section 31 of the Health Act 1999. 		<p>The Council must consider and prioritise performance reviews as detailed in the agreement and ensure that these are undertaken within the time frame specified in the agreement.</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
2. Cont	<p>The Council is also required to not less than every three years carry out a full review of the arrangements taking into account the Council's obligations in respect of the best value duty and monitoring arrangements. A formal report should be prepared to record the outcome of the review.</p> <p>At the time of the audit, the required reviews were not evidenced as being performed.</p> <p>Section 14.6 of the agreement requires the Trust to agree performance management and a supervisory framework for all staff with the Council in relation to the arrangements. This was not clearly defined or evidenced as agreed with the Trust.</p>		<p>The review of the arrangements should be reported formally.</p> <p>Performance management and a supervisory framework for all staff with the Council in relation to the arrangements should be clearly defined and evidenced as agreed with the Trust.</p> <p>Priority 1</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
3	<p><u>Roles and Responsibilities</u></p> <p>The role of the Council's Authorised Officer (CAO) who is empowered to act on behalf of the Council in relation to the Agreement is not formally assigned, although it was established that an appointment was being considered. The operational responsibility for the Agreement is not defined or formally assigned.</p> <p>In an interview with the Strategic Commissioner, Client Resources (ECHS) concerns were raised over the authorisation process for Mental Health packages. The Business Support Officer (BSO) is a key officer in this process and is the link between the Trust's care management and Bromley. The BSO receives all panel decisions and uploads care packages to the Authority's case management system to create the service agreement and thus payment. As there is no connection between the Trust's case management system and Bromley's all supporting documentation and communication is via e-mail. At the time of the audit the BSO had no line management.</p> <p>In interview with the Service Accountant concerns were raised over the upload of service agreements to the case management system, ending services in a timely manner, accuracy of information and possible lack of reviews and changes.</p>	<p>Where the roles and responsibilities that relate to the agreement have not been clearly defined or formally assigned, there is a risk that vital agreement management tasks are not performed or a lack of accountability.</p> <p>Where the responsibility for oversight is not clearly assigned, there is a risk of failure of the Service.</p>	<p>Roles and responsibilities should be clearly defined for officers involved in the Adult Mental Health agreement; including the Agreement Manager with responsibilities for performance monitoring and reporting.</p> <p>The oversight responsibility to provide the overall leadership for Mental Health services in Bromley, including overseeing the S.31 agreement should be clearly defined and assigned</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

APPENDIX A

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
3. Cont	<p>In interview with the Strategic Commissioner the need to reconcile the two case management systems was discussed and agreed that this function is not currently undertaken. With no reconciliation the role of the BSO is critical.</p> <p>No audit testing on client data or service agreements has been undertaken at this time however the weakness in process was supported by a recent e-mail trail evidenced by the BSO whereby for two separate instances the Council was being invoiced for care provided to clients, but neither client was a Mental Health service user on the case management system and there was no record of these cases going to panel.</p> <p>The BSO is a temporary appointment through the Authority's contracted agency provider. The funding for this post expired on 31 March 2018 and there were no plans to replace this officer. At the time of meeting with the BSO (20 March 2018) there were no arrangements in place for the handover of his role.</p>		<p>The role of the BSO should be defined and procedure notes developed to ensure continuity of service delivery. The BSO should be included in a Bromley Team and given clear lines of report.</p> <p>Priority 1</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
4	<p><u>Service Agreement reviews</u></p> <p>Following Mental Health Services Practice Review Group procedures, all clients where decisions have been made to provide services are required to be reviewed within 3 and 6 months.</p> <p>At the audit meeting 20/3/18 the BSO stated that there were approximately 200 Mental Health clients spread across 4 teams (3 Mental Health Teams and 1 Older persons team) but that the service agreement reviews for these were not being conducted, with some up to 4 years overdue. Examination of the 'Mental Health PRG Funding Agreement 2016 to 2017' spreadsheet provided confirmed that service reviews from July 2016 were outstanding and overdue.</p> <p>The Business Support Officer confirmed that the Strategic Commissioner had engaged 2 temporary care managers in December 2017 to review all cases and identify any potential savings. At the end of audit meeting on the 18/4/18 the Director suggested that all outstanding reviews had now been completed.</p> <p>At a meeting with the BSO and the Strategic Commissioner on the 24/4/18 the current position for reviews was discussed and evidenced. From the summary spreadsheet started in week commencing 7/3/18 and regularly updated from panel information and decision sheets, the outstanding reviews are as follows:-</p>	<p>There is a risk that client needs are not being appropriately met or that services are being unnecessarily provided.</p>	<p>Ensure that all service agreement reviews are conducted for all clients in a timely manner and in line with agreed procedures.</p> <p>Ensure that the Trust's care managers deliver the client reviews in line with agreed procedures and the terms of the agreement</p> <p>Priority 1</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

APPENDIX A

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4 cont	<p>Bromley East 27 cases >12 months, 2 cases 6 to 12 months and 13 cases review completed in time</p> <p>Bromley West 48 cases >12 months, 17 cases 6 to 12 months and 34 cases review completed in time</p> <p>Older People 18 cases >12 months, 5 cases 6 to 12 months and 8 cases review completed in time</p> <p>CMHRES 2 cases > 12 months, 2 cases 6 to 12 months and 1 case review completed in time.</p> <p>The 30 cases identified as >£900 per week are not included in this summary; the BSO is currently updating the results of the review undertaken by the temporary care managers engaged by Bromley for this group of clients.</p> <p>To achieve a rapid turn round and maximise potential savings, cases with no potential to reduce or change were abandoned and not fully reviewed by the temporary care managers engaged by Bromley.</p> <p>The summary spreadsheet evidenced by the BSO on the 24/4/18 and updated from the case management system shows 53% of clients with a review outstanding for more than 12 months.</p>		

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
5	<p><u>Management Reporting</u></p> <p>The agreement requires the Trust to submit a quarterly performance management report to the Bromley Joint Mental Health Board. This should include a:</p> <ul style="list-style-type: none"> - The Trust’s Quality Governance Report (QGR); - The Trust’s Bromley Management Report (BOMR); - Service and Financial Framework Report (SaFFR); - Referrals, Assessments and Packages of care (RAP); - Performance Assessment Framework (PAF); -Trust Start ratings; - Performance Improvement Plan; and - Delivery Improvement Statement (DIS). <p>At the time of the audit, Internal Audit noted that a Quarterly Performance Management Report was not being prepared as required.</p>	<p>Where reports are not produced and circulated as required, there is a risk that the Council is unaware of relevant issues, which then in turn cannot be corrected promptly.</p>	<p>Liaise with the Trust to ensure that Performance Management Reports are produced and submitted as required.</p> <p>Priority 1</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
6	<p><u>Budget Monitoring</u></p> <p>The agreement requires the Trust to prepare and submit monthly and quarterly budget reports in relation to the pooled fund and hold monthly monitoring meetings to consider these reports.</p> <p>It was established that between January and December 2017, the Trust prepared budget reports for only July and October 2017 and no meetings were held. Quarterly budget reports were not provided to the Council. The Service Accountant confirmed that the budget monitoring received from the Trust is adequate and in line with the Council's budget monitoring schedule. The Trust's accountant and the Service Accountants will correspond and confirm by e-mail any issues arising during the year. The October 2017 budget report for 'LB S75 OPMH' showed that the expenditure was on target and a favourable year-end variance of £2k was projected.</p>	<p>Where budget monitoring reports are not produced or submitted as required, there is a risk that the Council does not have access to timely information to make appropriate and effective budgetary decisions which could result in discrepancies not being identified in a timely manner.</p>	<p>The requirement to submit budget monitoring reports should be specified in a change control document.</p> <p>Priority 3</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>Variation to Contract</p> <p>The Council should critically review its agreement with the Trust for the exercise of Mental Health functions.</p> <p>Any significant variation to agreement must be supported by a change control document.</p>	1	<p>A project plan is in place to review the services currently included within the agreement. An Interim Mental Health Board has been established to oversee the project</p>	Interim Director Programmes	August 2018
2	<p><u>Performance Measures and Monitoring</u></p> <p>The performance measures for the arrangement should be clearly defined and agreed by the parties. These should be regularly reported on and monitored.</p>	1	<p>A review of required performance measures set out in the Agreement has already commenced to ensure they are outcomes-based and meet statutory reporting requirements.</p> <p>Meetings are being set up with the Trust to develop data sets in line with the Council's requirements. The CCG is being included in these discussions as part of the plan to develop an integrated performance dashboard which</p>	Interim Director Programmes	August 2018

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2 cont	Any substitution for performance meetings should be formally recognised as such and the minutes evidence attendance of the Trust's representatives and discussion of issues arising from delivering the agreement.		<p>spans both social care and health care.</p> <p>This work will continue alongside the review (Finding 1) so that performance measures are developed to reflect any service delivery variations agreed within part of the review.</p> <p>The Interim Mental Health Board will receive and scrutinise performance data.</p> <p>Records will be kept as per the recommendation. The Interim Mental Health Board will have oversight of the Trust's performance, including the Audit report priority 1 recommendations.</p>	Director of Adult Social Care	From the end of Q1 2018 onwards

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2 cont	Similarly any replacement to the Mental Health Board should be formally agreed to meet the terms of the Section 31 agreement.		<p>The interim Mental Health Board will be established and have met for the first time</p> <p>This Board will review current governance arrangements required by the Agreement and recommend whether a new permanent Mental Health Board is needed or whether it can be through existing governance i.e. Integrated Commissioning Board reporting to the Health and Wellbeing Board.</p>	<p>Director of Adult Social Care</p> <p>Director of Adult Social Care</p>	<p>June 2018</p> <p>Regularly through the next 6 months</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2 cont.	The Council must consider and prioritise performance reviews as detailed in the agreement and ensure that these are undertaken within the time frame specified in the agreement.		<p>Performance reviews will take place as per the agreement</p> <p>A joint approach is being taken to move towards integrated contract management and procurement with the CCG. This includes the development of a joint contract management framework for mental health by aligning the Council's contract monitoring meetings with those of the CCG. Both organisations have separate contracts with the Trust for the provision of the various mental health services and functions, with different end dates. Ultimately the plan is to merge these contracts so that joint decisions can be made on service design, future procurement and contract management, to enable best practice and innovation.</p>	Interim Director Programmes	From end of Q1 2018 onwards

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2 cont.	<p>The review of the arrangements should be reported formally.</p> <p>Performance management and a supervisory framework for all staff with the Council in relation to the arrangements should be clearly defined and evidenced as agreed with the Trust.</p>		<p>Annual reviews will be undertaken at the end of each financial year. Any agreed variations to the arrangements will be implemented thereafter</p> <p>The Director for ASC provides professional supervision to the social care lead (employed by the Trust), and advises on recruitment and retention and warrant AMHPs. (see 3 below)</p>	<p>Interim Director Programmes</p> <p>Director of Adult Social Care</p>	<p>Annually by May each year</p> <p>Completed</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Roles and Responsibilities</u></p> <p>Roles and responsibilities should be clearly defined for officers involved in the Adult Mental Health agreement; including the Agreement Manager with responsibilities for performance monitoring and reporting.</p> <p>The oversight responsibility to provide the overall leadership for mental health services in Bromley, including overseeing the S.31 agreement should be clearly defined and assigned.</p> <p>The role of the BSO should be defined and procedure notes developed to ensure continuity of service delivery. The BSO should be included in a Bromley Team and given clear lines of report.</p>	1	<p>A variation to the agreement is being negotiated to bring a proportion of the funding back into Council control, in order to appoint an interim mental health specialist, to act as Agreement Manager, and who will have responsibility for monitoring and reporting.</p> <p>Current oversight of this agreement is the responsibility of the Director of Adult Social Care.</p> <p>The BSO post will report to the Mental Health specialist once appointed. In the interim, the postholder reports to the Director of ASC.</p>	<p>Director of Adult Social Care</p> <p>Director of Adult Social Care</p> <p>Director of Adult Social Care</p>	<p>August 2018</p> <p>Completed</p> <p>August 2018</p>

REVIEW OF CONTRACT MANAGEMENT FOR ADULT MENTAL HEALTH FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p><u>Service Agreement Reviews</u></p> <p>Ensure that all service agreement reviews are conducted for all clients in a timely manner and in line with agreed procedures.</p> <p>Ensure that the Trust's care managers deliver the client reviews in line with agreed procedures and the terms of the agreement</p>	1	<p>All overdue reviews have been undertaken and sent through to the Care Placement Team who enters the information on.</p> <p>The Team is currently undertaking a data cleansing exercise to establish the true position, to ensure previously undertaken reviews are recorded on the Authority's case management system.</p>	<p>Director of Adult Social Care</p> <p>Director of Adult Social Care</p>	<p>Completed</p> <p>July 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p><u>Management Reporting</u> Liaise with the Trust to ensure that Performance Management Reports are produced and submitted as required.</p>	1	<p>The Trusts provide the Council with monthly reports as required for statutory SALT reporting.</p> <p>A meeting has been arranged with the Trust to review and refresh the existing requirements, for reporting as a standing item to the Interim Mental Health Board.</p>	Interim Director Programmes	August 2018
6	<p><u>Budget Monitoring</u> The requirement to submit budget monitoring reports for the pooled fund should be specified in a change control document.</p>	3	Budget monitoring reports are currently received on a quarterly basis. The Trust have been asked to provide monthly monitoring reports in future.	Interim Director Programmes/Head of Finance ECHS	June 2018

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT
CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF CREDITORS FOR 2017-18

Issued to: Claudine Douglas-Brown, Assistant Director - Exchequer Services

Cc: Peter Turner, Finance Director (final report only)
John Nightingale, Head of Revenues and Benefits (final report only)
David Bradshaw, Head of Education, Care and Health Services Finance (final report only)

Prepared by: Internal Auditor (Audit contractor on behalf of LBB) and Principal Auditor

Reviewed by: Audit Manager (Audit contractor on behalf of LBB) and Head of Audit

Date of Issue: 26 October 2018

Report No.: CEX/02/2017/AU

REVIEW OF CREDITORS AUDIT FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Creditors. The audit was started in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.

AUDIT SCOPE

3. The original scope of the audit was outlined in the Terms of Reference issued on 26 February 2018.

AUDIT OPINION

4. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

5. Controls noted to be in place and working well based on the audit work conducted included:
 - The ledger control account was reconciled to the creditors control account on a monthly basis;
 - Regular duplicate payment monitoring was taking place;
 - Appropriate goods and services received checks were being evidenced prior to payments being made;
 - Payments were being correctly coded in the accounting records; and
 - VAT payments were correctly identified.

REVIEW OF CREDITORS AUDIT FOR 2017-18

- Invoices are paid promptly.
6. Our testing identified the following issues, which we would like to draw to management's attention:
- The set-up/amendment form required for all new set-ups/amendments made to the Creditor Masterfile did not require authorisation by a Budget Holder or other designated manager within the Business Service Area, which has requested the set up/amendment;
 - There was no regular monitoring arrangement in place to identify purchase orders (POs) raised retrospectively to invoices. For seven iproc transactions sampled, the POs were raised retrospectively;
 - The code to the safe where blank cheques were kept was not changed periodically;
 - One case, for a non-iproc payment of £230,382.91, was authorised by an officer with insufficient delegated financial authority;

SIGNIFICANT FINDINGS (PRIORITY 1)

7. The following significant finding was identified:
- A set-up/amendment form is required for all new set-ups/amendments to the Creditors' Masterfile. Whilst section 1 of the form is completed by an officer in the business service area which requires the supplier to be set-up/amended, the form is not checked or signed off by the budget holder or other designated manager within that business service area.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

8. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

9. We would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>Set-up/Amendment Forms</u></p> <p>A set-up/amendment form is required for all new set - ups/amendments to the Creditors' Masterfile.</p> <p>It was identified that, whilst section 1 of the set-up/amendment form is completed by an officer in the business service area which requires the supplier to be set-up/amended, the form is not checked and signed-off as approved by the budget holder or other designated manager within that business service area.</p>	<p>Where the set-up/amendment form is not checked and authorised by a budget holder or other designated manager within that business service area, there is a risk that inappropriate set-ups/amendments to suppliers accounts are made, which could lead to fraud.</p>	<p>The Council should ensure that before the supplier set-up/amendment form is processed, it is checked and authorised by a budget holder or other designated manager within that business service area to confirm that the change is valid.</p> <p>The details of the designated manager should be made known to the Exchequer contractor to check the authorised signature before making the change accordingly.</p> <p>(Priority 1)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation																								
2	<p><u>Retrospective Purchase Orders</u></p> <p>Testing of a sample of 10 iproc orders identified seven cases where the PO was raised retrospectively to the invoice. These were for the following cases:</p> <table border="1" data-bbox="282 571 1178 1173"> <thead> <tr> <th data-bbox="282 571 584 683">Invoice Number</th> <th data-bbox="584 571 880 683">Purchase Order Date</th> <th data-bbox="880 571 1178 683">Invoice Date</th> </tr> </thead> <tbody> <tr> <td data-bbox="282 683 584 751">418666004APR17</td> <td data-bbox="584 683 880 751">24/04/2017</td> <td data-bbox="880 683 1178 751">04/04/2017</td> </tr> <tr> <td data-bbox="282 751 584 820">F0030259</td> <td data-bbox="584 751 880 820">07/09/2017</td> <td data-bbox="880 751 1178 820">24/08/2017</td> </tr> <tr> <td data-bbox="282 820 584 888">BAAIV000035</td> <td data-bbox="584 820 880 888">20/04/2017</td> <td data-bbox="880 820 1178 888">11/04/2017</td> </tr> <tr> <td data-bbox="282 888 584 957">67693</td> <td data-bbox="584 888 880 957">06/04/2017</td> <td data-bbox="880 888 1178 957">22/03/2017</td> </tr> <tr> <td data-bbox="282 957 584 1026">1838</td> <td data-bbox="584 957 880 1026">29/06/2017</td> <td data-bbox="880 957 1178 1026">09/05/2017</td> </tr> <tr> <td data-bbox="282 1026 584 1094">40820</td> <td data-bbox="584 1026 880 1094">19/10/2017</td> <td data-bbox="880 1026 1178 1094">30/09/2017</td> </tr> <tr> <td data-bbox="282 1094 584 1173">1457684191504</td> <td data-bbox="584 1094 880 1173">11/08/2017</td> <td data-bbox="880 1094 1178 1173">16/05/2017</td> </tr> </tbody> </table>	Invoice Number	Purchase Order Date	Invoice Date	418666004APR17	24/04/2017	04/04/2017	F0030259	07/09/2017	24/08/2017	BAAIV000035	20/04/2017	11/04/2017	67693	06/04/2017	22/03/2017	1838	29/06/2017	09/05/2017	40820	19/10/2017	30/09/2017	1457684191504	11/08/2017	16/05/2017	<p>Where POs are raised retrospectively to invoices, the authorisation requirements are being bypassed and there is a risk that inappropriate purchases are made.</p>	<p>A retrospective Purchase Orders report should be run on a periodic basis by a designated officer in Finance Directorate. The results should be provided to Directors who should enquire from the relevant officer as to why an order was raised retrospectively.</p> <p>(Priority 2)</p>
Invoice Number	Purchase Order Date	Invoice Date																									
418666004APR17	24/04/2017	04/04/2017																									
F0030259	07/09/2017	24/08/2017																									
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67693	06/04/2017	22/03/2017																									
1838	29/06/2017	09/05/2017																									
40820	19/10/2017	30/09/2017																									
1457684191504	11/08/2017	16/05/2017																									

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>This issue was raised during the previous audit of Creditors in November 2016 and a retrospective Purchase Orders report was run by the Head of Exchequer Services at the request of Internal Audit. The information was provided to Heads of Service who were asked to address the issue with their budget managers and staff who were responsible for raising the PO's.</p> <p>There is no arrangement in place for a retrospective Purchase Orders report to be run by someone in Finance Directorate on a regular basis and for the results to be reported to senior management for any action they may wish to take.</p>		
3	<p><u>Custody of Blank Cheques</u></p> <p>Blank cheques should be stored in a secure location.</p> <p>The location to the key for where the safe is stored, containing the blank cheques, is known by three staff members.</p> <p>Audit was also advised that the code to the safe is not changed on a regular basis. It is not known when the safe code was last changed/updated.</p>	<p>Where the safe code is not changed on a regular basis, there is a risk of unauthorised access to the blank cheques which could result in inappropriate spends being made.</p>	<p>The safe code should be changed on a regular basis in addition to when one of the three key staff leave the Council/job role.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4	<p><u>Authorisation Limits for Payments</u></p> <p>Payments for goods and services are required to be authorised in line with the Council’s Financial Regulations.</p> <p>Testing of 10 non-iproc payments identified one case (invoice no. PGBCS000018) where a payment of £230,382.91 was authorised by the Head of Operations on behalf of the SEN Operations Manager.</p> <p>According to the authorisation limits set out in the Council’s Financial Regulations for placing orders and payments, payments between £100,000 and £249,000 should be authorised by the Assistant Director or Director.</p>	<p>Where payments are not approved according to the authorisation limits set out in the Council’s Financial Regulations, there is a risk that inappropriate or incorrect payments are processed by the Council and cannot be recovered.</p>	<p>When checks carried out by the Exchequer contractor identify invoices for payment which have not been authorised by an officer with the correct level of authority as per the Council’s Financial Regulations, the invoice should not be processed for payment.</p> <p>The information should then be referred to the Head of Exchequer Services.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>The Council should ensure that before the supplier Set-Up/Amendment Form is processed, it is checked and authorised by a Budget Holder or other designated manager within that Business Service Area to confirm that the change is valid.</p> <p>The details of the designated manager should be made known to the Exchequer contractor to check the authorised signature before making the change accordingly.</p>	1	<p>The supplier set up form and process has been revised in consultation with Internal Audit and now includes the requirement for authorisation by the budget holder or other designated manager. This will either be a manager within the business service area or within the Contracts and Commissioning team (e.g. for changes to suppliers of care services). The new form will be rolled out to all service departments by 31st October 2018.</p>	Assistant Director - Exchequer Services	31 October 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	A retrospective Purchase Orders report should be run on a periodic basis by a designated officer in Finance Directorate. The results should be provided to Directors who should enquire from the relevant officer as to why an order was raised retrospectively.	2	A retrospective Purchase Order report will be run twice a year and the results will be provided to Directors.	Interim Contract and Operations Manager (Exchequer)	31 October 2018
3	The safe code should be changed on a regular basis in addition to when one of the three key staff leave the Council/job role.	2	The safe code will be changed on a quarterly basis from now on and also when one of the three key staff leave the Council or change their job role.	Head of Revenues and Benefits	31 October 2018
4	When checks carried out by the Exchequer contractor identify invoices for payment which have not been authorised by an officer with the correct level of authority	2	The Exchequer contractor has been instructed to ensure no invoice is processed where it has not been properly authorised in accordance with Financial	The Exchequer contractor's Operations Manager/Interim Contract and	Implemented

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.



FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF EDGEBURY PRIMARY SCHOOL AUDIT FOR 2018-19

Issued to: Mrs J Box, Head Teacher

Cc: Mr H Pritchard, Chair of Governors (final report only)
Schools Finance Team, (final report only)
Gillian Palmer, Interim Director of Education (final report only)
Ade Adetosoye, Executive Director of ECHS (final report only)

Prepared by: Principal Auditors

Date of Issue: 19th June 2018

Report No.: ECHS/21/2017/AU

REVIEW OF EDGEBURY PRIMARY SCHOOL AUDIT FOR 2018-19

INTRODUCTION

1. This report sets out the results of our systems based audit of Edgebury Primary School Audit for 2018-19. The audit was carried out in quarter 1 as part of the programmed work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the school's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 19/03/18. The period covered by this report is the 12 month period from April 2017.

AUDIT SCOPE

4. The scope of the audit is detailed in the Terms of Reference.

MANAGEMENT SUMMARY

5. Internal Audit visited the school on the 1st May 2018. Controls were in place and working well in the areas of financial management, governance arrangements, safeguarding assets and for primary accounting, bank reconciliation, DBS checks, income, petty cash and credit cards. However there were issues arising as follows:-
 - For 1/20 payments examined the Head Teacher had authorised the purchase order and the invoice. The authorised signatories list nominates 3 officers as required by Financial Regulations and the procedures allow for adequate separation of duties but there should be a contingency to cover absenteeism. For 3/20 payments selected the submitted invoice did not detail a unique invoice reference as required by accounting convention and to mitigate the risk of duplicate payment. 1/20 payment was not supported by an authorised purchase order.

REVIEW OF EDGEBURY PRIMARY SCHOOL AUDIT FOR 2018-19

- IR35 online questionnaires had not been completed to support all payments to named individuals
- The contract register should include the value of the contract. Examination of the bank history identified one supplier that should be included on the contracts register.
- The Governors minutes do not record that the annual voluntary fund accounts had been audited and certified.
- The pecuniary interest forms for two Governors had not been signed and dated and for one Governor no signature.

SIGNIFICANT FINDINGS (PRIORITY 1)

6. None

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

7. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

AUDIT OPINION

8. Overall, the conclusion of this audit was that substantial assurance can be placed on the effectiveness of the overall controls. Opinion definitions are given in Appendix C.

ACKNOWLEDGEMENT

9. We would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Finding	Risk	Recommendation
1	<p>From the bank history for the 12 months period starting April 2017 a sample of 20 payments was selected for audit examination.</p> <p>The current authorised signatory list detailed three officers. Whilst this complies with Financial Regulations and the need to evidence separation of duties there is no resilience or cover as three officers must be involved in the expenditure process. Audit testing evidenced 1/20 payments tested whereby the Head Teacher had authorised both the purchase order and invoice.</p> <p>For 3/20 payments selected the submitted invoice did not detail a unique invoice reference as required by accounting convention and to mitigate the risk of duplicate payment.</p>	<p>Payments may not be made in compliance with Financial Regulations and the School's own procedures.</p>	<p>The school should consider nominating a senior member of staff to be added to the authorised signatory list for the expenditure process.</p> <p>The school should request that suppliers submit invoices to comply with accounting conventions, specifically a unique invoice number.</p> <p>Priority 2</p>

DETAILED FINDINGS

No.	Finding	Risk	Recommendation
2	<p>Payments to 4 named individuals were identified on the bank history report. On line questionnaires had not been completed to evidence the self –employed status and payment via invoice rather than payroll.</p>	<p>Financial penalties imposed for non-compliance to HMRC IR 35 Regulations.</p>	<p>The completed online questionnaires and outcome should be dated and authorised by the Head Teacher annually.</p> <p>To ensure compliance the online assessment should be completed to support any payment to a named individual. Priority 2</p>
3	<p>The Contract Register is reported to Governors annually; minuted for the Resources Committee 14/03/17. This is a comprehensive document that allows Governors to have an oversight of contractual arrangements. However the values of the contract/agreements have not been included and should be available to Governors to ensure information for decision making is complete.</p> <p>From the bank history report, payments to suppliers were selected to check to the contract register. One provider had been omitted and should be added to the register.</p>	<p>Contractual arrangements may not be transparent.</p> <p>Governors have insufficient information to enable informed decisions regarding contractual arrangements for the school.</p>	<p>Extend the information shown on the contracts register to report the annual cost and the whole life value of all contracts and agreements.</p> <p>Update the contracts register with the provider identified.</p> <p>Priority 2</p>

DETAILED FINDINGS

No.	Finding	Risk	Recommendation
4	<p>The year ending 31/8/17 voluntary fund accounts were evidenced as certified by the Honorary Auditor on the 9/10/17. The minutes for the Resources Committee record that the voluntary fund was discussed but do not specify that the accounts has been audited and certified. Similarly the May 2017 Resources minutes state that the fund had been audited but no reference to the accounting period.</p>	<p>Governors are not aware of the certified status of the voluntary fund.</p>	<p>The Resources Committee minutes should record that the certified audited accounts for the voluntary fund have been presented to Governors.</p> <p>Priority 3</p>
5	<p>The pecuniary interest forms for the staff and Governors were checked and verified to the establishment and Governor lists. Forms for three Governors had been completed but not signed and dated.</p>	<p>Governors/Staff may be involved in making financial and/or business decisions relating to organisations which they have a pecuniary interest without the school knowing.</p>	<p>Pecuniary interest forms should be completed annually, signed and dated.</p> <p>Priority 3</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>The school should consider nominating a senior member of staff to be added to the authorised signatory list for the expenditure process.</p> <p>The school should request that suppliers submit invoices to comply with accounting conventions, specifically a unique invoice number.</p>	2	We are adding Inclusion Manager, Senior Leader as an authorised signatory.	Finance Officer	July 2018
2	<p>The completed online questionnaires and outcome should be dated and authorised by the Head Teacher annually.</p> <p>To ensure compliance the online assessment should be completed to support any payment to a named individual.</p>	2	All future invoices payable to private individuals will have a completed IR35 printed and signed by the Head Teacher.	Finance Officer	June 2018

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p>Extend the information shown on the contracts register to report the annual cost and the whole life value of all contracts and agreements.</p> <p>Update the contracts register with the provider identified.</p>	2	Service contract spreadsheet already updated with total cost and duration as suggested.	Finance Officer	June 2018
4	<p>The Resources Committee minutes should record that the certified audited accounts for the voluntary fund have been presented to Governors.</p>	3	The voluntary fund was last audited on 9 th October 2017 and in future this will be documented on all minutes of the Resources meeting.	Finance Officer and Head Teacher	June 2018
5	<p>Pecuniary interest forms should be completed annually, signed and dated.</p>	3	Missing governor signatures are to be obtained ASAP and kept on file.	Head Teacher	July 2018

SCHOOLS OPINION DEFINITIONS

As a result of their audit work auditors should form an overall opinion on the extent that actual controls within the school provide reasonable assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the system and school procedures objectives tested.

Substantial Assurance

While there is a basically sound system and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the schools finances. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to Governors, material income losses.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse.

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FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF HOME TUITION 2017-18

Issued to: Pip Hesketh - Interim Head of Service, Access and Inclusion
Debbie Partington – Lead Teacher, Home and Hospital Tuition Team
Gillian Palmer – Interim Director of Education
David Bradshaw - Head of Finance, ECHS
Naheed Chaudhry - Assistant Director, Strategy Performance and Business Support
Ade Adetosoye - Deputy Chief Executive, Executive Director ECHS (final only)

Prepared by: Principal Auditor

Date of Issue: 26th October 2018

Report No.: ECHS/026/2017/AU

REVIEW OF HOME TUITION 2017-18

INTRODUCTION

1. This report sets out the results of our systems based review of the Home Tuition Team for 2017/18. The audit was started in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 1st February 2018.
4. The Home and Hospital Tuition Team has three distinct areas of service; the hospital team at the PRUH, Electively Home Educated children, and the Home Tuition service for children not able to attend school for physical, medical or mental health reasons. Children with an Education, Health and Care Plan (EHCP) may also receive Home Tuition for a limited period funded from the SEN budget. The Nightingale Centre had been part of this service but was set up as a Bromley maintained Pupil Referral Unit from January 2017. This move resulted in £450K transferred from the Home Tuition budget code in 2017/18. The actual spend for Home Tuition in 2017/18 was £831,196 offset by £811,282 recharges to Primary, Secondary and Behavioural Services budgets.

AUDIT SCOPE

5. The scope of the audit is detailed in the Terms of Reference. This review considered the Home Tuition service only, no testing was completed for the Hospital Team or Elective Home Education.

AUDIT OPINION

6. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls for the Home Tuition Team. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

7. The objective of the audit was to review the system for referral of cases to the Home Tuition service and the payment to tutors. The audit review tested a sample of 20 cases selected from the Home Tuition database. These cases were then used to test referral documentation, reviews, allocation of hours, timesheets, attendance records and the use of the proprietary procurement system. From the audit testing and interviews with the Home Tuition Team the following issues have been identified to be addressed by management:-
- The outcome letter issued to the parent /carer following the core panel meeting could not be evidenced for 6/20 children; the outcome letter did not specify the number of hours approved; specific conditions of panel approval were not met.
 - The database did not detail the latest medical evidence and for 11 cases there was no dated entry in this field.
 - There is no standard input for the review fields and the weekly discussions and updates are not formalised. For the 6 weekly review completed by the tutors 2/20 could not be located in the dedicated folder on the shared area.
 - The database has the potential to support the work of the team to record key information and be used as a monitoring and review tool. However there is no standard input format to allow any filtering or sort function and key fields such as allocated hours have been left blank.
 - The timesheets submitted by the Bromley tutors are completed according to an agreed standard. Information is not checked to the database and there is no independent verification by the parent / carer that those hours have been delivered. The mileage claims need to conform to the agreed Bromley policy.
 - There is no meaningful check completed on the timesheets submitted by the agency tutors. The timesheets were not in a standard form and did not detail consistent information. There is no agreed procedure of how the timesheet should be completed. Sample testing identified specific issues with individual tutors to be addressed by the team.
 - Attendance registers for the Spring half term could not be found for 5/9 agency tutors; two minor discrepancies relating to hours claimed matched to attendance registers available that need to be resolved. For Bromley tutors 1/5 attendance

REVIEW OF HOME TUITION 2017-18

registers could not be found and for 3 tutors differences between the attendance register and timesheet could be over claimed time and will need to be resolved. There is no check between the attendance registers and the timesheets.

- Requirements uploaded to the procurement system did not have an end date and were for more hours than allocated. There were no meaningful checks on the hours booked to the hours claimed and the rates applied for each tutor. The engagement of tutors at the Link has not been open to competitive tendering.
 - The Home Tuition Team have not completed the online training modules for Financial Regulations, Fraud awareness, Information Assurance or Internal Controls
 - There are no procedures to support the operational processes for the finance and administrative officers. The work flow chart evidenced to show the referral, allocation and delivery of service is not owned, dated or version controlled and does not consider the role of the panel or engagement of tutors.
 - Boxed historic documents have been left at Midfield Centre since the team moved to the Civic Centre site in October 2017.
8. The findings of the audit testing have been discussed with the Lead Teacher during the course of the audit and the need to review procedures and implement change accepted. Following the end of audit meetings the Department have responded to the findings and written an improvement plan to implement the recommendations. The Director of Education confirmed that an external review of the quality of education provided by the Home Tuition Team and its impact on children's learning has been commissioned for quarter 3.

SIGNIFICANT FINDINGS (PRIORITY 1)

There are 5 priority 1 findings as follows:-

Core Panel Decisions

The Core Panel meets fortnightly with a multi-disciplinary membership. The outcome letter for a sample of 20 pupils selected from the Home Tuition database on the 11.6.18 was checked. The main points arising were:-

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REVIEW OF HOME TUITION 2017-18

- Outcome letter or panel decision not evidenced for 6 pupils
- Hours are not specified on the outcome letter or panel decision, this is accepted practice as the default will be 5 hours per week.
- Outcome letter not signed
- Hours only declared for 9 cases on the database and no provision to record changes to agreed provision
- For 1/20 panel decision was to not accept given information was incomplete. Not clear that this case went back to panel or if a decision was reached out of panel
- For 1/20 panel decision 12.9.17 was to review at panel 12.12.17 but not evidenced as having been resubmitted
- For 1/20 pending decision dependent on resolution of funding issues.

Database

The database was introduced at the start of the academic year 2017/18 and is used to record all pupils assigned to the service. It is acknowledged that at the time the database was created the objective was to capture core data but it should be developed to monitor hours, allocations and review dates.

The database was the primary source of information for the audit and 2 of the findings relate directly to information not being recorded. Similarly the checks on timesheets planned hours, delivered hours and expenditure should also be supported by the database and information was inaccurate or missing.

The database is a live document and should be updated regularly but there was no retention of data as changes were made to retain an audit trail to support expenditure and service delivery. There is no standard input and formatting that allows manipulation of the data to monitor key information.

The key information to be recorded is the hours agreed at panel, the planned hours and the hours allocated to the tutor to be provided and charged. Online learning will also need to be captured to support payment of the invoice for this service.

Certain fields should be mandatory and the allocated hours would be a prime example. Of the 113 cases that had been to panel and were current at some point in the academic year 2017-18, 51 had the allocated hours completed and for 62 the field was blank. At £40 per hour and a default of 5 hours per week this could represent £12,400 expenditure per week not supported by information on the database (62 pupils X 5 hours X £40 ph.)

REVIEW OF HOME TUITION 2017-18

Payments to Agency Tutors

Home Tuition approved by panel will be allocated to Bromley tutors in the first instance but when demand exceeds this resource the Lead Teacher will engage agency tutors using the proprietary purchasing system.

All the tutors currently used by the service are from Supplier A. A walk through test with the Finance Officer identified that limited checks are undertaken on the submitted timesheets; verification of the tutor name and arithmetical accuracy of the claim. There is no check to:-

- confirm hours claimed to hours agreed
- temporary variations due to weekly availability of the child
- comparison to the attendance sheets that should be returned half termly
- signature of the parent/carer to confirm service delivery.

The timesheets for agency tutors for week ending the 23.2.18 was selected for audit examination; 9 related to tutors and 1 related to the exam officer who does not have any contact time tutoring. The main issues are detailed at appendix A but can be summarised as:-

- no standard format of timesheet or consistent completion of the document including interpretation and representation of hours and minutes.
- no declaration on the timesheet to confirm that the claim is correct
- arithmetic errors on the hours claimed
- hours claimed for one child by two tutors
- notation on the timesheet relating to activities that did not relate tutor contact time

Attendance Registers

All tutors, Bromley and agency, are required to complete the weekly attendance sheet for each child and this should be returned at the end of each half term.

REVIEW OF HOME TUITION 2017-18

The spring term attendance records were checked to the timesheets for both the Bromley (February 2018) and agency (w/e 23/2/18) tutors.

The main issues arising for agency staff were that:-

- For 5 of the nine tutors tested attendance records could not be found and for 2 of the tutors the team confirmed in an e-mail that these two tutors had never submitted attendance records and that this had been an ongoing problem.
- For 1 tutor at the Link, the attendance sheet cannot be used to support hours claimed as 14 children are recorded over the week and tuition is not 1:1
- The attendance sheet did not agree to the hours/days claimed on the timesheets for two of the tutors.

The main issues arising for Bromley tutors tested for the week 19th to the 23rd February 2018 were that:-

- For 1 of the 5 tutors sampled no attendance record could be found
- For 3 of the tutors the hours claimed were above the hours declared on the attendance records.

The timesheets are submitted weekly for agency and monthly for Bromley staff. The attendance sheets do not come in until the end of the half term; there is no check on the information reported or comparison to the timesheets.

Procurement and the Use of Supplier A

The Home Tuition service will use Bromley tutors as the first choice if the hours are available and there is an appropriate match of resources and need. The second option is to source tutors through the procurement system provided by the purchasing system.

The Lead Teacher will upload the requirement to the system specifying the hours to be allocated, needs of the child and start date. The requirement is then available to all tutors vetted and registered to the system. Responses to the published requirement are sent to the requester once closed and the lowest cost provider should be selected. For the Home Tuition Service only Supplier A has responded for all requirements posted.

The Lead Teacher raised concerns during the course of the audit that the system does not meet the flexible and urgent needs of their service whereby a replacement tutor may be required for the same day. Another issue was that once a tutor is selected on lowest cost and accepted, a contract is issued but the Lead Teacher will still need to assess the suitability of the tutor and potential match to a student. If the allocation is not appropriate the contract is cancelled and the process starts again.

REVIEW OF HOME TUITION 2017-18

Internal Audit are not in a position to comment on the appropriate use on the system but support the need for robust, transparent procurement in an area that was previously investigated and found inadequate and poorly controlled. Any procedure to procure tutors must comply with Financial Regulations and Contract Procedure Rules and evidence an adequate contractual arrangement with the provider.

The review of budget monitoring identified that:-

- the expenditure code set up in the purchasing system for SEN pupils was incorrect. Home Tuition will procure tutors for SEN cases, temporarily assigned to Home Tuition but the cost remains with SEN. The Service accountant was alerted and worked with the Lead Teacher to identify the miscodings and correct. Procurement confirmed that the codes were entered when the system was set up but could be changed for each requirement.
- the engagement of two tutors from Supplier A working at the Link, is not subject to competitive tendering as the requirement on the system is set to “manual” rather than “tender”. This effectively means that the engagement of two tutors is not subject to competitive tendering. The annual cost for one tutor is £77,220 based on a confirmed hourly rate of £66, 30 hours per week and 39 weeks per year.
- the cumulative spend report identifies £8,750 to the owner of the proprietary purchasing system in 2017/18 and £20,000 in 2018/19 but the summary spreadsheet maintained by accountancy of the weekly invoices show £471,366 to them for 2017/18. Accountancy explained that as the payments are made from a holding account and recharged rather than individual expenditure codes, the value is not captured on cumulative spend

The audit test to check the sample of agency tutors and allocated pupils to ensure that the engagement was supported by a requirement, a contract and that the rates, hours and start dates agreed to the weekly payment was not completed. The Home Tuition Team were not able to access the website to provide the information required for testing. This indicates a training issue that can be addressed as the procedure to check and verify engagements is developed and the necessary controls put in place.

From interview with the Senior Procurement Officer and initial testing on the sample indicated that the main issues arising at an operational level are that:-

- Of the 13 contracts declared 5 started in the academic year 2017/18, 2 16/17, 2 15/16, 2 14/15 and 1 in 13/14.
- None of the requirements state an end date, a start date only is specified.

REVIEW OF HOME TUITION 2017-18

- The Lead Teacher confirmed that there are open engagements on the system no longer used but cannot be closed on the system.
- For a sample of two requirements the Senior Procurement Officer evidenced that 11 and 8 providers were invited to bid for a requirement set up by Home Tuition but all cancelled except Supplier A. The owner of the proprietary purchasing system have not done any review work to suggest why providers do not bid for Home Tuition work but the Senior Procurement Officer suggested that it is the short period of time between the close time and review time.
- There are service agreements for more hours than are allocated.
- A check on one requirement evidenced a bid of £48 per hour for 10 hours but the weekly payment summary for this agreement showed that the value regularly exceeded this amount. This should be a basic check undertaken by the Team but is not currently considered.
- The Lead Teacher confirmed that no checks are made on the rates charged; the team do not have access to the weekly spreadsheet that is attached to the invoice. The invoices for February 2018 and July 2018 were checked for the Home Tuition engagements; rates had both increased and decreased but the Lead Teacher was not aware of any change and had not received any uplift or change of rate notification.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

10. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

No.	Findings	Risk	Recommendation
1	<p>Core Panel Decisions</p> <p>The Core Panel meets fortnightly with a multi-disciplinary membership. Referrals are received from a school or from the SEN Service using a standard template and supporting documentation. All panel meetings are minuted and the outcome posted to a folder created for each child.</p> <p>A sample of 20 pupils selected from the Home Tuition database on the 11.6.18 was checked. The main points arising were:-</p> <ul style="list-style-type: none"> • Outcome letter or panel decision not evidenced for 6 pupils • Hours are not specified on the outcome letter or panel decision, this is accepted practice as the default will be 5 hours per week. • Outcome letter not signed • Hours only declared for 9 cases on the database and no provision to record changes to agreed provision • For 1/20 panel decision was to not accept given information was incomplete. Not clear that this case went back to panel or if a decision was reached out of panel • For 1/20 panel decision 12.9.17 was to review at panel 12.12.17 but not evidenced as having been resubmitted • For 1/20 pending decision dependent on resolution of funding issues. 	<p>Decisions to accept a pupil to the Home Tuition Service may not be made by the approved authorising body in this case the core panel.</p> <p>The decision of the panel may not be followed; specifications may not be imposed on the placement.</p>	<p>The panel decision and outcome letter must be evidenced for each child receiving Home Tuition.</p> <p>If the Home Tuition is to be time limited this should be specified on the panel decision and the case returned to panel for discussion and extension.</p> <p>All outcome letters must be signed by the authorising officer.</p> <p>The panel administrator should record the conditions attached to any pending decisions and evidence that those are met prior to commencement of the service. Similarly any decisions to return a case to panel should be diarised and the referral resubmitted.</p> <p>Priority 1</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p>Medical Evidence</p> <p>Home Tuition referrals on medical grounds should be supported by medical evidence such as the consultant’s letter. Referrals from the SEN Service for children with an EHCP will not require additional medical evidence.</p> <p>For the sample of 20 pupils selected from the Home Tuition database 11.6.18 the date of the latest medical evidence was noted and the status of each pupil checked with the Lead Teacher. The main issues arising were that:-</p> <ul style="list-style-type: none"> • For 8 cases the date and/or details of medical evidence had been entered on the database although for 3 of these cases the date was 2015. • No entry on the database for 5 cases. • 7 cases were SEN cases and therefore medical evidence not required (2 had been incorrectly added to the database as MM (mental health) rather than SEN) <p>The team could not evidence that the medical evidence was filed or stored in team folders.</p>	<p>Pupils accepted by the service do not meet the eligibility criteria specified.</p> <p>Medical evidence held may be out of date and circumstances may have changed if the evidence is not updated regularly (annually)</p>	<p>All pupils receiving Home Tuition, eligible as being unable to attend school for health reasons should be supported by a letter from the relevant consultant; a letter from the GP should not be accepted.</p> <p>Although Home Tuition should be a short term provision placements have spanned academic years and the medical evidence should be updated annually.</p> <p>Staff should be reminded to update the database with the date of the medical evidence.</p> <p>Priority 2</p>

No.	Findings	Risk	Recommendation
3	<p>Reviews</p> <p>The HT team meet every Thursday and talk through all live cases. The HT spreadsheet is colour coded to show urgent review, review actions and review every three weeks and review columns have been set up to show actions or comments on a monthly basis.</p> <p>There is no standard input entry for these and is an informal record for each pupil. Discussion with the team indicated that much day to day knowledge is retained by the Lead Teacher and not recorded.</p> <p>Target dates and outcomes should be included in the team reviews and evidence a trail between panel decisions and conditions.</p> <p>The tutors complete a 6 weekly review that is sent to the parent/carer, school and HT. The submitted reports are held for each pupil in the shared area and outline progress that half term. For the selected audit sample, Spring Term reports were evidenced;</p> <ul style="list-style-type: none"> • 2/20 could not be found in the standard folder but the Lead Teacher was aware of the cases and would follow up • 2/20 were not dated but assumed to be Spring Term given the date of posting • 2/20 had not started service/not given support medically unfit. <p>Internal Audit could not comment on the content of the review or the performance management of the tutors but did confirm that the Lead Teacher checks all reviews and signs them off.</p>	<p>The proposed outcome for the pupil may not be met.</p> <p>A pupil may stay in the service longer than needed or proposed by the core panel.</p>	<p>Formalise the review discussions and input format to allow manipulation of the data for monitoring.</p> <p>Key dates must be identified and the nominated action confirmed as complete. Conditions stipulated at Panel must be met and resubmitted as necessary.</p> <p>Monitor receipt of the half termly reports received from the tutors to ensure they are received in a timely manner, dated and posted to the shared area.</p> <p>Priority 2</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
4	<p>Database</p> <p>The database was introduced at the start of the academic year 2017/18 and is used to record all pupils assigned to the service. It is acknowledged that at the time the database was created the objective was to capture core data but it should be developed to monitor hours, allocations and review dates.</p> <p>The database was the primary source of information for the audit and findings have been raised in 1 and 2 above with regard to missing information for core panel decisions and medical records. Similarly the checks on timesheets planned hours, delivered hours and expenditure should also be supported by the database and as discussed in finding 5 below information was inaccurate or missing.</p> <p>The database is a live document and should be updated regularly and retain an audit trail of change. Data should therefore be retained and amendments shown as strike through with a comment box detailing the changes and action to be taken.</p> <p>The database should be saved as a permanent document at the end of each half term to support the service delivery of the team.</p> <p>There is no standard input and formatting that allows manipulation of the data to monitor key information.</p> <p>The key information to be recorded is the hours agreed at panel, the planned hours and the hours allocated to the tutor to be provided and charged. Online learning will also need to be captured to support payment of the invoice for this service.</p> <p>Certain fields should be mandatory and the allocated hours would be a prime example. Of the 113 cases that had been to panel and were</p>	<p>Expenditure is not adequately supported by documentation.</p> <p>Expenditure and service delivery is not adequately monitored.</p> <p>Reliance on one officer to know key information such as allocation of hours does not satisfy business continuity.</p>	<p>The database must be developed to include the key areas discussed.</p> <p>Assign ownership of the database and devolve responsibility to update the database in a timely manner to ensure data is complete and accurate.</p> <p>Retain a permanent record of the database every half term to provide and use the strike through and comments box in excel to ensure that there is an adequate audit trail.</p> <p>Develop standard input and format for all fields to allow manipulation of the data for monitoring purposes.</p> <p>Create mandatory fields to capture key information such as agreed, planned and delivered hours.</p>

REVIEW OF HOME TUITION 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>current at some point in the academic year 2017-18, 51 had the allocated hours completed and for 62 the field was blank. At £40 per hour and a default of 5 hours per week this could represent £12,400 expenditure per week not supported by information on the database (62 pupils X 5 hours X £40 ph.)</p> <p>The database should be used to record all activity and could be developed to monitor key information to support the daily operations of the team.</p>		<p>Include maintenance of the database in the procedures guide.</p> <p>Develop a suite of reports that could be generated from the database to support monitoring the service.</p> <p>Priority 1</p>
5	<p>Payment to Bromley Tutors</p> <p>Home Tuition hours will be allocated to the bank of Bromley tutors in the first instance. These tutors are paid through Bromley payroll and expenditure monitored on EBM. Tutors are required to submit monthly timesheets attaching car mileage claims and parking receipts.</p> <p>The timesheets are signed by the claimant, declaring the information to be correct, certified by the Lead Teacher and processed by the Finance Officer.</p> <p>A sample of 5 tutors submitting claims in February 2018 was selected for audit examination. The main issues arising were:-</p> <ul style="list-style-type: none"> The hours claimed are not checked to the database and the information on the database is incomplete. 	<p>Unauthorised expenditure incurred by the Authority.</p> <p>Hours delivered and paid for do not agree to the allocated hours for that child.</p> <p>Non compliance to Council HR policy and procedures for car mileage.</p>	<p>The team must complete meaningful checks on the timesheets prior to authorisation and payment.</p> <p>Tutors must complete the timesheet by an agreed date and format including the level of detail to be specified by the Home Tuition Team.</p> <p>An additional check would be for the parent/carer to sign the relevant line to confirm attendance.</p>

REVIEW OF HOME TUTORION 2017-18

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No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • The Finance Officer relies on the Lead Teacher to identify and variances; there is no formal record of changes. • There is no provision on the timesheet for the carer/parent to sign that the hours declared have been worked. It is noted that the carers/parent should sign the attendance sheets but these are not available until the end of each half term. • The child’s name or initials were not entered onto the timesheet in all cases. • The car mileage claims do not conform to the standard, whereby the home to work mileage is deducted from the first visit. • For 2/5 the time sheet had a printed name not signature as the form is submitted electronically and tutor has no facility to scan. The e-mail would need to be retained to evidence that the time sheet was sourced from the named claimant. • 4/5 timesheet hours claimed could not be checked to the database as the allocated hours had not been uploaded and for the other case the hours delivered were less than the agreed. 		<p>The timesheet should be supported by the approved hours allocated to each child as detailed on the database and approved by Panel.</p> <p>Need to consult with HR to ensure that the tutors are correctly claiming car mileage in line with agreed corporate policies.</p> <p>Priority 2</p>

No.	Findings	Risk	Recommendation
6	<p>Payments to Agency Tutors</p> <p>Home Tuition approved by panel will be allocated to Bromley tutors in the first instance but when demand exceeds this resource the Lead Teacher will engage agency tutors using the proprietary purchasing system. This will be discussed in more detail in finding 8.</p> <p>All the tutors currently used by the service are from Supplier A. Timesheets are received weekly and checked before the provider uploads to the procurement system for the Finance Officer to approve on the website.</p> <p>A walk through test with the Finance Officer identified that limited checks are undertaken on the submitted timesheets; verification of the tutor name and arithmetical accuracy of the claim. There is no check to:-</p> <ul style="list-style-type: none"> • confirm hours claimed to hours agreed • temporary variations due to weekly availability of the child • comparison to the attendance sheets that should be returned half termly • signature of the parent/carer to confirm service delivery. <p>The timesheets for agency tutors for week ending the 23.2.18 was selected for audit examination; 9 related to tutors and 1 related to the exam officer who does not have any contact time tutoring. The main issues arising were that:-</p> <ul style="list-style-type: none"> • There was no standard format submitted and in one case there was no company logo on the claim form . 	<p>Unauthorised expenditure incurred by the Authority.</p> <p>Hours delivered and paid for do not agree to the allocated hours for that child.</p>	<p>The checks on the weekly submitted timesheets for the agency tutors must be meaningful including a check that the hours claimed agree to allocated hours.</p> <p>A procedure to document and check temporary changes and cancellations should be considered.</p> <p>The parent/carer should sign the relevant line on the claim form to support service delivery.</p> <p>The Team must review and update their procedures and instructions for agency tutors to complete the weekly timesheet in line with the specific findings of the audit sample check.</p> <p>Priority 1</p>

REVIEW OF HOME TUITION 2017-18

DETAILED FINDINGS

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No.	Findings	Risk	Recommendation
6 cont	<ul style="list-style-type: none"> • There was no standard completion of the form, 2/9 claims had not been signed by the parent/carer and for 1/9 the tutor had signed in the signature box. • Childs name or initials not specified on the claim • No provision on the timesheet for the tutor to declare that the hours claimed are correct • 2/9 timesheets related to tutors at the Link who are not assigned individual children but provide the service delivered at the Link. 1 tutor claims 30 hours per week (6 hours per day Mon –Fri); another claims 14 hours at the Link and 10 hours against an S Proc reference, • Arithmetic errors on the claim form, 5 hours claimed but should be 4 hours (EF) • In some instances “1.2 hours” related to 1 hour 20 minutes but was also taken as 1 hour 12 minutes/ “1.4 hours” was 1 hour 40 minutes or 1 hour 24 minutes • Claim included hours for “<i>updating records</i>” additional to the 12 min per hour planning time claimed. • The policy is for the tutor to still claim if the parent gives insufficient notice but this is controlled/declared by the tutor with no independent check or challenge. • Note on timesheet that tutor undertook a trip out. The risk assessment, insurance implications and parental consent should be evidenced. 		

REVIEW OF HOME TUITION 2017-18

DETAILED FINDINGS

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No.	Findings	Risk	Recommendation
6 cont	<ul style="list-style-type: none"> For 1 child 20 hours 30 minutes have been allocated according to the database with two tutors both named. For the sample week one tutor claimed 18.5 hours and the other 14 hours. 		
7	<p>Attendance Registers</p> <p>All tutors, Bromley and agency, are required to complete the weekly attendance sheet for each child and this should be returned at the end of each half term.</p> <p>The spring term attendance records were checked to the timesheets for both the Bromley (February 2018) and agency (w/e 23/2/18) tutors.</p> <p>The main issues arising for agency staff were that:-</p> <ul style="list-style-type: none"> For 5 of the nine tutors tested attendance records could not be found and for 2 of the tutors the team confirmed in an e-mail that these two tutors had never submitted attendance records and that this had been an ongoing problem. For one tutor at the Link, the attendance sheet cannot be used to support hours claimed as 14 children are recorded over the week and tuition is not 1:1 For 1 tutor the 1.2 hours was claimed on the Wed and Thurs but the attendance sheet shows 2 hours missed each day as the child was unwell. It is unclear from the attendance record when the cancellation was received. 	<p>Tutors are paid for hours that have not been delivered.</p> <p>Hours claimed are not supported by independent records</p>	<p>All tutors must return the attendance sheets, in the agreed format, within the time period specified by the service.</p> <p>The service should consider recalling the attendance sheets more regularly to compare to the approved allocated hours and the timesheets.</p> <p>Discrepancies between attendance sheets, approved hours and timesheets should be discussed with the individual tutor and cleared.</p> <p>Priority 1</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • For 1 tutor hours were claimed on a Tuesday but the attendance sheet records Wednesday. <p>The main issues arising for Bromley tutors tested for the week 19th to the 23rd February 2018 were that:-</p> <ul style="list-style-type: none"> • For 1 of the 5 tutors sampled no attendance record could be found • For 3 of the tutors the hours claimed were above the hours declared on the attendance records. 2 hours above, 1 hour 40 minutes above and 7 hours claimed and no hours on the attendance sheet (5/2 to 9/2). <p>The timesheets are submitted weekly for agency and monthly for Bromley staff. The attendance sheets do not come in until the end of the half term; there is no check on the information reported or comparison to the timesheets.</p>		

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
8	<p>Procurement and the Use of Supplier A</p> <p>As discussed above the Home Tuition service will use Bromley tutors as the first choice if the hours are available and there is an appropriate match of resources and need. The second option is to source tutors through the procurement system.</p> <p>The Lead Teacher will upload the requirement to the system specifying the hours to be allocated, needs of the child and start date.</p> <p>The requirement is then available to all tutors vetted and registered to the proprietary purchasing system. Responses to the published requirement are sent to the requester once closed and the lowest cost provider should be selected. For the Home Tuition Service only one provider, Supplier A has responded.</p> <p>The Lead Teacher raised concerns during the course of the audit that the purchasing system does not meet the flexible and urgent needs of their service whereby a replacement tutor may be required for the same day. Another issue was that once a tutor is selected on lowest cost and accepted, a contract is issued but the Lead Teacher will still need to assess the suitability of the tutor and potential match to a student. If the allocation is not appropriate the contract is cancelled and the process starts again.</p> <p>Internal Audit are not in a position to comment on the appropriate use on the system but support the need for robust, transparent procurement in an area that was previously investigated and found inadequate and poorly controlled. Any procedure to procure tutors must comply with Financial Regulations and Contract Procedure Rules and evidence an adequate contractual arrangement with the</p>	<p>Non compliance to Contact Procedure Rules.</p>	<p>In the first instance the Department should consider if the purchasing system is fit for purpose for the Home Tuition Service. If the conclusion is that it does not meet their needs then an alternative should be explored. Any alternative must comply to Financial Regulations and Contract Procedure Rules</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>provider.</p> <p>The review of budget monitoring identified that:-</p> <ul style="list-style-type: none"> the expenditure code set up in the purchasing system for SEN pupils was incorrect. Home Tuition will procure tutors for SEN cases, temporarily assigned to Home Tuition but the cost remains with SEN. The Service accountant was alerted and worked with the Lead Teacher to identify the miscodings and correct. Procurement confirmed that the codes were entered when the system was set up but could be changed for each requirement. the engagement of two tutors working at the Link, is not subject to competitive tendering as the requirement on the purchasing system is set to “manual” rather than “tender”. This effectively means that the engagement of both tutors is not subject to competitive tendering. The annual cost for one tutor is £77,220 based on a confirmed hourly rate of £66, 30 hours per week and 39 weeks per year. the cumulative spend report identifies £8,750 to the owner of the proprietary purchasing system in 2017/18 and £20,000 in 2018/19 but the summary spreadsheet maintained by accountancy of the weekly invoices show £471,366 to them for 2017/18. Accountancy explained that as the payments are made from a holding account and recharged rather than individual expenditure codes, the value is not captured on cumulative spend <p>The audit test to check the sample of agency tutors and allocated pupils to ensure that the engagement was supported by a</p>	<p>Expenditure may not be accurately reflected in the Authority’s accounts.</p> <p>Challenge from alternative providers if the procurement process is not robust and transparent.</p> <p>Cumulative spend with a provider may not be adequately monitored.</p> <p>Errors may not be detected if</p>	<p>If the Department continues to use the purchasing system then the following recommendations will need to be implemented to remedy the weaknesses identified in this finding.</p> <p>All engagements requested by the Home Tuition Team in respect of SEN pupils should be checked to ensure that the correct expenditure code has been assigned.</p> <p>The engagement of the agency tutors working at the Link should be reviewed to ensure that this commission meets with Contract</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>requirement, a contract and that the rates, hours and start dates agreed to the weekly payment was not completed. The Home Tuition Team were not able to access the website to provide the information required for testing. This indicates a training issue that can be addressed as the procedure to check and verify engagements is developed and the necessary controls put in place.</p> <p>This testing had been delayed as it relied on the Lead Teacher to be on site to access the website and was not completed before the start of the summer break. The Lead Teacher had provided a requirement reference for each tutor but without access to the system did not allow any testing to be undertaken. The Senior Procurement Officer confirmed that these references were the service agreements not requirement and also provided start dates and rates.</p> <p>Initial findings indicate that for the 16 possible tutor/pupil agreements:-</p> <ul style="list-style-type: none"> • 1/16 has two long running contracts • Of the 13 contracts declared 5 started in the academic year 2017/18, 2 16/17, 2 15/16, 2 14/15 and 1 in 13/14. • None of the requirements state an end date, a start date only is specified. • The Lead Teacher confirmed that there are open engagements on the system no longer used but cannot be closed on the system. • For a sample of two requirements the Senior Procurement Officer evidenced that 11 and 8 providers were invited to bid for a requirement set up by Home Tuition but all cancelled 	<p>the users are not familiar and adequately trained in the system including processes before and after their involvement and role.</p> <p>Expenditure is not supported by a robust procurement process that would negate any challenge from alternative providers.</p> <p>Open requirements may be used to post incorrect hours</p>	<p>Procedure Rules specifically the need to evidence competitive tendering.</p> <p>The cumulative spend with the provider should be considered as part of budget monitoring.</p> <p>The Home Tuition Team should request training in all aspects of the system as identified in this audit. This will enable the team to identify system access and reports that will allow an adequate level of checking and control.</p> <p>The service requests should include an appropriate end date. It is suggested that the time period does not span academic years.</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>except Supplier A.</p> <ul style="list-style-type: none"> The owner of the purchasing system has not done any review work to suggest why providers do not bid for Home Tuition work but the Senior Procurement Officer suggested that it is the short period of time between the close time and review time. If more than one provider bids they are ranked and given the opportunity to resubmit a bid within the review time. This is not relevant to Home Tuition as only Supplier A bid for work There are service agreements for more hours than are allocated. A check on one requirement evidenced a bid of £48 per hour for 10 hours but the weekly payment summary for this agreement showed that the value regularly exceeded this amount. This should be a basic check undertaken by the Team but is not currently considered. Once the invoice from the owner of the purchasing system has reached Procurement each service head and user would have authorised their charged hours on the website and authorised. 	<p>The requirements may not offer the engagement to a full range of providers and achieve competitive tendering.</p> <p>Payment made to the provider may not be the agreed rate.</p>	<p>The contract with the provider of the purchasing system is due for renewal next year. The new contract should consider the performance and review data that is available from any system provider, specifically feedback in cases where providers repeatedly fail to bid for available work.</p> <p>The Team must develop a process to review the submitted timesheets from agency tutors and check to agreed rates. Similarly the agreed hours to be provided that week should be reconciled to the payment for that tutor.</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>The Lead Teacher confirmed that no checks are made on the rates charged; the team do not have access to the weekly spreadsheet that is attached to the invoice. The invoices for February 2018 and July 2018 were checked for the Home Tuition engagements; rates had both increased and decreased but the Lead Teacher was not aware of any change and had not received any uplift or change of rate notification.</p>		<p>The Team must confirm the hourly rates paid to the agency tutors currently engaged by the service.</p> <p>Any variation to the rates agreed when the service agreement is accepted should be supported by an annual uplift notification or communication specific to that individual.</p> <p>Priority 1</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
9	<p>Mandatory Training</p> <p>The Home Tuition Team have not completed the online training modules for Financial Regulations, Fraud Awareness, Information Assurance or Internal Controls.</p> <p>The current version of Financial Regulations on-line training has been removed recently from the Info Aware site. The module is being rewritten and will be available in the new year. In the meantime we advise managers to refer their staff to the relevant sections of the Financial Regulations; Internal Audit and Finance will offer advice when requested.</p> <p>Given the findings identified in this report these training modules would enable the Team to understand the need for key controls and compliance to Corporate Financial Regulations.</p> <p>During the course of the audit there were two cases of information security breaches to raise concern:-</p> <ul style="list-style-type: none"> • The admin officer was asked to evidence the virtual learning costs for two children and not being on site provided her user name and password in an e-mail to the auditor. • The Finance Officer logs onto the procurement system to authorise the weekly agency payment using the Lead Teacher user name and password. The value of this authorisation will vary but for February 2018 and July 2018 was £19K and £9K respectively. 	<p>Officers may not comply to Corporate Regulations and follow good practice during their daily operations.</p> <p>Inadequate training does not allow officers to identify fraud and system weaknesses.</p> <p>Non - compliance to agreed policies and procedures with regard to Information Assurance for a team handling sensitive data.</p>	<p>Liaise with Training and Development to ensure that the Home Tuition Team access on line training modules available that would support the financial roles undertaken as part of their daily routines.</p> <p>Officers to be reminded of the need to comply with information assurance policies and maintain a high level of awareness around the handling and access to sensitive data.</p> <p>Priority 2</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
10	<p>Procedures</p> <p>There are procedures available on the shared area to outline the processes within the Team. There is a work flow chart to document the process from the referral, consideration of tutor availability, allocation, reviews and reintegration. This document is not dated, version controlled or owned by an officer. The flow chart does not include the role of the core panel as the principle point of decision making and authorisation. Neither does the flow chart consider the use of agency tutors and the engagement of tutors through the procurement system.</p> <p>There are no operational procedures to document the roles and responsibilities of the finance and admin officers including checking timesheets and maintenance of the database.</p> <p>This is a small team that work closely together but rely on the knowledge and experience of the Lead Teacher that is not formally recorded and reliant on her availability.</p> <p>During the audit it was noted that the Finance Officer works in her M drive. Although it is acknowledged that HR records and timesheets are sensitive documents, folders can be password protected or access limited but must be posted to the Corporate drive.</p>	<p>Without written procedures there is no business continuity and too much reliance placed on the individual officer.</p> <p>Business continuity may be challenged dependent on the availability of the manager.</p> <p>Access to documents relevant to the operation of the service will not be available to other officers as needed.</p>	<p>All work flow charts and procedure notes should be owned, dated, version controlled with a proposed revision date and available in the shared area.</p> <p>The procedures should include all processes used in the delivery of the service.</p> <p>The Team should develop their record keeping to ensure that the information held by the Lead Teacher can be shared and available to the Team in her absence to allow effective delivery of the service.</p> <p>All records related to the operational delivery of the service must be stored on the shared area and protected by limited access or password control as appropriate.</p> <p>Priority 2</p>

No.	Findings	Risk	Recommendation
11	<p>Storage of archived data</p> <p>The Home Tuition Team had been located in offices located at an Academy but moved to the Civic Centre during the Autumn Term 2017. Historical data has been left in the office at the Academy boxed and ready to be archived.</p> <p>If the documents meet the retention requirements, the Team should consider alternative options for retaining historic data such as scanning and storing electronically. If there is no alternative the archived data should be made ready for dispatch to the off site facility.</p>	<p>Data storage arrangements may not comply with GDPR.</p>	<p>Sensitive data should be secured and comply with record retention policies and GDPR legislation.</p> <p>The Team should be aware of their retention policy and confirm that the documents need to be archived.</p> <p>The historic data must be removed from the Academy site, secured and if no other alternatives such as electronic storage are available, be sent to the off site storage facility.</p> <p>Management should refer to the guidance notes available to ensure that the boxes display the correct information, including the destroy date and that an adequate inventory is held on a shared area to enable the records to be retrieved.</p> <p>Priority 2</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>Core Panel Decisions</p> <p>The panel decision and outcome letter must be evidenced for each child receiving Home Tuition.</p> <p>If the Home Tuition is to be time limited this should be specified on the panel decision and the case returned to panel for discussion and extension.</p>	1	<p>The service accepts that the quality and rigour of recording on the database was variable at the time of audit. Improvements have been made to rectify this and, over the next 3 months, the database will be moved onto the education service MIS</p> <p>The operation of Core Panel has been reviewed. The revised process is for an initial outcome letter followed with a Home/ School contract. The latter specifies the number of hours to be provided initially and the planned duration of the intervention.</p> <p>It is not always appropriate for Core Panel to determine the number of hours of tuition that a child should receive. The aim is to provide the statutory educational entitlement but, in response to the specific needs of each child, the number of hours of tuition is likely to be built up gradually. Recommendations to Core Panel for will be based on professional judgement and discussion with the child and their family.</p> <p>The revised process for Core Panel is to allocate Home Tuition in 6 week blocks with a regular review, to limit the risk of drift for children.</p> <p>A quality assurance process, undertaken by the Head of Service on a termly basis will include checks that cases are being reported to Core Panel for review</p> <p>The cases referred to in the report have been reviewed: case 1 returned to Core Panel on 7 March and was agreed.</p>	<p>Lead Teacher Home and Hospital Tuition</p> <p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion</p>	<p>March 2019</p> <p>November 2018</p> <p>November 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>All outcome letters must be signed by the authorising officer.</p> <p>The panel administrator should record the conditions attached to any pending decisions and evidence that those are met prior to commencement of the service. Similarly any decisions to return a case to panel should be diarised and referral resubmitted.</p>		<p>case 2 – the record reviewed by the Head of Service does not use the phrase ‘pending’. The paperwork presented to Core Panel on 27/06/17 was incomplete and the case was reviewed 11/07/17. AT started Home Tuition on 15/07/17. The funding query related to the parents’ previous decision for Elective Home Education and did not delay the provision for the child.</p> <p>In future any deferred decision will include the reason.</p> <p>Case 3 progressed to Post 16 provision. However, the case should have returned to core panel and this is an omission.</p> <p>This is agreed and will be implemented with immediate effect.</p> <p>This is agreed and will be implemented with immediate effect.</p> <p>A check will be made on this aspect of the database records during the termly QA process.</p>	<p>Head of Service, Access and Inclusion</p> <p>Head of Service Access and Inclusion</p> <p>Head of Service Access and Inclusion</p>	<p>November 2018</p> <p>November 2018</p> <p>November 2018</p> <p>November 2018</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p>Medical Evidence</p> <p>All pupils receiving Home Tuition, eligible as being unable to attend school for health reasons should be supported by a letter from the relevant consultant; a letter from the GP should not be accepted.</p> <p>Although Home Tuition should be a short term provision placements have spanned academic years and the medical evidence should be updated annually.</p> <p>Staff should be reminded to update the database with the date of the medical evidence.</p>	2	<p>Practice is now robust and letters from GPs are no longer accepted as sufficient evidence. Core Panel has been strengthened since September 2018 by a senior manager from CAMHS providing oversight of referrals from CAMHS.</p> <p>The date of the last medical evidence is now entered on the database, as is a system to alert staff to the next date when evidence needs to be provided.</p> <p>Termly QA will monitor compliance</p>	<p>Lead Teacher Home and Hospital Tuition</p> <p>Head of Service, Access and Inclusion</p>	<p>November 2018</p> <p>November 2018</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p>Reviews</p> <p>Formalise the review discussions and input format to allow manipulation of the data for monitoring.</p> <p>Key dates must be identified and the nominated action confirmed as complete. Conditions stipulated at Panel must be met and resubmitted as necessary.</p> <p>Monitor receipt of the half termly reports received from the tutors to ensure they are received in a timely manner, dated and posted to the shared</p>	2	<p>The service accepts this was an area of weakness but one that they have been working hard to improve.</p> <p>Home and Hospital Tuition Team is developing (since September 2018) a record keeping framework using Pupil Provision Maps (as per SEN Code of Practice) and specialist advice has been sought to create this framework.</p>	Lead Teacher, Home and Hospital Tuition	System embedded March 2019

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p>Database</p> <p>The database must be developed to include the key areas discussed.</p> <p>Assign ownership of the database and devolve responsibility to update the database in a timely manner to ensure data is complete and accurate.</p> <p>Retain a permanent record of the database every half term to provide and use the strike through and comments box in excel to ensure that there is an adequate audit trail.</p> <p>Develop standard input and format for all fields to allow manipulation of the data for monitoring purposes.</p> <p>Create mandatory fields to capture key information such as agreed, planned and delivered hours.</p> <p>Include maintenance of the database in the procedures guide.</p> <p>Develop a suite of reports that could be generated from the database to support monitoring the service.</p>	1	<p>The plan is to transfer the database in line with other services and initial discussions have taken place to start the process. Operational responsibility for the database will sit with a single person, including following the transfer.</p> <p>The service had implemented this process since November 2017 and screenshot is available for review.</p> <p>Mandatory fields and standard formats for fields are being built into the revised database in preparation for transfer. Guidance for staff will be developed by the officer with operational responsibility for the database. A maintenance guide is a task that will be allocated to the operational role as described above.</p> <p>We agree that this is essential and will implement the recommendation.</p>	<p>Lead Teacher, Home and Hospital Tuition</p> <p>N/A</p> <p>Lead Teacher , Home and Hospital Tuition</p> <p>Lead Teacher, Home and Hospital Tuition</p>	<p>March 2019</p> <p>Completed</p> <p>January 2019</p> <p>March 2019</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p>Payment to Bromley Tutors</p> <p>The team must complete meaningful checks on the timesheets prior to authorisation and payment.</p> <p>Tutors must complete the timesheet by an agreed date and format including the level of detail to be specified by the Home Tuition Team.</p> <p>An additional check would be for the parent/carer to sign the relevant line to confirm attendance.</p> <p>The timesheet should be supported by the approved hours allocated to each child as detailed on the database and approved by Panel.</p> <p>Need to consult with HR to ensure that the tutors are correctly claiming car mileage in line with agreed corporate policies.</p>	2	<p>The service recognises that there are risks of falsifying timesheets in a system that relies upon lone working. There is now a checking system in place in which the attendance report is now received alongside the tutor's timesheet. Each tutor has a daily planner which is signed by parents and the Lead Teacher checks these signatures are in place. All parts of hours are now standardised to remove the risk of interpretation. Revised timesheet layout is available for review.</p> <p>Spot checks of timesheets will be conducted on a monthly basis.</p> <p>Core Panel operates a rag rating system in which children are not rated green until they are safely settled in the provision allocated to them. This system was introduced last academic year. From November 2018, Core Panel will consider the allocation of hours as part of the regular update from the previous meeting and will not rate a child as green until this has been confirmed as added to the database.</p> <p>This was acted upon at the end of the last academic year and is in place.</p>	<p>Lead Teacher Home and Hospital Tuition</p> <p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion</p>	<p>Completed</p> <p>November 2018</p> <p>November 2018</p> <p>Completed</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p>Payment to Agency Tutors</p> <p>The checks on the weekly submitted timesheets for the agency tutors must be meaningful including a check that the hours claimed agree to allocated hours.</p> <p>A procedure to document and check temporary changes and cancellations should be considered.</p> <p>The parent/carer should sign the relevant line on the claim form to support service delivery.</p> <p>The Team must review and update their procedures and instructions for agency tutors to complete the weekly timesheet in line with the specific findings of the audit sample check.</p>	1	<p>This is an identical process to the one now in place for Tutors supplied by the LA.</p> <p>Spot checks are conducted on a monthly basis</p> <p>This is in place .Changes are recorded on the pupil attendance record which is available for review.</p> <p>This is in place.</p> <p>This is in place. The new procedure (available for review) was issued on 13 September and reinforced at training for tutors on 11 October.</p>	<p>Lead Teacher</p> <p>Head of Service</p> <p>Lead Teacher</p> <p>Lead Teacher</p> <p>Lead Teacher</p>	<p>Completed</p> <p>November 2018 Completed</p> <p>Completed</p> <p>Completed</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
7	<p>Attendance Registers</p> <p>All tutors must return the attendance sheets, in the agreed format, within the time period specified by the service.</p> <p>The service should consider recalling the attendance sheets more regularly to compare to the approved allocated hours and the timesheets.</p> <p>Discrepancies between attendance sheets, approved hours and timesheets should be discussed with the individual tutor and cleared.</p>	1	<p>This system has been in place since July 2017. Example of attendance sheet available for review .</p> <p>Since September 2018 the attendance collection now happens on a monthly basis rather than 6 weekly to coincide with the timesheets.</p> <p>Since September 2018, standardised attendance sheets and timesheets allow for easier checking. This was first tested for the September pay run and we were able to discuss the issues with the tutors checked.</p>	<p>Lead Teacher, Home and Hospital Tuition</p> <p>Lead Teacher</p> <p>Lead Teacher</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
8	<p>Procurement and the Use of Supplier A</p> <p>In the first instance the Department should consider if the purchasing system is fit for purpose for the Home Tuition Service. If the conclusion is that it does not meet their needs then an alternative should be explored. Any alternative must comply to Financial Regulations and Contract Procedure Rules</p> <p>If the Department continues to use the purchasing system then the following recommendations will need to be implemented to remedy the weaknesses identified in this finding.</p> <p>All engagements requested by the Home Tuition Team in respect of SEN pupils should be checked to ensure that the correct expenditure code has been assigned.</p> <p>The engagement of the agency tutors working at the Link should be reviewed to ensure that this commission meets with Contract Procedure Rules specifically the need to evidence competitive tendering.</p> <p>The cumulative spend with the provider should be considered as part of budget monitoring.</p>	1	<p>The service believes that the purchasing system, as currently configured, does not meet the needs of the service. It does not allow the flexibility required to match provision to the needs of individual children and the pattern of demand. The service maintains that a tendering process to engage a suitable agency would better meet the needs of the service.</p> <p>There may be a solution. Re-configuring access rights, previously blocked for the service, would allow tendering from a range of providers. This is being raised with the supplier and subsequent actions will flow from this.</p> <p>All codes have been checked and are correct currently.</p> <p>The service recognises the high expenditure against this and will explore alternatives to the current arrangements by December 2018, following discussion with the current supplier. Whatever the outcome of those discussions, the intention is to reduce the use of agency tutors.</p>	<p>Head of Service, Access and Inclusion</p> <p>Lead Teacher, Home and Hospital Tuition</p> <p>Head of Service, Access and Inclusion</p>	<p>November 2018</p> <p>Completed</p> <p>December 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>The Home Tuition Team should request training in all aspects of the system as identified in this audit. This will enable the team to system access and reports that will allow an adequate level of checking and control.</p> <p>The service requests should include an appropriate end date. It is suggested that the time period does not span academic years.</p> <p>The contract with the provider of the purchasing system is due for renewal next year. The new contract should consider the performance and review data that is available from any system provider, specifically feedback in cases where providers repeatedly fail to bid for available work.</p> <p>The Team must develop a process to review the submitted timesheets from agency tutors and check to agreed rates. Similarly the agreed hours to be provided that week should be reconciled to the payment for that tutor.</p>		<p>The service recognises there has been a lack of training for staff and a request for training forms part of the planned discussions with, the system provider.</p> <p>Whilst the service agrees that specifying an end date for each service request would increase management controls, the current system (as far as the Service is aware) does not allow for extensions and with the added consideration that we cannot chose who is allocated to an assignment, not having an ability to extend an individual commission, creates a risk of reduced continuity for the young person. System functionality will be explored with the supplier.</p> <p>Agreed. Advice will be sought from ECHS Commissioning</p> <p>This system is in place as of September 2018, using the same process for Agency tutors as Bromley tutors. Please see Finding 5.</p>	<p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion</p> <p>Lead Teacher, Home and Hospital Tuition</p>	<p>December 2018</p> <p>December 2018</p> <p>December 2018</p> <p>Completed</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>The Team must confirm the hourly rates paid to the agency tutors currently engaged by the service.</p> <p>Any variation to the rates agreed when the service agreement is accepted should be supported by an annual uplift notification or communication specific to that individual.</p>		<p>The hourly rate is confirmed in the contract process at the beginning, however it is noted by the service that during audit some anomalies in hourly rates were found. We are now working closely with the agency to make sure these are consistent.</p> <p>The service recognises that this will be a new process within the system. Anomalies in the hourly rate were both in excess and less than the hourly rate agreed. The service is looking into why this is recorded as such and how the system records the hourly rate whilst hours fluctuate.</p>	<p>Lead Teacher, Home and Hospital Tuition</p> <p>Lead Teacher, Home and Hospital Tuition</p>	<p>December 2018</p> <p>December 2018</p>
9	<p>Mandatory Training</p> <p>Liaise with Training and Development to ensure that the Home Tuition Team access on line training modules available that would support the financial roles undertaken as part of their daily routines.</p> <p>Officers to be reminded of the need to comply with information assurance policies and maintain a high level of awareness around the handling and access to sensitive data.</p>	2	<p>The training recommended is not currently available. The Lead Teacher will complete Online Financial Training as quickly as when the course becomes available.</p> <p>GDPR and compliance to it is detailed in the Home Tuition improvement plan .The Lead Teacher has completed the PIA and this has highlighted the changes.</p>	<p>Lead Teacher, Home and Hospital Tuition</p> <p>Lead Teacher, Home and Hospital Tuition</p>	<p>December 2018</p> <p>December 2018</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
10	<p>Procedures</p> <p>All work flow charts and procedure notes should be owned, dated, version controlled with a proposed revision date and available in the shared area.</p> <p>The procedures should include all processes used in the delivery of the service</p> <p>The Team should develop their record keeping to ensure that the information held by the Lead Teacher can be shared and available to the Team in her absence to allow effective delivery of the service.</p> <p>All records related to the operational delivery of the service must be stored on the shared area and protected by limited access or password control as appropriate.</p>	2	<p>A new workflow procedure is in place as of September 2018 (available for review)</p> <p>All of the central team have access to the N drive where all pertinent information is held. As of September 2018 all student files have been standardised. A list of caseworker allocation is available centrally so in a caseworker's absence the cases are able to be picked up by the other members of the team.</p> <p>Operational delivery documents are currently stored on the N drive. It is limited by access to just the central members of the team</p>	<p>Lead Teacher, Home and Hospital Tuition</p> <p>Lead Teacher, Home and Hospital Tuition</p> <p>Lead Teacher, Home and Hospital Tuition</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
11	<p>Storage of archived data</p> <p>Sensitive data should be secured and comply with record retention policies and GDPR legislation.</p> <p>The Team should be aware of their retention policy and confirm that the documents need to be archived.</p> <p>The historic data must be removed from the Academy site, secured and if no other alternatives such as electronic storage are available, be sent to the off site storage facility.</p> <p>Management should refer to the guidance notes available to ensure that the boxes display the correct information, including the destroy date and that an adequate inventory is held on a shared area to enable the records to be retrieved.</p>	2	<p>All sensitive data is stored on the N drive and the service is working with the recommendations of the PIA to make sure their email systems are GDPR compliant. Nothing is held on the M drive. Any sensitive data being sent via email is being sent securely via Egress switch.</p> <p>The service improvement plan recognises the need to update policies.</p> <p>This is agreed and arrangements are being made.</p> <p>This is agreed</p>	<p>Head of Service, Access and Inclusion</p> <p>Lead Teacher, Home and Hospital Tuition Service</p> <p>Head of Service, Access and Inclusion</p> <p>Head of Service, Access and Inclusion,</p>	<p>Completed</p> <p>March 2019</p> <p>February 2019</p> <p>February 2019</p>

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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THE LONDON BOROUGH
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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

Issued to: Vinit Shukle, Head of ISD
Dee Jackson, IT Contract and Operations Manager

Cc: Mark Bowen, Director of Corporate Services

Prepared by: Senior Internal Auditor (Audit contractor on behalf of LBB) and Principal Auditor

Reviewed by: Audit Manager (Audit contractor on behalf of LBB) and Head of Audit

Date of Issue: 16 October 2018

Report No.: CEX/13/2017/AU

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of IT Project Management for 2017-18. The audit was carried out in quarter one of 2018-19 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. A Client Team for the London Borough of Bromley (LBB) liaise with the Council's IT contractor who is contracted to undertake projects for departments within LBB.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 10th April 2018.

AUDIT OPINION

5. Overall, the conclusion of this audit was that Substantial Assurance can be placed on the effectiveness of the control framework. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

6. Controls noted to be in place and working well, based on the sample testing conducted, included:
 - A copy of the Project Change Control Notice (CCN) process, which is in line with PRINCE 2 methodology was obtained and confirmed to be up-to-date.
 - Bromley staff were able to access information regarding project applications via the OneBromley intranet page.
 - A sample of three CCNs was tested with the CCN documentation for these being readily available.

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

- The CCN documentation obtained was confirmed to detail the costs and descriptions of works to be undertaken, with catalogue references, descriptions, number of days, cost per day and total costs included.
- The purchase orders raised in all three CCNs tested matched the agreed costings.
- Weekly meetings were held to discuss on-going projects and their progress.

However, we would like to bring to management attention the following issues:

- Examination of three CCNs identified that in all three cases the information included on the CCN was not complete.
- The Delivery Status spreadsheet in place was not complete, i.e. this did not detail all the projects in place that were either still in the processing stage or in the completed stage of delivery.
- There were three main forums where projects were discussed, namely: The Partnership Board, the LBB IT contractor Governance Portfolio Meetings (monthly), and the Information Technology Engagement Group (ITEG) weekly meetings. Minutes were taken for the Partnership Board but not for the other two forums, although the status and actions for each project arising from the ITEG meetings were recorded on the Delivery Status spreadsheet. The minutes of the Partnership Board which we evidenced did not however include any information on the performance of IT projects.
- Terms of reference for the ITEG had been drawn up but were not sufficiently detailed. The LBB IT contractor Governance Portfolio meetings and the Partnership Board did not have a Terms of Reference (ToR) in place.
- Although the amounts to be paid for individual projects were approved by the project originators eg Heads of Service, these amounts then formed part of a monthly invoice from the Council's IT contractor. The amount invoiced for several of the payments in our sample testing had not been authorised for payment at the correct level of financial authority ie Head of ISD or the Contract Monitoring ISD Manager (CM).
- Testing of 10 payments for the sample of three CCNs identified that the invoices received did not specify in detail the goods / services provided.
- There was no evidence of a 'lessons learned' review carried out for two of the three projects in our sample.

SIGNIFICANT FINDINGS (PRIORITY 1)

7. There were no priority one recommendations raised as part of this audit.

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

8. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

9. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1.	<p>CCN Forms</p> <p>A Change Control Notice (CCN) contains the following: Part A – Initiation (1.1.1. of the Initiation of Projects document (IPD)); Part B – Evaluation (1.3.1 the Project Plan of the IPD); and Part C – Authority to Proceed (1.3.5 IPD).</p> <p>Testing of a sample of the CCNs for three IT Projects (namely: CCN0164 – Housing; CCN0176A – Decommissioning of Libraries, and CCN0205 – CRM) found these to be incomplete as follows:</p> <ul style="list-style-type: none"> • CCN0164 – Part A of the CCN had information missing such as: which cost centre the project should be costed against, which service is being amended, details of benefits expected to be realised and consequences of non-implementation of the CCN. <p>Part C - the authority to proceed was not signed. It was not indicated that the CCN was approved.</p> <p>An updated version of the CCN was provided to evidence that costs had been amended. On the updated version both the originator and sponsors signatures were missing, although an email had been received from the project sponsor providing</p>	<p>Where CCNs are not fully completed there is a risk that the project does not deliver what is required.</p>	<p>All CCN's should be fully completed before work commences.</p> <p>Projects should only be commissioned once the Head of ISD has had oversight of the project verifying that the CCN's are properly completed.</p> <p>(Priority 2)</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>the cost code to authorise the purchase order being raised by ISD.</p> <ul style="list-style-type: none"> CCN0176A – Part A, did not detail the benefits to be realised or the consequence of not undertaking the CCN. Part C - Authority to proceed, it is not indicated if the project was accepted or rejected. CCN0205 – Part A, the business unit and cost centre sections were not completed. In addition, the originator’s signature was not completed. Part C - No indication of whether the CCN has been approved or rejected. Both the Originator and the Sponsor did not sign Part C of the CCN. 		
2.	<p><u>Central Projects Record</u> A delivery status spreadsheet is maintained of projects that have been completed and those that are in the process of being completed. The spreadsheet was provided by the Contract monitoring ISD manager. However, one out of the three projects sampled were not included on the delivery status spreadsheet, (CRM project).</p>	<p>Where the central record spreadsheet is not complete, there is a risk that projects not included on it may not have their progress monitored.</p>	<p>Management should ensure that all projects requested are put onto the central record ‘Delivery Status Spreadsheet’. (Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

No.	Findings	Risk	Recommendation
3.	<p><u>Forums for Project Discussions</u></p> <p>There are three sets of meetings where projects are discussed:</p> <ul style="list-style-type: none"> • The Partnership Board; • LBB IT contractor Governance Portfolio Meetings (monthly); and • ITEG (weekly). <p><u>The Partnership Board</u></p> <p>The Partnership Board is a high level meeting where projects are discussed. We were able to evidence the minutes and accompanying presentations of the last three meetings held in July, August and September 2018. We noted however that:-</p> <ul style="list-style-type: none"> • The minutes for each of the three meetings show previous actions documented but the ‘Actions from previous meetings’ item in the presentation reports prepared by the Council’s IT contractor is blank, and • The ‘Project Performance’ item in the July meeting minutes is blank and the item in the August meeting minutes shows ‘16/8 - project performance to be reported next meeting’. The minutes of the subsequent meeting in September however show the same identical wording with no 	<p>Where there are no formal meeting minutes for the forums where projects are discussed, and/or a lack of timely, accurate and complete information, there is a risk that any actions or important decisions cannot be recalled to and/or referred to at a future date.</p>	<p>Minutes should be taken for all forums where projects are discussed and clearly state the actions discussed and agreed. Presentations should include information which is timely, accurate and complete.</p> <p>(Priority 2)</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>information reported.</p> <p><u>LBB IT contractor Project Portfolio Meetings</u> These are monthly meetings between the LB of Bromley client team and the IT contractor staff discussing the CCNs. A presentation by the IT contractor details the performance of the projects with the projects being 'RAG' rated. Although the IT Contractor's PowerPoint presentations were provided, there was no evidence of meeting minutes.</p> <p><u>ITEG</u> The ITEG meetings are not formally minuted, although information about individual projects is discussed and included in a cumulative tracking document: a CCN Tracker Spreadsheet. The date of the meeting is noted and the information is documented. The CCN Tracker Spreadsheet is a cumulative tracking document.</p>		
4.	<p><u>Terms of References for Forums</u> A Terms of Reference (ToR) details the purpose of the group / forum / board. ITEG has a ToR in place. However, the ToR does not sufficiently</p>	<p>Where ToRs are not in place and are not sufficiently detailed, there is a risk that groups / forums / boards are unaware of their</p>	<p>The ToR should be reviewed for the ITEG and ensure that it represents all roles and responsibilities sufficiently.</p>

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 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>detail the membership or quorum requirements. In addition there are a number of objectives within the ToR that do not seem to be demonstrated by the ITEG. For example – ‘to ensure sufficient detail is captured from the business to adequately complete Part A’. From issue one above it has been highlighted that there are sections within the CCN which are incomplete.</p> <p>No ToRs were provided for the Partnership Board or the LBB IT contractor Governance Portfolio Meetings.</p>	<p>responsibilities and decisions are not undertaken at the correct authority level.</p>	<p>ToRs should be put in place for the Partnership Board and the LBB IT contractor Project Portfolio Meetings.</p> <p>(Priority 2)</p>
<p>5.</p>	<p><u>Payments for Work Completed</u></p> <p>Testing of ten payments from a sample of three CCNs (namely: CCN0164, CCN0176A and CCN0205) established that the following process was in place:</p> <ul style="list-style-type: none"> Blanket purchase orders were in place for each CCN (orders that cover the total cost of the project which are netted against work as it is completed. Payment is then made for services undertaken). The IT contractor emails the ISD Client Team with work undertaken which is then reconciled with the details of the work requisitioned in Confirm (the IT system used to record 	<p>Where there is a lack of oversight by the Head of ISD and the CM on large payments being paid, there is a risk of non-compliance with Financial Regulations and erroneous payments being made.</p>	<p>Management should ensure that the monthly invoices received from the Council’s IT contractor are authorised for payment at the correct level of financial authority i.e. Head of ISD or the Contract Monitoring ISD Manager (CM), depending on the amount invoiced.</p> <p>(Priority 2)</p>

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Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>project information).</p> <ul style="list-style-type: none"> An email is then sent to the originator to approve the payment for the specified amount. Once approved (by email) the invoice is received from the IT contractor and then this is sent to accounts payable for payment. <p>Some payments were for significant amounts: (for example CCN0176A was a payment of £74,505 in February 2018, which was evidenced as being approved by the Infrastructure Consultant); however we were informed by the Head of ISD and the CM (Contract Monitoring ISD manager) of the client team that they do not have sight of any expenditure before it is paid. The Head of ISD and the CM were aware of costs from the CCN but not when payments were made on an on-going basis.</p>		
6.	<p><u>Invoice Descriptions</u></p> <p>According to section 8.7 of the Financial Regulations <i>'before payment is made it should be ensured that goods and services have been received'</i>. Therefore without sufficient detail on invoices, it is unclear what goods and services relating to a project have been provided.</p> <p>Discussion with the Business Support Manager (BSM) identified</p>	<p>Where an invoice is not specific, there is a risk that the Council is paying for goods / services that have not been delivered.</p>	<p>The Client Team should request the IT Contractor to include on their invoices sufficient detail of the goods / services provided.</p> <p>(Priority 2)</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

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 Identification of suggested areas for improvement

REVIEW OF IT PROJECT MANAGEMENT FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>that the invoices did not detail all the completed works that constitute the total value of that the invoice. For example, invoice number 472968 has a gross value of £74,342.49, but it was not specified on the invoice what works the invoice related to.</p> <p>Prior to an invoice being raised, an email is sent from the IT contractor to the Client Team detailing what project work has been completed and how much they will be invoicing for that month. An invoice is then raised against the CCN value of the purchase order based on that information.</p>		
7.	<p><u>Lessons Learned</u></p> <p>According to PRINCE2, one of the objectives of the ‘closing of the project’ stage is the following ‘<i>Capture lessons resulting from the project and complete the Lessons Learned Report</i>’.</p> <p>There was a ‘Lessons Learned Log’ completed for the CRM project but there was no evidence of a similar log completed for the other two projects in our sample.</p>	<p>Where lessons learned are not documented throughout the life of the project, there is a risk that project failures and successes are not identified and used going forwards.</p>	<p>After each project a ‘Lessons Learned Log’ should be completed.</p> <p>(Priority 3)</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1.	<p>All CCN's should be fully completed before work commences.</p> <p>Projects should only be commissioned once the Head of ISD has had oversight of the project verifying that the CCN's are completed accordingly.</p>	2	<p>Agreed. In future, we will check to ensure that CCNs are fully completed. We should add that email correspondence is kept to evidence that the approval of the project originator and sponsor was obtained before the project commenced.</p> <p>Agreed. The completed CCNs are reviewed, and consequently agreed or rejected, at the ITEG weekly meetings, which are attended by representatives from the IT contractor and the Head of ISD and the ISD Contract Monitoring Manager. From now on, we will insert a table in the following week's ITEG meeting email, showing the project CNN number and the 'Agreed' or 'Rejected' decision formally recorded.</p>	Head of ISD and the ISD Contract Monitoring Manager.	31 October 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2.	It should be ensured that all projects being undertaken are put onto the 'Delivery Status Spreadsheet' - central record once approved.	2	Agreed. We will ensure from now on that all projects are included on the spreadsheet.	Head of ISD and Contract Monitoring Manager ISD	31 October 2018
3.	Minutes should be taken for all forums where projects are discussed and clearly state the actions discussed and agreed. Presentations should include information which is timely, accurate and complete.	2	Partly agreed. ITEG meetings are held weekly and updates on projects discussed are noted and recorded on the ITEG spreadsheet following every meeting. The actions required are circulated after each meeting. Minutes are not therefore considered necessary. Powerpoint presentations provided by the IT contractor for every Project Portfolio Board meeting are in lieu of formal minutes and clearly state 'Open' and 'Closed' actions for projects. These are discussed and agreed with ISD at each meeting. Minutes are not therefore	Head of ISD and Contract Monitoring Manager ISD	31 October 2018

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>considered necessary.</p> <p>For the Partnership Board however we will ensure in future that the discussions about project performance are clearly documented in the meeting minutes. We will also ensure that meeting presentations clearly show the actions arising from the previous meeting.</p>		
4.	<p>The ToR should be reviewed for the ITEG and ensure that it represents all roles and responsibilities sufficiently.</p> <p>ToRs should be put in place for the Partnership Board and the LBB Project Portfolio Meetings.</p>	2	<p>Agreed. The ToR for ITEG will be reviewed now and annually in future.</p> <p>ToRs will be put in place for the Partnership Board and the IT contractor's Project Portfolio Board meetings.</p> <p>The purpose of the Project Portfolio Board meeting is documented in the Powerpoint presentation provided at each meeting by the IT contractor so we will use this to create a ToR for that forum.</p>	Head of ISD and Contract Monitoring Manager ISD	31 October 2018

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5.	Management should ensure that the monthly invoices received from the IT contractor are authorised for payment at the correct level of financial authority ie Head of ISD or the Contract Monitoring ISD Manager (CM), depending on the amount invoiced.	2	Agreed. We will ensure that the IT contractor's invoices are authorised at the correct level of financial authority before they are passed to Liberata for payment.	Head of ISD and Contract Monitoring Manager ISD	31 October 2018
6.	The Client Team should request the IT contractor to include on their invoices sufficient detail of the goods / services provided.	2	Agreed. We will instruct the IT contractor to include details of the goods and/or services provided on each monthly invoice.	Head of ISD and Contract Monitoring Manager ISD	31 October 2018
7.	After each project a 'Lessons Learned Log' should be completed.	3	Agreed. This would not be appropriate for smaller work packages but we will implement it for all large projects in future. Any areas for improvement which are identified will then be fed into future project needs.	Head of ISD and Contract Monitoring Manager ISD	31 October 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

FINAL INTERNAL AUDIT REPORT

ENVIRONMENT AND COMMUNITY SERVICES

PCNs AUDIT FOR 2017-18

Issued to: Angus Culverwell, Assistant Director, Traffic and Parking
Nigel Davies, Executive Director ECS
Claire Martin, Head of Finance ECS and Corporate
Allen Herve, Contracts & Operations Manager
Kelle Akala, Performance and Debt Recovery Manager

Cc: Dave Hogan, Head of Internal Audit

Prepared by: Principal Auditor

Date of Issue: 18/09/2018

Report No: ECS/02/2017/AU

REVIEW OF PCNs AUDIT 2017-18

INTRODUCTION

1. This report sets out the results of our systems based review of PCNs Audit 2017-18. The audit was carried out in Q1 of 2018-19 as part of the programmed work specified in the 2017/18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations. Any Priority 1 recommendations or Nil/Limited Assurance opinions must be considered for inclusion in the Department's Risk Register.

AUDIT SCOPE

3. The scope of the audit was outlined in the Terms of Reference issued on 27/02/2018.

AUDIT OPINION

4. Overall, the conclusion of this audit was that substantial assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

5. This review focused on the new parking enforcement contract. The following controls were tested as part of the audit:
 - Robust governance arrangements are in place for contract monitoring.
 - The contract is monitored at the appropriate level of seniority by suitably trained and skilled officers.
 - Management information is obtained from the contractor on a timely basis and is checked for accuracy.
 - Contractor performance is measured and monitored against performance standards and milestones set out in the contract.

REVIEW OF PCNs AUDIT 2017-18

- Contract delivery failures and/or declining contractor performance is identified at an early stage and dealt with properly in line with contractual requirements.
 - The financial position of the contract is monitored throughout the contract term to identify likely overspends at the earliest opportunity.
 - Contract variations and amendments are managed robustly with standard processes for requesting, approving and administering the variations.
6. Controls were reviewed by way of checking supporting documents and sample testing.
 7. A random sample of 10 KPIs for monitoring Parking Enforcement by the contractor was reviewed to ensure they were being monitored. Supporting documents to monitor each sampled KPI were requested for two random months. The supporting information was reviewed to ensure that monitoring information is provided by the contractor in a timely manner, the information is reviewed by management, discussed at contract monitoring meeting and penalties are applied if applicable. The sample testing highlighted some contract monitoring issues which are detailed in finding 1 and 2 below.
 8. A random sample of 20 PCNs issued for the period April 2017 to March 2018 was also reviewed to ensure that the PCNs are progressed in a timely manner and appeals are managed as per the procedure. The progression of PCNs and administration of appeals was found to be satisfactory for the sampled PCNs.
 9. The contractor is responsible for collection and banking of the income. Internal audit reviewed the reconciliation process for the PCN income to ensure receipts are accounted for appropriately. The issues highlighted are detailed in Finding 3.
 10. Five recommendations made within the 2016-17 report were followed up as part of this audit.
 - Three recommendations related to processes that are performed by the contractor (timely progression of PCNs, running of stuck reports and use of correct cancellation codes) which are kept under review by management.
 - A recommendation relating to effective enforcement for foreign vehicles has been implemented as the new contract now includes enforcement for foreign vehicles within Bromley.

REVIEW OF PCNs AUDIT 2017-18

- Management advised that the recommendation relating to keeping policies and procedures updated has been implemented and all policies and procedures were updated at the start of the new contract in April 2017. However, during the course of this audit it was noted that the out of date versions of some procedure notes were held on shared drive by the contractor. This sometimes causes confusion.

SIGNIFICANT FINDINGS (PRIORITY 1)

10. There are no priority one findings in this report.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

11. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

12. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p>The sample testing of 10 KPIs highlighted the following issues which require management attention:</p> <p>Application of Enforcement KPIs 1 to 6 was reviewed for June 2017 and December 2017. Overall performance related defaults of £7,283 and £ 11,815 were applied for June 2017 and December 2017 respectively. However, it was noted that the following defaults were not applied:</p> <p>Enforcement KPI 1 was not achieved in June 2017 and a default of £75 which should have been applied was not applied.</p> <p>Enforcement KPI 2 was not achieved in June 2017 and a default of £100 which should have been applied was not applied.</p> <p>Enforcement KPI 1 and 2 are measured by the percentages of cases that were uploaded late out of the total issued for that category. Each PCN later than that counts towards this KPI. The Head of Parking advised that the contractor has been granted an additional 24 hours for the PCNs to be uploaded. This agreement is not documented.</p>	<p>Performance of the contractor is not managed, leading to ineffective service delivery and value for money not being obtained.</p>	<p>Management should ensure that the information to support the KPIs should be thoroughly reviewed and defaults are consistently applied.</p> <p>Any decisions to not apply defaults should be recorded along with the justification.</p> <p>Any changes to the specifications should be formally documented and retained.</p> <p>[Priority 2]</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	Enforcement KPI 4 was not achieved in December 2017 and a default of £250 which should have been applied was not applied. The Head of Parking confirmed that he agreed that this default should not be applied; however no evidence of this agreement was retained.		
2	The sample of 10 KPIs tested included the Clean KPIs 2 & 3. It was noted that inspections to assess the cleanliness of car parks are ad hoc.	Performance of the contractor is not managed, leading to ineffective service delivery and value for money not being obtained.	<p>A rolling plan for inspections should be put in place to ensure all sites are visited over a period of time.</p> <p>[Priority 2]</p>
3	<p><u>Review of reconciliation process:</u></p> <p>The contractor is responsible for collection and banking of the income. Internal audit reviewed the reconciliation process for the PCN income to ensure receipts are accounted for appropriately. The contractor provides information of all payments received and banked against ICT software (3sixty) and all payment systems, including web, phone and authorities payment files. From the start of the contract, all revenue</p>	Failure to undertake appropriate checks lead to potential losses to the authority.	<p>Outstanding queries relating to the PCN income for 2017-18 should be resolved with the contractor as soon as possible.</p> <p>Going forward discrepancies should be</p>

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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>streams were treated separately. Each amount coming in would be recorded according to the amount it was allocated for (e.g. bailiffs). The Data Analyst in the Parking section would check that that amount had been received at their end. There would often be some overlap between normal PCN payments, and bailiff cheques. The cheques often got mixed up, and they sometimes got confused with cheques for permit income. This caused problems with the reconciliation when it became difficult to confirm the amount for each stream.</p> <p>The Head of Parking advised that the reconciliation of the PCN income for the financial year 2017-18 is still ongoing due to difficulties in reconciling daily, weekly and monthly amounts for different payment types and for different categories. At the time of writing this report, Parking are awaiting on a response from the contractor detailing the outcomes of PCN exceptions that needed to be cleared for the end of financial year 2017-18.</p> <p>An updated process for reconciliation has been put in place from April 2018 to address the above issues. Now all PCN payments are collated into one monthly spreadsheet, divided by day. Each daily amount for each stream can be tracked on the sheet, and easily checked against Oracle to ensure it had</p>		<p>investigated as soon as they are identified. The procedure for the reconciliation of PCN income should be documented by the Parking section and Finance.</p> <p>[Priority 2]</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>been received in our accounts. Refunds are accounted for on the same document, and monthly totals are verified. Any discrepancies are more easily flagged, since the contractor is responsible for the attribution of payments to the revenue sources.</p> <p>The PCN income reconciliation undertaken by Finance was reviewed for the Month of May 2018 and June 2018. The reconciliation was satisfactory.</p> <p>It was also noted that the PCN income reconciliation procedure has not been documented by the Parking section and Finance.</p>		
4.	<p>Financial and budget monitoring meetings are held between Parking and Finance on a monthly or by-monthly basis depending on the requirements for finance to report. Minutes of these meetings are not kept by the Parking section.</p>	<p>Failure to undertake financial monitoring may lead to potential losses to the authority.</p>	<p>The financial position of the contract should be monitored throughout the contract term to identify likely overspends at the earliest opportunity.</p> <p>Financial and budget monitoring meetings should be minuted when it</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
			<p>is carried out. The issues discussed and the action plan to address them should be recorded and followed up at future meetings. [Priority 2]</p>
5.	<p>As part of the follow up of recommendations made in the PCN audit 2016-17, management advised that the recommendation relating to keeping policies and procedures updated has been implemented and all policies and procedures were updated at the start of the new contract in April 2017.</p> <p>However, during the course of this audit it was noted that the out of date versions of some procedure notes were held on shared drive by the contractor. This sometimes causes confusion.</p>	<p>Incorrect action may be taken due to out of date procedures.</p>	<p>All policies and procedures should be kept up-to date and the latest version should be held on the system.</p> <p>[Priority 3*]</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>Management should ensure that the information to support the KPIs should be thoroughly reviewed and defaults are consistently applied.</p> <p>Any decisions to not apply defaults should be recorded along with the justification.</p> <p>Any changes to the specifications should be formally documented and retained.</p>	2	<p>Agreed. All records of changes will and have more recently been stored/saved with the final monthly contract KPI records/invoice, rather than in email exchanges, as was formally done earlier in the contract, which lead to difficulty in finding records of decisions.</p> <p>Agreed - As above.</p> <p>Agreed - These are recorded as CCNs</p>	<p>Head of Parking</p> <p>Head of Parking</p> <p>Head of Parking</p>	September 2018
2	A rolling plan for inspections should be put in place to ensure all sites are visited over a period	2	Car Park Inspections & CP Inspection Photos Procedure. Version 1.1 Updated April 2018.	Car Park, Facilities & Assets	September 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	of time.		<p>States: 'An area of the Borough will be inspected by the Parking team weekly for example the below is for Beckenham, Penge, W Wickham & Hayes. The spreadsheet shows the results of these inspections'.</p> <p>Inspections have taken place on a very regular basis and in instances where 'matter of maintenance or repair' has been identified it is recorded. For example in the Bec, Penge WE & Hayes visit schedule 118 items were identified in the 11 Car Parks within that area.</p> <p>However, visits with a negative finding have not been recorded.</p> <p>The contractor has developed an</p>	Manager	

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Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>'inspection APP' which Parking Services are looking to use in the near future.</p> <p>The contract spec: ref 15.1.2 clause states that the contractor should keep a record of cleaning visits.</p> <p>6.1.4 Clause stating the contractor must visit 'not less than weekly.</p> <p>LBB have requested that these are sent over in summary form monthly to LBB.</p>		
3	<p>Outstanding queries relating to the PCN income for 2017-18 should be resolved with the contractor as soon as possible.</p>	2	<p>Agreed – Year one as explained had a number of challenges which were constantly being worked through during 17/18.</p>	Head of Parking	September 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>Going forward discrepancies should be investigated as soon as they are identified.</p> <p>The procedure for the reconciliation of PCN income should be documented by the Parking section and Finance.</p>		<p>Agreed. Clear Lines of responsibility now exist in terms of producing the data, scrutinising data and reconciling payments.</p> <p>A comprehensive process manual for each and every income stream is to be shared with Finance and Audit colleagues during September 2018.</p>	<p>Head of Parking</p> <p>Head of Parking</p>	<p>Immediate</p> <p>During September 2018</p>
4	<p>The financial position of the contract should be monitored throughout the contract term to identify likely overspends at the earliest opportunity.</p> <p>Financial and budget monitoring meetings should be minuted when it is carried out. The</p>	2	<p>Agreed – And this is undertaken on at least a monthly basis. Finance colleagues are told monthly of the level of defaults and or any variances to the contract value inking notification of any CNNs. Agreed, although regular meetings do take place and the formal position is subsequently confirmed</p>	<p>Head of Parking</p> <p>Head of Parking</p>	<p>September 2018</p> <p>September 2018</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	issues discussed and the action plan to address them should be recorded and followed up at future meetings.		via email, then reported to DMT before being reported to Members. It should be noted that EBM and FBM are signed off for the agreed final financial position. Future meetings will be minuted.		
5	All policies and procedures should be kept up-to date and the latest version should be held on the system.	3*	Agreed.	Head of Parking	End of October 2018

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT

FOLLOW UP INTERNAL AUDIT REVIEW OF REABLEMENT 2017-18

Issued to: Adesina Suleiman, Interim Direct Services Manager,
Joy Bennett, Group Manager,
Carol Brown, Operations Manager,
Tricia Wennell, Head of Assessment & Care Management,
Stephen John, Director, Adult Social Care,
Naheed Chaudhry, Assistant Director: Strategic & Business Support Services,
David Bradshaw, Head of ECHS Finance,
Ade Adetosoye, Executive Director of ECHS (Final Only)

Prepared by: Principal Auditor,

Date of Issue: June 20th 2018
Report No.: ECHS/24/2017/FU

INTRODUCTION

1. This report sets out the results of our systems based follow up audit of Reablement. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017 Internal Audit Plan, agreed by the Director of Finance and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. This service has had a change of management with the new Interim Direct Services Manager being in post in February 2018.

AUDIT SCOPE

4. This follow up review considered the final audit report issued in March 9th 2017 and was restricted to identifying progress made on implementing the previously agreed recommendations.

MANAGEMENT SUMMARY

5. Of the previous 10 agreed recommendations, 1 has been fully implemented, 2 are being progressed for completion, 7 have not been implemented. The recommendations not being implemented relate to; detailing current reablement users, performance data, asset register, procedures in both teams, outcome measurement tool, support plans, service agreements and reablement reviews.

SIGNIFICANT FINDINGS (PRIORITY 1)

6. Included within the 7 outstanding recommendations are 2 priority one findings. One was found to be partially implemented that related to the performance measures and data and as such should now be downgraded to a priority 2 recommendation.
7. The second recommendation was previously reported as no longer applicable due to the service transferring out. However, the service is now to be retained in house and the finding was re-tested. This related to the Outcome Measurement Tool and issues arose in 4 out of five cases. Therefore, this has been re-recommended.

DETAILED FINDINGS/MANAGEMENT ACTION PLAN

8. Appendix A provides information on the recommendations that are being followed-up and Appendix C give definitions of the priority categories.

ACKNOWLEDGEMENT

9. We would like to thank all staff contacted during this review for their help and co-operation

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
1	<p><u>Number of Clients in the Reablement Service</u></p> <p>The Department should consider the need for a more comprehensive way of identifying and detailing the current reablement users.</p> <p>CareFirst reports identifying service users should be reconciled to the records held to ensure that the information held on CareFirst is accurate and complete.</p>	<p>The Re-ablement provider service has its own weekly record of how many clients are in the service measured on a daily basis.</p> <p>This information is made available to finance allowing them to cross check the information held in Carefirst.</p> <p>The provision of a more detailed list of SU's will be discussed with the Director.</p>	<p>The new system started July 16 and will be reviewed following the market testing of the service or 31st March 2018</p>	2	Group Manager, Re-ablement.	<p>A spreadsheet is produced weekly by the Reablement Assessment Team of all Reablement clients.</p> <p>Additionally, a spreadsheet is circulated by Finance of all 'open' reablement service agreements '. This also highlights when it appears that the service user has been in reablement for more than 6 weeks.</p> <p>Audit Testing showed that there were service users that appeared on the Reablement Assessment spreadsheet but did not appear on Carefirst.</p>	Partially Implemented.
2	<p><u>Performance Management Data</u></p> <p>Robust and accurate performance data should be available, accessible and provide useful management information. This data for the identified and agreed measures must be regularly</p>	<p>The KPI's are monitored on a weekly basis by the Head of Service and the Re-ablement Management Team.</p> <p>Current figures for the 13 weeks up to and including week</p>	<p>30th of September 2017.</p>	1		<p>Audit testing raised a few queries in relation to the performance data which have been raised with the Interim Direct Services Manager. The Direct Services Manager advised that CQC were on site on 2/5/18 so the auditor emailed a few queries that were to be clarified.</p>	Partially Implemented.

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
	<p>reviewed, variances investigated and reconciled to staff claims on a monthly basis.</p> <p>Management must ensure that contracted hours are being delivered by staff and that all performance data is accurate and complete.</p> <p>Management must monitor and investigate the reasons why performance measures are not being satisfied.</p>	<p>commencing 6th Feb are;</p> <p>Contact Time – 63% Office Time – 10% Travel Time – 28%</p> <p>The monitoring will continue and staff are constantly reminded about the need to be accurate with their timing and reporting.</p> <p>Following discussions with HR all staff will be informed that overtime/additional hours claims will not be authorised if their monthly hours, as identified on Ezitracker, are lower than their contractual hours for the month in question. The three performance indicators referred to</p>				<p>Overall the KPI's have improved since they were last tested.</p> <p>In some weeks travel time has increased but there may be various reasons for this.</p>	

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
		<p>were agreed as indicators of the service being provided and were never intended as individual performance indicators for individual staff.</p> <p>Unfortunately, there are a number of factors which make the KPI's unsuitable for individual staff. For example, cancellations of visits, visits that are curtailed due to SU's fatigue, hospital discharges not happening and on occasions SU's not being at home. An example of this is that on 22nd February, between 18:49 and 19:29, one member of staff had three calls cancelled as follows; 1 x Agency already</p>					

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
		<p>on site. Re-ablement not informed. 1 x Already in bed, no help needed. 1 x Daughter on-site, no help needed.</p> <p>The shortfall identified by audit will be investigated but cancellation figures may not be complete as data collection had not started at that point and specific travel time figures for the two periods identified may not be available as Ezitracker data is not kept beyond three months. The possibility for retrieval is being explored but this may be a chargeable service. However the Re-ablement management team</p>					

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
		<p>believe that the shortfall was the result of the reporting system which allocated an across the board 25% for all staff travel time. This was changed in Sept/Oct 2016 to reflect the actual time the staff spent travelling as it had become clear that a generic travel time missed a significant number of hours as the travel time was in excess of 25% and was therefore no longer accurate enough for monitoring purposes.</p> <p>An example for w/c 3rd October thru to w/c 24th October 2016 there were 1,871 re-ablement hours available. The service could account for 1,859, a</p>					

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
		<p>shortfall of 11 hours (0.68%).</p> <p>Subsequent monitoring has shown that the Re-ablement service regularly delivers more weekly hours than are actually available.</p>					
3	<p><u>Reablement Asset Register</u></p> <p>The Reablement service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded. The stock list should be regularly reviewed and signed off by a senior officer.</p>	<p>Re-ablement has set-up an asset register which has documented the number of mobiles phones and non-disposable PPE items, e.g. Jackets.</p>	January 31 st 2017.	2	Group Manager, Re-ablement	<p>The asset register was requested from the Group Manager.</p> <p>It was found that the asset register did not include the individual asset numbers/ reference and also details of which staff member had been allocated the relevant asset.</p>	Outstanding Re-recommendation.
4	<p><u>Reablement Service Procedures</u></p> <p>Policies & Procedures for the reablement service should be fully reviewed and updated, stating the responsible officer and be version controlled. The areas discussed in this report should be considered and</p>	<p>The Re-ablement Service and Procedures manual will be updated to show the change the service has made to how it records the performance data.</p>	1 st April 2017.	2	Group Manager, Re-ablement	<p>The procedure manual was found to still require updating..</p> <p>The Direct Services Manager confirmed that the procedure manual needed to be reviewed going forward.</p>	Outstanding Re-recommendation

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
	included if appropriate. On completion, procedures should be made available to all staff.						
5	<p><u>Insurance Certificates for Business Use</u></p> <p>All current staff using their vehicles for business journeys should be insured for business use.</p>	<p>The two Insurances that were found to be out of date were:-</p> <p>1. The staff member was on long term sick and had not been asked for her certificate.</p> <p>2. The staff member was on Annual Leave.</p> <p>These were both updated when the staff returned to work.</p>	Immediate. Completed as detailed.	2	Group Manager, Re-ablement	<p>A sample of staff was selected to confirm that the current and relevant business insurance was in place.</p> <p>It was found that all staff tested had the relevant business insurance in place.</p>	Implemented
6	<p><u>Outcome Measurement Tool</u></p> <p>Staff need to be reminded that the outcome measurement tool to assess suitability for the service must be completed until a decision is made to the contrary. The scoring index must be applied consistently.</p>	All Team Leaders have been reminded verbally and in writing to ensure that staff complete the OMT in all cases.	Completed September	1	Operations Manager, Short Term Intervention. Head of	<p>Sample testing showed that issues arose with all 5 cases at the time of testing. Two of the OMT were found to be incomplete and there was no OMT located on Carefirst for the three remaining cases.</p> <p>Due to the change to the service and the sample testing the recommendation remains</p>	Outstanding. Re-recommendation.

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
	Management should determine whether the Outcome Measurement Tool should continue to be used to determine the service users suitability for the reablement service, as is detailed within the current procedural guidance. Cases highlighted within this audit should be investigated.	The OMT will be reviewed	30 th 2017		Service, Assessment & Care Management / Operations Manager, Short Term Intervention.	<p>as outstanding.</p> <p>The Operations Manager advised on 23/4/18 that all staff have been reminded that they are to commence the OMT when referring for this service. This email was circulated last year.</p> <p>The OMT has not been reviewed, as previously planned, as Reablement will no longer be commissioned out. Care Management will now need to look at what is being used elsewhere as a benchmark and make a decision moving forward.</p>	
7	<u>Support Plans</u> The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.	All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to TLs. Staff will be informed and will be required to update the cases.	Completed March 31 st 2017	2	Head of Service, Assessment & Care Management Operations Manager, Short Term Interventions.	<p>Audit testing showed that there was no support plan held on Carefirst for Sample 3.</p> <p>The Operations Manager advised that PRG continue to scrutinise support plans for accuracy and if the plans reflect the assessed needs.</p>	Outstanding Re-recommendation.

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
8	<p><u>Service Agreements</u></p> <p>Service agreements should be updated and authorised in a timely manner. Cases should be investigated and updated as necessary.</p>	<p>All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to Team Leaders.</p> <p>Staff will be informed and will be required to update the cases.</p>	<p>Completed</p> <p>March 31st 2017</p>	2	<p>Head of Service, Assessment & Care Management.</p> <p>Operations Manager, Short Term Interventions.</p>	<p>A sample of clients were selected at random. It was found that one service agreement for Reablement, Sample 5, had not been authorised at the time of testing.</p> <p>Additionally, there was no service agreement for Sample 2, but this service user appeared on the Reablement Assessment spreadsheet.</p>	Outstanding Re-recommendation.
9	<p><u>Reablement Reviews</u></p> <p>Reablement Reviews should be undertaken to determine whether the service users still require the service over the full period of up to six weeks or if there is the possibility of setting up a care package due to ongoing needs, or whether the service can be terminated.</p>	<p>All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to TLs.</p> <p>Staff will be informed and will be required to update the cases</p>	<p>Completed</p> <p>March 31st 2017</p>	2	<p>Head of Service, Assessment & Care Management.</p> <p>Operations Manager, Short Term Interventions.</p>	<p>Audit testing showed that there were no reablement reviews located on Carefirst for Samples 2, 4 and 5.</p>	Outstanding Re-recommendation.

No	Recommendation	Management Comment	Target Date	Priority	Responsibility	Follow-up comments	Status
10	<p><u>Reablement Assessment Policies & Procedures</u></p> <p>Policies & Procedures for the Reablement Assessment team should be revised in full and should reflect the Care Act and not Fair Access to Care, stating the responsible officer and be version controlled and made available to all staff.</p> <p>The areas discussed in this report should be considered and included if appropriate.</p>	<p>All documents will be reviewed and updated.</p> <p>Service is subject to future commissioning considerations and the Head of Service will work with any new provider on the development of documents if appropriate.</p>	January 31 st 2018	2	Head of Service, Assessment & Care Management / Operations Manager, Short Term Intervention.	The Operations Manager advised that this is work in progress. We now have a Policy Officer who we work closely with to update these policies and procedures. In addition, we will be liaising with the Interim Manager for Reablement Direct Care Services to be involved with this work.	Outstanding Re-recommendation.

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
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1	<p><u>Number of Clients in the Reablement Service</u></p> <p>The Department should consider the need for a more comprehensive way of identifying and detailing the current reablement users.</p> <p>CareFirst reports identifying service users should be reconciled to the records held to ensure that the information held on CareFirst is accurate and complete.</p>	2*	<p>A spreadsheet is produced weekly by the Reablement Assessment Team of all Reablement clients. This report is shared with the Group Manager and the Direct Services Manager to identify service users who need review to be completed by Facilitators. It is also used to identify the number of service users in the service. Additionally, a spreadsheet is circulated by Finance of all 'open' reablement service agreements '. This also highlights when it appears that the service user has been in reablement for more than 6 weeks. Audit Testing showed that there were service users that appeared on the Reablement Assessment spreadsheet but did not appear on Carefirst. The list from Finance is now monitored every week by the Direct Services Manager. Request for data cleaning is sent to the</p>	Direct Services Manager	N/A
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Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
			<p>relevant team leader to close open service agreements and this has significantly improved the data although not completely eliminated. This recommendation should be reported as fully implemented from the Reablement point of view as the actual responsibility for cleaning the data falls on other teams once raised with the team managers.</p>		
2	<p><u>Performance Management Data</u></p> <p>Robust and accurate performance data should be available, accessible and provide useful management information. This data for the identified and agreed measures must be regularly reviewed, variances investigated and reconciled to staff claims on a monthly basis.</p> <p>Management must ensure that contracted hours are being delivered by staff and that all performance data is accurate</p>	1*	<p>Overall the KPI's have improved since they were last tested. There is now an agreed process in place for reviewing the performance data from Ezitracker. The Admin staff who compile the data will produce a report every 2 weeks and share this with the Group Manager and the Direct Care Services Manager. The Admin staff is well experienced in doing this and she will seek clarification with the Facilitators and Planners if she is not clear about the information provided. Admin staff will raise to Group Manager any unresolved issue and this will be further</p>	Direct Services Manager	On-going

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
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	<p>and complete.</p> <p>Management must monitor and investigate the reasons why performance measures are not being satisfied.</p>		<p>escalated. The most recent available data on 14/05/18 provides the following information:</p> <p>Contact time – 62.40 (KPI 65-70%): This is affected by several factors some of which are beyond the service control such as unplanned cancellations or staff getting better sooner than expected. On-going monitoring to be continued and improvement plan to be implemented once identified.</p> <p>Travel time – 27.55% (KPI 20-25%): In some weeks travel time has increased but there may be various reasons for this such as difficulty in managing the rota system with the current number of staff and service users and the geographical spread of areas that needs to be covered.</p> <p>Variance 1.40%: This shows that overall staff are putting in more hours than their contracted hours. The baseline used in managing</p>		
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Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
			<p>staff hours is that any negative variance of up to 0.5hour will be discussed with the staff to identify the reason and identify how to manage situation better.</p> <p>Office time – 11.20% - No KPI is set for office time but this is expected to be reduced with increase in staff mobile working.</p>		
			<p>The most recent available data on 21/05/18 provides the following information: Contact time – 63.58 (KPI 65-70%): This is affected by several factors some of which are beyond the service control such as unplanned cancellations or staff getting better sooner than expected. On-going monitoring to be continued and improvement plan to be implemented once identified. Travel time – 26.96% (KPI 20-25%): In some weeks travel time</p>		

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
			<p>has increased but there may be various reasons for this such as difficulty in managing the rota system with the current number of staff and service users and the geographical spread of areas that needs to be covered.</p> <p>Variance 2.60%: This shows that overall staff are putting in more hours than their contracted hours. The baseline used in managing staff hours is that any negative variance of up to 0.5hour will be discussed with the staff to identify the reason and identify how to manage situation better.</p> <p>Office time – 12.01% - No KPI is set for office time but this is expected to be reduced with increase in staff mobile working.</p>		

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Reablement Asset Register</u></p> <p>The Reablement service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded. The stock list should be regularly reviewed and signed off by a senior officer.</p>	2*	<p>The asset register has been updated and now includes the name of individual staff and telephone numbers allocated. The Register has been further updated to include recent laptops allocated to the staff. The Register is checked as correct by the Group Manager. This recommendation should be recorded as completed.</p>	Group Manager Reablement	N/A
4	<p><u>Reablement Service Procedures</u></p> <p>Policies & Procedures for the reablement service should be fully reviewed and updated, stating the responsible officer and be version controlled. The areas discussed in this report should be considered and included if appropriate. On completion, procedures should be made available to all staff.</p>	2*	<p>The procedure manual was updated prior to CQC Inspection on 02/05/18. The CQC found the records to be up to date for their requirement. Some of the new policies in place are the Infection Control Policy, Medication Administration policy, Gifts and Hospitality Policy, Raising Concerns and Whistleblowing policy. The Business Continuity Plan was also updated and signed off. The Reablement Group Manager and Direct Services Manager will</p>	Group Manager Reablement	September 30th 2018

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
			continue to review and update the procedure as appropriate and make the necessary improvement.		
6	<p><u>Outcome Measurement Tool</u></p> <p>Staff need to be reminded that the outcome measurement tool to assess suitability for the service must be completed until a decision is made to the contrary. The scoring index must be applied consistently.</p> <p>Management should determine whether the Outcome Measurement Tool should continue to be used to determine the service user's suitability for the reablement service, as is detailed within the current procedural guidance. Cases highlighted within this audit should be investigated.</p>	1*	<p>All staff have been reminded that they are to commence the OMT when referring for this service. This email was circulated last year.</p> <p>The OMT has not been reviewed by Provider A as previously planned. Care Management will now need to look at what is being used elsewhere as a benchmark and make a decision moving forward.</p>	Operations Manager	October 31st 2018.

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
7	<p><u>Support Plans</u> The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.</p>	2*	PRG continue to scrutinise support plans for accuracy and if plans reflect the assessed needs.	Operations Manager	October 31st 2018.
8	<p><u>Service Agreements</u> Service agreements should be updated and authorised in a timely manner. Cases should be investigated and updated as necessary.</p>	2*	As above	Operations Manager	October 31st 2018.
9	<p><u>Reablement Reviews</u> Reablement Reviews should be undertaken to determine whether the service users still require the service over the full period of up to six weeks or if there is the possibility of setting up a care package due to ongoing needs, or whether the service can be terminated.</p>	2*	As above	Operations Manager	October 31st 2018.

Original recommendation No.	Recommendation	Priority	Management Comment	Responsibility	Agreed Timescale
10	<p><u>Reablement Assessment Policies & Procedures</u></p> <p>Policies & Procedures for the Reablement Assessment team should be revised in full and should reflect the Care Act and not Fair Access to Care, stating the responsible officer and be version controlled and made available to all staff.</p> <p>The areas discussed in this report should be considered and included if appropriate.</p>	2*	This is work in progress. We now have a Policy Officer who will work closely with the Interim Direct Services Manager, where appropriate.	Operations Manager	April 1st 2019.

Definition of priority categories.

Priority 1

**Required to address major weaknesses
and should be implemented as soon as
possible**

Priority 2

**Required to address issues which do
not
represent good practice**

Priority 3

**Identification of suggested
areas for improvement**

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FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

Issued to: Sara Bowery, Director of Housing
Lynnette Chamielec, Head of Allocations & Accommodation
Phillip Dodd, Group Manager Housing Management and Acquisition
Claudine Douglas-Brown, Assistant Director, Exchequer Services
David Bradshaw, Head of Finance ECHS
Naheed Chaudhry, Assistant Director Strategy, Performance and Business Support
Aneesa Kaprie, Interim Head of Service, CLA and LCT

Cc: Ade Adetosoye, Executive Director of ECHS and Deputy Chief Executive (Final only)

Prepared by: Senior Internal Auditor

Date of Issue: 29th October 2018

Report No.: ECHS/12/2017/AU

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Temporary Accommodation for 2017/18. The audit was started in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 01 March 2018.
4. The Temporary Accommodation service is split between the Housing Team (within Bromley) and the Exchequer Contractor's Housing Accommodation Charges Team. The review also considered the Housing Rent Accounts raised for Leaving Care clients.

AUDIT SCOPE

5. The scope of the audit is detailed in the Terms of Reference.

AUDIT OPINION

6. Overall, the conclusion of this audit was that Substantial Assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

7. Controls noted to be in place and working well included:

- Sign Up packs were in place and appropriately reviewed for a sample of 20 temporary accommodation cases sampled;
- Sign Up packs and checklists were being sent to the Housing Accommodation Charges Team (HAC) in all 20 cases sampled;
- Two new Visiting Officers have been introduced to complete property inspections to confirm that tenants are residing in temporary accommodation awarded;
- Contracts were in place with landlords where placements were being offered for 20 temporary accommodation placements sampled;
- Accurate information was included on the system regarding the payments required, in the sign up packs and the confirmed rent payments;
- Eviction referrals were being sent to Housing on the basis of recovery action taken by HAC for a sample of 10 eviction cases sampled;
- Eviction referrals were reviewed by Housing and either agreed or rejected in the aforementioned eviction sample tested;
- Performance reports were run on a monthly basis by HAC detailing arrears, debts and the collection statistics. These reports were sent to Housing.

However, we would like to bring the following issues to management attention - Housing bullet points 1-2, HAC 3 &4, Finance 5 and Leaving Care Team bullet point 6:-

- Evidence of the Landlord being notified of a new tenant placement could not be identified as having been retained in three out of 20 cases sampled;
- Landlords are not always notified of evictions in a timely manner, with one out of 10 cases sampled identifying that there was a delay in the notice to quit being sent. In addition, there was one instance from the 10 selected where there was no evidence that the landlord had been notified of the tenant's eviction.
- Arrears collection procedures (for current tenants) are not always being followed. There were three out of 10 instances where reminder 1 letters were not sent out in a timely manner. In addition, there were two out of eight cases sampled where reminder 2 letters were not sent out in a timely manner.
- A sample of 10 former arrears cases identified that in two instances out of 10, the arrears had been documented as written off but no action had been taken to write off the debt. For four out of 10 of the cases sampled, the 1st and 2nd reminder letters were not timely, and in one case action had not been undertaken on a case for over one full year.

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

- Issues found by Housing as a result of the reconciliations completed by HAC do not have relevant dates relating to the identification of the issue and an appropriate deadline for the issue;
 - Debts in error have been identified as having been created where tenant's records are not appropriately removed from the database when they leave the property.
8. At the time of the audit testing, HAC was responsible for the set-up of rent accounts. It was found that for the sample of current rent accounts, in 6 out of the 20 cases examined, there was a delay of more than three days between the sign-up-pack being received and requested by the Housing Team and the date at which the rent accounts were set up on the system. No recommendation has been made in this report given that the responsibility for setting up rent accounts was transferred from HAC to Housing in July 2018 and no audit testing was completed on sign ups after the change.

SIGNIFICANT FINDINGS (PRIORITY 1)

9. There were no priority one recommendations raised as part of this audit.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

10. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

11. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1	<p><u>Confirmation of placements to Landlord (Housing Team)</u></p> <p>For a sample of 20 temporary accommodation placements selected we identified that in 17 cases there was confirmation of the placement to the landlord available on file but in three cases we were unable to see evidence of this.</p>	<p>Where landlords are not notified of any new placements there is a risk that duplicate placements may be allocated and also a risk that landlords may not be receiving the correct fees for their properties. This could result in reputational damage for the Council.</p>	<p>Management should remind staff to keep evidence of all notifications to landlords and ensure that landlords are notified in a timely manner for all placements.</p> <p>(Priority 2)</p>
2	<p><u>Eviction Notification to the Landlord (Housing)</u></p> <p>For a sample of 10 evictions selected, it was identified that in three cases the eviction was not authorised as the tenant increased their payments.</p> <p>For the remaining seven cases the eviction was authorised and subsequently in all seven cases a notice to quit was sent to the tenant. Of these seven cases:</p> <ul style="list-style-type: none"> • There was one instance where the landlord was notified a month after the notice to quit had been sent out (not in a timely manner), and • One instance where there was no evidence to confirm that the landlord had been notified of the eviction. 	<p>Where the landlord is not notified or is not notified in a timely manner of an eviction there is a risk that they are unable to monitor their placements and may be unhappy with the Council's service, resulting in reputational damage.</p>	<p>Management should remind staff of the requirement to notify landlords of eviction proceedings in a timely manner and should ensure this procedure is being followed.</p> <p>(Priority 2)</p>

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
3	<p><u>Arrears Current Tenants (HAC)</u></p> <p>For a sample of 10 arrears cases selected we confirmed that:</p> <ul style="list-style-type: none"> • In seven cases a first reminder was sent in a timely manner but in three cases the reminders were delayed by at least three months; • For the remaining eight cases, in two instances the second and final reminder letters were not sent in a timely manner due to a backlog. <p>The arrears procedure was checked to the Sundry Debtors, Mortgage and Corporate Debt, Service Level Agreement provided by Exchequer Services.</p> <p>Discussions with the Team Leader identified that there has been a backlog of chasing arrears due to the increase in temporary accommodation placements. As a result there have been some delays in chasing arrears. The aim is to act upon these delays and ensure that they do not occur in the future.</p>	<p>Where arrears are not chased in a timely manner there is a risk that the repayments will not be made which could result in financial loss for the Council.</p>	<p>The Exchequer contractor should be reminded to follow the Sundry Debtors Mortgages Contract section 2.20 to recover debts in a timely manner.</p> <p>Management should be informed of sundry debts so that they can monitor any long outstanding arrears.</p> <p>(Priority 2)</p>

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
4	<p><u>Debt Recovery for Former Tenants (HAC)</u></p> <p>For a sample of ten former tenants (debts in place) we identified the following;</p> <ul style="list-style-type: none"> For two cases they were documented as write offs on the monitoring spreadsheet however these have not yet been written off. No action has been taken with regards to these debts. <p>Discussions with the Team Leader identified that the HAC team are currently completing a review of all former tenants who have been documented as written off to confirm if they actually have been written off and if not recovery action will be taken in line with procedures.</p> <ul style="list-style-type: none"> In four cases the first reminder and second reminder letters were not sent in (14 days after payment initially due - reminder 1 and a further 14 days after the first reminder letter is sent – reminder 2) resulting in debts outstanding for a long period. For one account there was information regarding the debtors’ ability to pay the debts in July 2016 due to being vulnerable and unable to manage finances. Further action in the form of reminder letters begun again in January 2018. <p>Discussions confirmed delay were due to the accumulation of work as previously mentioned and the team are trying to currently still trying to manage the backlog.</p>	<p>Where debt recovery procedures are not followed and debt is not collected there is a risk of financial loss for the Council which cannot be recovered.</p>	<p>Management should ensure that the review of debts which are documented as ‘written off’ on the monitoring spreadsheet is completed to make sure that all status’ are correct on the spreadsheet.</p> <p>Where the debts have not been written off action should be taken to either chase the debts or write them off if appropriate.</p> <p>Staff should be reminded to follow procedures and ensure debts are chased up in a timely manner. Where there are delays management should be informed so that they can monitor any long standing debts.</p> <p>(Priority 2)</p>

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
5	<p><u>Issues Log (Finance - Accounts)</u></p> <p>An issues log is maintained where issues found are detailed along with the status of each issue. Follow up meetings are held between the Exchequer contractor and Finance.</p> <p>The issue log is a live document and it was recently introduced in Q2. For the end of the 2017/18 financial year there were four issues outstanding. As at July 2018 there still remains three issues to resolve. These are with respect to two opening balancing figures of the system and £34,000 worth of LCT personal charges.</p> <p>The issues log does not include dates of when issues were identified and subsequently cleared so audit are unable to verify if issues are cleared in a timely manner.</p>	<p>Where there are no timescales included on the issues log there is a risk that issues remain for long periods of time and are not appropriately actioned and dealt with.</p>	<p>Management should consider including the date the issue was identified and recorded and assign an appropriate deadline for its resolution within the Issues log.</p> <p>(Priority 2)</p>

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
6	<p><u>Debts Raised in Error – Leaving Care Team</u></p> <p>Audit was advised that on a weekly basis a movement spreadsheet is sent from the Leaving Care Team (LCT) team to the Exchequer contractor. This should show all LCT clients moving in and out of properties. The Exchequer contractor then manually updates the system with this information. No checks are undertaken by the Exchequer contractor on whether there is another client still booked to that accommodation.</p> <p>Audit was made aware of one LCT case where two clients were effectively booked to the same property creating a debt of £31,000. This caused a ‘debt raised in error’ and was required to be adjusted. It is unclear who approved this adjustment. It is understood that this is not an isolated case but there is no process to identify “debts raised in error” which is overstating the total debt value.</p> <p>The error occurred because a change and termination of one placement was not detailed on the movement sheet before a new client was assigned to the same property. The accuracy of information shown on the system for the LCT clients relies on the quality of information supplied by the LCT. There is currently no report from the system available to identify possible duplications but initial enquiries with the System Support Officer indicates that a BOXI report may be able to capture data as an exception report which could be issued to LCT to check.</p>	<p>Where there are ‘debts raised in error’ due to tenants not being appropriately removed from properties there is a risk that debts are overstated and the LBB are anticipating receiving more money than they are going to obtain.</p>	<p>All case workers to be reminded to update the Income Officer (LCT) immediately placements change.</p> <p>The Income Officer (LCT) should ensure that the information recorded on the movement sheet is accurate. Placements should be terminated in a timely manner to prevent duplication of clients being assigned to the same address.</p> <p>LCT should explore the possibility of generating a regular BOXI report to identify different names and start dates at the same address. This report would support the Income Officer (LCT) and identify duplicates before any impact on the rent accounts.</p> <p>(Priority 2)</p>

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p>Housing</p> <p>Management should remind staff to keep evidence of all notifications to Landlords and ensure that Landlords are notified in a timely manner for all placements.</p>	2	<p>Agreed. 1:1 format has been reviewed to include drill down on a selection of cases each month. Dip sample to be reviewed by senior managers.</p>	<p>1:1's TM – Allocations</p> <p>Head of Allocations & Accommodation - Dip sample</p>	November 2018
2	<p>Housing</p> <p>Management should remind staff of the requirement to notify landlords of eviction in a timely manner and should ensure this procedure is being followed.</p>	2	<p>Staff do receive reminders however following the audit recommendation we will be compiling a process checklist to ensure that all steps are appropriately followed.</p>	<p>Head of Allocations & Accommodation</p>	March 2019

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p>HAC</p> <p>Staff should be reminded to follow procedures and ensure arrears are chased up in a timely manner. Where there are delays management should be informed so that they can monitor any long outstanding arrears.</p>	2	<p>The Exchequer contractor has been reminded of the need to ensure the service level requirements are adhered to and debts are followed up in a timely manner.</p> <p>Due to the increase in the caseload the resources dealing with this area of work was increased in April 2018 any backlog that remains is being cleared.</p>	Exchequer contractor Senior Operations Manager	November 2018

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p>HAC</p> <p>Management should ensure that the review of debts which are documented as 'written off' on the monitoring spreadsheet is completed to make sure that all status' are correct on the spreadsheet. Where the debts have not been written off action should be taken to either chase the debts or write them off if appropriate.</p> <p>Staff should be reminded to follow procedures and ensure debts are chased up in a timely manner. Where there are delays management should be informed so that they can monitor any long outstanding debts.</p>	2	<p>The Exchequer contractor has been reminded that it is their responsibility to review the write off spreadsheet and ensure it is kept up to date and the information is accurate.</p> <p>The Exchequer contractor will carry out a review and take the appropriate remedial action by the deadline date.</p>	Exchequer contractor - Senior Operations Manager/Operations Manager	November 2018

REVIEW OF TEMPORARY ACCOMMODATION AND RENT ACCOUNTS FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p>Finance</p> <p>Management should consider including the date the issue was identified and recorded and assign an appropriate deadline for its resolution within the Issues Log.</p>	2	<p>The issue log was introduced during the last year to keep a track and manage issues within the quarterly HAC Reconciliation.</p> <p>The additional of the dates is a good idea and will be implemented, but this won't stop an issue being on the log for a long time as some of the issues require supplier input to resolve and this is outside of ours and the Exchequer contractor's hands.</p>	Senior Accountant	October 2018

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p>Leaving Care Team</p> <p>All case workers to be reminded to update the Income Officer (LCT) immediately placements change.</p> <p>The Income Officer (LCT) should ensure that the information recorded on the movement sheet is accurate. Placements should be terminated in a timely manner to prevent duplication of clients being assigned to the same address.</p> <p>LCT should explore the possibility of generating a regular BOXI report to identify different names and start dates at the same address. This report would support the Income Officer (LCT) and identify duplicates before any impact on the rent accounts.</p>	2	<p>All case workers to be reminded that the Income Officer must be informed when there is any change to a placement.</p> <p>A new Income Officer has recently been appointed which has been a good opportunity to review working practices. Checking the accuracy of the movement sheet prior to submission to the Exchequer contractor will be prioritised.</p> <p>LCT will request help from colleagues in Housing and the Exchequer contractor to provide a regular report from the system to support the work of the Income Officer and identify potential duplications.</p>	Group Manager Leaving Care	Nov 2018

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT

ENVIRONMENT AND COMMUNITY SERVICES DEPARTMENT

REVIEW OF VEHICLE CROSSOVERS AUDIT FOR 2017-18

Issued to: Garry Warner, Assistant Director (Highways)
Daniel Gordon, Highway Area Manager

Cc (Final only): Nigel Davies, Executive Director, Environment and Community Services
Claire Martin, Head of Finance, Environment and Community Services and Corporate
Sarah Foster, Head of Performance Management and Business Support

Prepared by: Principal Auditor

Date of Issue: 11th September 2018

Report No: ECS/04/2017/AU

REVIEW OF VEHICLE CROSSOVERS AUDIT 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Vehicle Crossovers. The audit commenced in quarter four as part of the programmed work specified in the 2017/18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.

AUDIT SCOPE

3. The scope of the audit was outlined in the Terms of Reference issued on 9th February 2018.

AUDIT OPINION

4. Overall, the conclusion of this audit was that Substantial Assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

5. The construction of Vehicle Crossovers forms part of the Minor Works contract which, from 2010 until 30th June 2018 was operated by Contractor A. Its remit also included day to day reactive maintenance works including repairs to pot holes, minor scheme works and operating the Council's fleet of winter maintenance vehicles. The recommendation for the award of the new contract for Highway Maintenance (Major and Minor), for a term of eight years from 1st July 2018 to Contractor B, was approved by the Executive on 20th April 2018. The audit covers a time period for which Contractor A was responsible for delivery of the contract and all references to 'the contractor' should be read as 'Contractor A' unless otherwise stated.

REVIEW OF VEHICLE CROSSOVERS AUDIT 2017-18

6. Between 2015/16 and 2017/18, 835 Crossovers were paid for through the Cost Centre 711679 with the detail depicted in Table 1 below:-

Table 1

Year	Number of Crossovers	Total paid	Average payment
2015/16	292	£239k	£820
2016/17	286	£209k	£731
2017/18	257	£194k	£754
Total	835	£642k	

7. Our testing identified the following issues which we would like to draw to management's attention:-

Policy and Guidelines - Application of charges and income

- Report ES 11110 'Criteria for approval of Footway Crossovers' was submitted to the Environment PDS on 18th January 2012 recommending approval of:-
 - a) revised Policy and Guidelines,
 - b) the introduction of a non returnable application fee set at £100 and administration charge of £200 for every installation, with any administration costs over and above this figure being charged to the applicant,
 - c) the introduction of a non returnable combined application and administration fee set at £100 for every application to extend (widen) an existing Crossover.

Examination of the Vehicle Crossover Estimate form shows the £200 administration charge referred to in b) above as 'fixed admin' and there is no reference to the possibility of costs over and above this figure being recouped from the applicant.

Policy and Guidelines - Review of charges

- The Policy and Guidelines presented to Environment PDS in January 2012 state in Paragraph 28 'Fees and Charges' that, *'the fees and charges will be regularly reviewed by officers, in light of relevant legislation/regulation, changes in contracts and changes in resource costs. Any revisions considered necessary will be implemented under delegated powers.* In view

REVIEW OF VEHICLE CROSSOVERS AUDIT 2017-18

of the fact that the application fee of £100, the £200 administration fee and the ability to recoup administration costs over the £200, were set in 2012, the department may wish to review the scale of charges during implementation of the new contract.

Process and Procedures

- Whilst there is a process map in place for the Crossover procedure, not all members of staff involved in the function are aware of the document and it does not accurately reflect the current end to end process.

Documentation and record keeping

- Documentation to support the Crossover process is kept in a variety of forms, both paper and electronic, and locations, with no one definitive source of information.

Confirm System

- The Confirm system is manually set to select a random 10% sample of all Minor Works due for payment and automatically reports all jobs which, at that stage fall outside of a tolerance of +/- £50 or 5% when the 'value' on completion is compared to the 'value' initially recorded in the Confirm system. As the criteria for the samples is everything within the Minor Works contract and not just the 'Crossovers' element, the number of Crossovers randomly selected in the 10% sample for inspection could be nil.

Reconciliation of Data

- The Confirm system does not have a direct interface with the Financial System and therefore there is no automatic, or manual, reconciliation of the data (income from applicants and payments to the contractor) between the two systems.

Uplifts

- Uplifts payable to Contractor A for the whole of the Minor Works contract are applied in line with the 'Baxter' indices. These rates are published retrospectively necessitating a retrospective bulk payment to be made, the Crossover element of which is funded from the application and administration fees and is not recouped from the individual applicants. At the time of the audit, the 2016/17 and 2017/18 rates of 0.7% and 2.4% respectively had not been applied.

SIGNIFICANT FINDINGS (PRIORITY 1)

8. There are no significant findings.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

10. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>Policy and Guidelines - Application of charges and income</u> The minutes of the Environment PDS Committee Report ES 11110, 18th January 2012, 'Criteria for Approval of Footway Crossovers' confirm approval of an administration charge of £200 for every new installation, with the additional flexibility for <i>any administration costs over and above this figure being charged to the applicant</i>'. The Vehicle Crossover Estimate form shows the £200 as 'fixed admin' and there is no provision on the form for levying additional costs.</p> <p>Sample number 4 with the narrative 'construct block Crossover extension, use blocks that are on site' and Sample number 6 with the narrative 'extend existing Crossover', have had the £200 administration charge for every new installation applied. The narrative 'extension/extend' was at odds with the £200 new installation charge and it could not be established whether these jobs should have been treated as new Crossovers or as extensions and whether the charges applied were correct. It was noted for Sample number 4 that there was no reduction in the price of the job (either charged to the applicant or paid to the contractor), for using the 'blocks that are on site'.</p>	<p>Administration costs may not be recouped in full as authorised by the Policy.</p> <p>Incorrect/inconsistent charges may be applied to work carried out on existing Crossovers.</p>	<p>The Vehicle Crossover Estimate form should:-</p> <p>a) include provision for the levying of additional costs over and above the £200 administration fee.</p> <p>b) be clear and consistent across the narrative and charges as to whether the application is for a new Crossover or an extension to an existing Crossover and charged accordingly.</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Sample number 7 relates to the reconstruction of an existing Crossover to prevent the car from grounding and therefore the application and administration fees were not applied. Authorisation to wave these fees could not be located.</p> <p>Sample number 10 included a £320 charge for the removal and replacement of a tree. Whilst receipt of this amount could be confirmed, the transfer of funds to the Tree Planting and Maintenance code (068000 6130 F7013) could not be identified and was subsequently effected during the course of the audit on 26th June 2018.</p>	<p>Decisions to waive charges are not properly authorised</p> <p>Internal Accounts may not reflect the true position.</p>	<p>c) include provision for the waiving of fees.</p> <p>d) include provision for the apportionment of fees.</p> <p>Priority 2</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p><u>Policy and Guidelines - Review of charges</u> The 'Provision of Footway Crossovers; Policy and Guidelines' adopted in January 2012 states, in paragraph 28 (Fees and Charges) '<i>The fees and charges will be regularly reviewed by officers, in light of relevant legislation/regulation, changes in contracts and changes in resource costs. Any revision considered necessary will be implemented under delegated powers</i>'.</p> <p>In view of the fact that the application fee of £100, the £200 administration fee and the ability to recoup administration costs over and above the £200, as detailed in Committee Report ES 11110 were set in 2012, the department may wish to review the scale of charges during implementation of the new contract.</p>	<p>Fees which have been in place since 2012 may no longer cover the cost of providing the service.</p>	<p>The department should review the internal application (£100) and administration (£200) fees introduced in 2012 and consider if any changes should be made to reflect increases in costs.</p> <p>Priority 3</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
3	<p><u>Process and Procedures</u> Whilst there is a process map in place for the Crossover procedure, not all members of staff involved in the function are aware of the document and it does not accurately reflect the current end to end process, for example, the percentage of completed Crossovers checked prior to payment being made to the contractor.</p> <p>Sample number 5 was for the construction of a 'temporary Crossover to assist with building works. Once building works complete, construct permanent Crossover'. Charges had been levied accordingly with the applicant paying for, and the contractor being paid for, both the temporary (£534.06) and permanent (£672.05) Crossover. The notes against the enquiry on the Confirm system imply that the temporary Crossover was not constructed and it could not be established whether the cost of the temporary Crossover had been reclaimed from the contractor and refunded to the applicant.</p>	<p>The lack of up to date guidance may lead to the process not being carried out consistently.</p> <p>Payment may be received from an applicant, and paid to a contractor, for works which have not been undertaken.</p>	<p>A review of data flows and processes within the Crossovers workstream, including forms and aide memoires, should be undertaken, with the up to date procedure documented and made available to all relevant members of staff.</p> <p>The guidance should state when, and how, payment for elements of work which formed part of the initial specification and were not undertaken, can be recouped from the contractor and repaid to the applicant.</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
			<p>Where a temporary Crossover is to precede a permanent Crossover in a location, consideration should be given to separately priced, cross referred, jobs being raised. By separating the temporary and permanent elements of the work, the possibility of paying the contractor for work which has not been undertaken, will be reduced.</p> <p>Priority 2</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4	<p><u>Documentation and record keeping</u> Documentation to support the Crossover process is kept in a variety of forms, both paper and electronic, and locations. For example, the paper application forms, once the initial £100 application fee has been processed, are sent by internal post from the Exchequer Contractor to the Highways Area Manager at the Civic Centre and then onto the Technical Support Officer at the Central Depot. These, together with the paper Vehicle Crossover Estimate Forms which are completed by hand, are stored as paper files at the Civic Centre.</p> <p>Other elements of the process such as requests for the identification of utilities at the proposed work location are carried out via E mail, with scanned PDF attachments of the Vehicle Crossover Estimate forms being E mailed between the Central Depot and the Civic Centre, and copied to the contractor as their initial notification of the job.</p> <p>Running in parallel with these paper based and electronic (scanned/PDF/E mail) systems are the records held on Confirm, to which Contractor A had access.</p>	<p>A full audit trail may not be available.</p>	<p>The feasibility of scanning paper documents and uploading them to an agreed location in one system to ensure that there is a full audit trail, should be considered. Ideally this would be in a shared directory, so that it can be accessed by all relevant officers involved in the process when required.</p> <p>Priority 3</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Whilst all Crossover jobs are recorded on the Confirm system, there is no link between the enquiry record at the application stage and the record created once the application has been approved as meeting all criteria within the policy, and the applicant has confirmed that they wish to proceed. This fragmented system does not support the production of robust management information to the extent that the number of Crossovers applied for and completed within the year was not readily available.</p>		
5	<p>Confirm System The Confirm system is manually set to select a random 10% sample of all Minor Works due for payment and automatically reports all jobs which, at that stage fall outside a tolerance of +/- £50 or 5% when the 'value' on completion is compared to the 'value' initially recorded in the Confirm system. The items reported are automatically suppressed for payment pending a visual check of the work by a member of the Highways team (note, this could be the same inspector who initially undertook the estimate and authorised the work). As the criteria for the sample is everything within the 'Minor Works' contract and not just the 'Crossovers' element, the number of Crossovers randomly selected in the sample for inspection could be nil.</p>	<p>Works may not be carried out in line with the job specification.</p>	<p>The parameters of the 10% sample to be independently checked, to ensure that work has been carried out as specified, should be refined to ensure that each element of the Minor Works contract for which payment is being made is within the sample.</p> <p>Priority 2</p>

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
6	<p>Reconciliation of Data The Confirm system does not have a direct interface with the Financial System and therefore there is no automatic reconciliation of the data (income from applicants and payments to the contractor) between the two systems.</p> <p>The lack of reconciliation between Confirm and the Financial System was also raised as a Priority 2 recommendation in the 'Review of Confirm Audit for 2015/16' issued on 14th November 2016.</p>	<p>Income due may not be received and incorrect payments may not be identified.</p>	<p>To ensure that all income is accounted for, a periodic reconciliation of income received from applicants and recorded on the Financial System to the values on Confirm and the subsequent payments to the contractor (less the £200 (or higher) administration fee) should be carried out.</p> <p>Should an IT solution not be viable, the Highways Department should consider a manual reconciliation between the two systems in which a data extract is taken for a set time period (minimum quarterly).</p> <p>Priority 2</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
7	<p>Uplifts Uplifts payable to Contractor A for the whole of the Minor Works contract are applied in line with the ‘Baxter’ indices. These rates are published retrospectively necessitating a retrospective bulk payment to be made, the Crossover element of which is funded from the application and administration fees and is not recouped from the individual applicants.</p> <p>At the time of the audit, the 2016/17 and 2017/18 rates of 0.7% and 2.4% respectively had not been applied.</p>	<p>Delay in applying the published rates will result in a higher retrospective bulk repayment being made from the application and administration fees.</p>	<p>The current process for applying uplifts payable to the contractor should be reviewed to minimise the number and value of Crossovers for which a retrospective payment is made to the contractor funded from the application and administration fees.</p> <p>Priority 2</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p><u>Policy and Guidelines – Application of charges and income</u> The Vehicle Crossover Estimate form should:-</p> <p>a) include provision for the levying of additional costs over and above the £200 administration fee.</p> <p>b) be clear and consistent across the narrative and charges as to whether the application is for a new Crossover or an extension to an existing Crossover and charged accordingly.</p>	2	<p>a) Provision for the levying of additional costs over and above the £200 administration fee will be accommodated on the estimate form and policy documents.</p> <p>b) The estimate form and policy documents will be updated.</p>	<p>Highway Area Manager</p> <p>Highway Area Manager</p>	<p>October 2018</p> <p>October 2018</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	c) include provision for the waiving of fees. d) include provision for the apportionment of fees.		c) Criteria for waiving fees to be reviewed. d) Action has already been taken to address this issue.	Assistant Director (Highways) Completed	November 2018 n/a
2	<u>Policy and Guidelines – Review of charges</u> The department should review the internal application (£100) and administration (£200) fees introduced in 2012 and consider if any changes should be made to reflect increases in costs.	3	There are no changes in costs of providing vehicle crossings under the new contract that are not already reflected in the quotations. The current scale of administration charges is considered appropriate for the tasks involved, and usually covers all costs incurred. If additional administration costs are considered necessary, these will be picked-up at the quotation stage, and 1.a) above.	n/a	n/a

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Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Process and Procedures</u> A review of data flows and processes within the Crossovers workstream, including forms and aide memoires, should be undertaken, with the up to date procedure documented and made available to all relevant members of staff.</p> <p>The guidance should state when, and how, payment for elements of work which formed part of the initial specification and were not undertaken, can be recouped from the contractor and repaid to the applicant.</p>	2	<p>This process has been reviewed to bring all tasks within the Highways team. Processes will be documented and made available to all relevant members of staff.</p> <p>Separately priced, cross referred, jobs are raised, separating the temporary and permanent elements of the work.</p>	<p>Highway Area Manager</p> <p>Highway Area Manager</p>	<p>October 2018</p> <p>Completed</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	Where a temporary Crossover is to precede a permanent Crossover in a location, consideration should be given to separately priced, cross referred, jobs being raised. By separating the temporary and permanent elements of the work, the possibility of paying the contractor for work which has not been undertaken, will be reduced.				
4	<p><u>Documentation and record keeping</u> The feasibility of scanning paper documents and uploading them to an agreed location in one system to ensure that there is a full audit trail, should be considered. Ideally this would be in a shared directory, so that it can be accessed by all relevant officers involved in the process when required.</p>	3	Following the review of administering vehicle crossing applications, all future applications will be stored electronically for internal use.	Highway Area Manager	October 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p><u>Confirm System</u> The parameters of the 10% sample to be independently checked, to ensure that work has been carried out as specified, should be refined to ensure that each element of the Minor Works contract for which payment is being made is within the sample.</p>	2	All vehicle crossings will be included in sample inspections prior to payment.	Highway Area Manager	September 2018
6	<p><u>Reconciliation of Data</u> To ensure that all income is accounted for, a periodic reconciliation of income received from applicants and recorded on the Financial System to the values on Confirm and the subsequent payments to the contractor (less the £200 (or higher) administration fee) should be carried out.</p>	2	Discussions will be held with Finance in an effort to reconcile income and expenditure.	Highway Area Manager	November 2018

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	Should an IT solution not be viable, the Highways Department should consider a manual reconciliation between the two systems in which a data extract is taken for a set time period (minimum quarterly).				
7	Uplifts The current process for applying uplifts payable to the contractor should be reviewed to minimise the number and value of Crossovers for which a retrospective payment is made to the contractor funded from the application and administration fees.	2	The current process for applying uplifts payable to the contractor will be reviewed to improve accuracy of quotations – next uplift due in July 2019.	Assistant Director (Highways)	May 2019

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE, HEALTH SERVICES DEPARTMENT

REVIEW OF CONTINUING HEALTHCARE FUNDING FOR 2017-18

Issued to: Stephen John – Director of Adult Social Care
Tricia Wennell – Head of Assessment and Care Management
Alex Pringle – Operational Manager Care Services
Mandy Henry – Team Manager Learning Disabilities
David Bradshaw – Head of Finance ECHS

Cc: Naheed Chaudhry – Assistant Director, Strategy, Performance and Business Support
Ade Adetosoye – Executive Director ECHS (Final only)

Prepared by: Auditor

Date of Issue: 27th June 2018

Report No.: ECHS/09/2017/AU

REVIEW OF CONTINUING HEALTHCARE FUNDING AUDIT FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Continuing Healthcare (CHC) Funding. The audit was carried out in quarter Q4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued March 2018.
4. A process is in place for CHC funding with decisions being made between the Council, CCG's the Joint Funded Panel and the CHC Panel.

AUDIT SCOPE

5. The scope of the audit was outlined in the Terms of Reference.

AUDIT OPINION

6. Overall, the conclusion of this audit was that substantial assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

7. Controls noted to be in place and working well based on audit work conducted included:
 - Formal reporting lines are in place in the form of a Team Structure Chart;
 - The CHC Panel and Joint Funded Panel meet on a monthly basis;
 - Checklists and Decision Support Tools (DST) are completed and uploaded onto the case management system where possible; and
 - Joint funded cases are reviewed on a regular basis.
8. Our testing identified the following issues which we would like to draw to management's attention:
 - There were no policies and procedures in place covering the relevant areas for CHC/joint funding. Inconsistent practices were evidenced as being used for record keeping in the case management system.
 - There were no formal training records maintained to confirm training attendance by appropriate officers.
 - The terms of reference for the CHC Panel and the Joint Funding Panel were not evidenced as being finalised and approved, and did not detail quorum requirements.
 - For 13/20 cases sampled, checklists and DST's were not available to view on the case management system for the CHC / joint funded cases.
 - For 3/10 CHC cases sampled, confirmation could not be obtained to verify that the checklist, that had been completed solely by LBB, had been passed to the CCG in a timely manner.
 - For 1/10 cases, the end date for an individual's CHC funding could not be identified, which made it unclear whether a payment made by the Council towards the individual's health care should have been recovered from the CCG or not. The one off direct payment of £648 and was made on the 04/07/2017.
 - Decision sheets for eight out of 10 cases sampled from the Joint Funded Panel were not complete for all joint funded cases agreed.
 - In one case out of 10 joint funded cases sampled, details of the individual's care plan could not be located on to the case management system. For eight out of the 10 cases, a signed Service Agreement could not be located on the case management system.

REVIEW OF CONTINUING HEALTHCARE FUNDING AUDIT FOR 2017-18

- In three cases out of 10 joint funded cases sampled, invoices for the CCG had not been raised in a timely manner, leading to costs due to the Council not being recovered.

The individual cases were discussed with the Senior Care Manager (CHC) to seek resolution but remain as outstanding issues at this time.

SIGNIFICANT FINDINGS (PRIORITY 1)

9. There were no priority one recommendations raised as part of this audit.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

10. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

11. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>Policies and Procedures</u></p> <p>Policies, procedures and guidelines should be in place to help ensure that staff act consistently and in line with approved methodologies.</p> <p>It was identified that there were no policies and procedures covering any aspects of CHC funding / joint funding in place and available to staff.</p> <p>Testing of a sample of 10 CHC cases identified that staff members were using inconsistent document names and storing information in inconsistent locations on the case management system.</p>	<p>Where policies and procedures are not in place, there is a risk that inconsistent or out-of-date practices are adopted by staff.</p> <p>Where staff use inconsistent practices for the case management system, there is a risk that this information will not be easily accessible if required. This could result in duplication of work being completed or work not being completed accurately and timely.</p>	<p>Policies and procedures should be put in place for all aspects of CHC funding / joint funding. Areas to consider could be:</p> <ul style="list-style-type: none"> • Assessments; • Setting up of care plans/funding arrangements; • Reviews; • Appeals; • Fund recovery; and • Communication between CCG and LBB, and between care management staff and the finance team. <p>(Priority 2)</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p><u>Training</u></p> <p>Audit was advised that all care management staff had attended mandatory training in 2015 and external training in 2016 was delivered as 'on the job' training.</p> <p>However, there were no formal training records in place to verify which staff had attended this or other training. It was advised that there is a high turnover of care management staff and a high dependency on agency staff within the team.</p> <p>It is acknowledged that the Head of Assessment Management and Care Manager has now begun to produce a training log for key staff.</p>	<p>Where up-to-date training records are not maintained, there is a risk that gaps of knowledge are not identified leading to staff not being adequately equipped to carry out their duties.</p>	<p>A training record should be produced and maintained to ensure that all relevant staff have adequate training to carry out their duties.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
3	<p><u>CHC Panel and Joint Funded Panel Terms of Reference</u></p> <p>Terms of reference for groups, committees and panels inform members of meeting requirements, such as membership, quorum requirements and the frequency of meetings.</p> <p>Examination of the respective terms of references for the CHC Panel and the Joint Funded Panel provided identified that these are marked as 'draft' and staff were unable to confirm whether these had been finalised and approved.</p> <p>It was also identified that the respective terms of reference did not detail quorum requirements.</p>	<p>Where the terms of references are not approved and do not detail quorum requirements, there is a risk decisions stated by the Panels may not be upheld and that the roles and responsibilities assigned to the Panels are not performed.</p>	<p>The Council should ensure that both the CHC Panel and the Joint Funded Panel have finalised their terms of reference. The terms of reference should include the date these were approved and who by, as well as the quorum requirements.</p> <p>(Priority 3)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4	<p><u>Identification of Individuals Requiring CHC/Joint Funding</u></p> <p>Testing of 10 CHC funded cases and 10 joint funded cases identified that the following documents were not filed on to the case management system:</p> <ul style="list-style-type: none"> • 7 checklists for CHC funded cases; • 9 DSTs for CHC funded cases; • 6 checklists for joint funded cases; • 4 DSTs for joint funded cases; <p>We were informed that the missing cases were due to there being no formal requirement for the CCG to pass over their assessments to the Council. Thus, whilst both parties would be aware of the outcome, the Council might not have access to the actual documents as these are retained by the CCG in their records.</p> <p>For completeness of information, where appropriate, staff should record on the case management system that they have confirmed with the CCG that all the appropriate assessments were carried out.</p>	<p>Where assessment documents are not retained within the case management system, there is a risk that any outstanding assessments may not be identified.</p>	<p>The identified cases should be followed up and the outstanding documentation obtained.</p> <p>Where appropriate, Care Managers should record on the case management system a note confirming they have checked with the CCG that the required assessments were carried out by them even though a copy is not required to be on file.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
5	<p><u>Checklists passed to CCG in a timely manner</u></p> <p>Testing of 10 CHC cases and 10 joint funded cases identified three instances where the checklists were undertaken solely by an LBB staff member, instead of in collaboration with CCG staff.</p> <p>In two of the aforementioned cases emails on the case management system of LBB and CCG staff planning the DST suggests that the checklists were passed to CCG; however, the exact date when these checklists were passed to CCG could not be identified.</p> <p>In one instance, we obtained emails confirming the checklist had been sent to the CCG; however, this was undertaken approximately a month after the checklist was completed.</p>	<p>Where checklists are not passed to the CCG in a timely manner and accurate records of this are not retained, there is a risk that further delays will occur in conducting the DST assessment and reaching a funding agreement.</p>	<p>Staff should ensure all checklists are passed over to CCG as soon as practicably possible. The date these are communicated to the CCG should be clearly recorded on the case management system for completeness of records.</p> <p>(Priority 3)</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
6	<p><u>Case Management Record Keeping</u></p> <p>Testing of a sample of 10 individuals receiving CHC funding identified that in one case, the Council made a one off direct payment on the 4th July 2017 to the claimant totalling £648, which was not recovered from the CCG.</p> <p>We were unable to establish from the evidence available on the case management system whether the payment was granted before the CHC funding had stopped (in which case the costs should have been recovered from the CCG), or after the funding had stopped.</p> <p>Discussion with members of staff could also not establish the end date for CHC funding, so it is unclear whether these costs should have been recovered.</p>	<p>Where accurate records of funding arrangements are not maintained, there is a risk that the relevant costs are not recovered, leading to a financial loss to the Council.</p>	<p>The identified case should be investigated further to determine whether the costs should be recovered from the CCG or not.</p> <p>Clear and accurate records of beginning and end dates should be put on the case management system for any CHC funding to ensure all appropriate costs are recovered.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
7	<p><u>Joint Funding Decisions</u></p> <p>Recent joint funded cases are discussed and agreed at the Joint Funded Panel attended by LBB and CCG staff.</p> <p>Testing of 10 joint funded cases identified the following:-</p> <ul style="list-style-type: none"> • Eight cases where complete evidence on the case management system could not be located to confirm joint funding being agreed by both parties (emails, observations, panel papers and decision sheets). • One case where evidence to support that joint funding was agreed by both parties could not be located. • One case where the individual was documented on the case management system as being joint funded, but the decision sheet from the Mental Health Panel suggested the person was 100% LBB funded. Discussion with staff could not establish why this was the case. 	<p>Where there is no clear confirmation of the agreed cost split between the Council and CCG, there is a risk that appropriate costs might not be recovered by the Council and in case of a disagreement, there is no evidence to establish the correct cost split.</p>	<p>A decision sheet should be completed for all joint funded cases decided at the Panel to confirm the agreed split of costs.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
8	<p><u>Care Plans & Funding Arrangements on the Case Management System</u></p> <p>Care plans are started once the initial assessment has been completed. These will be reviewed and agreed when the joint funding is granted.</p> <p>Testing of 10 joint funded cases identified that there was one case where the claimant’s care plan could not be located on the case management system.</p> <p>Following the joint funding being granted, an Individual Service Contract between the Council and the Health Provider is set up by the brokerage team. An entry for the Service Agreement is also made on the case management system. Once this has been completed, the Exchequer contractor will invoice the CCG for the appropriate amount.</p> <p>Whilst an entry on the case management system for the Service Agreement for all 10 joint funded samples tested was verified, the individual service contract was only available on the case management system in two cases, (although in one case the version available was not signed by the Health Provider).</p>	<p>Where details of the care plans and funding arrangements are not recorded on the case management system, there is a risk that staff will not have adequate information for decision-making.</p>	<p>Details of the care plan for each joint funded individual should be put on the case management system to confirm that the Council is aware of care they are contributing towards.</p> <p>The Individual Service Agreement signed by all parties involved should be put uploaded onto the case management system to confirm the agreed payment plan and funding arrangements.</p> <p>(Priority 2)</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation																
9	<p><u>Recovery of Costs</u></p> <p>Testing of 10 joint funded cases identified three cases where no invoices had been sent out to the CCG. We were advised that this was because the contributions were only recently authorised on the case management system. However, all three funding agreements started over 10 months ago</p> <p><u>Joint - Funding break down.</u></p> <table border="1" data-bbox="282 699 1178 943"> <thead> <tr> <th>Reference</th> <th>Total</th> <th>LBB</th> <th>CCG</th> </tr> </thead> <tbody> <tr> <td>Sample 1</td> <td>£2,959.74</td> <td>£1,424.45</td> <td>£941.74</td> </tr> <tr> <td>Sample 2</td> <td>£1,295.00</td> <td>£1,082.00</td> <td>£213.00</td> </tr> <tr> <td>Sample 3</td> <td>£2,856.00</td> <td>£1,456.66</td> <td>£1,399.44</td> </tr> </tbody> </table> <p>For completeness of information, we were advised that it would be useful if care management staff could be provided with regular information regarding the financial position of the joint funded cases.</p>	Reference	Total	LBB	CCG	Sample 1	£2,959.74	£1,424.45	£941.74	Sample 2	£1,295.00	£1,082.00	£213.00	Sample 3	£2,856.00	£1,456.66	£1,399.44	<p>Where payments to the Council are not recovered in a timely manner, there is a risk that an accumulation of costs may give rise to a dispute with the CCG. This in turn may lead to costs not being recovered in full.</p> <p>Senior care management staff are not provided with information on the financial state of the joint funded cases for a complete overview of the case and the Authority's liability.</p>	<p>The Council should ensure the CCG is invoiced in a timely manner for all costs due to be recovered. Where this cannot be achieved due to any outstanding issues that need to be resolved before an invoice can be sent out, proactive action should be taken to resolve those as soon as possible to avoid an accumulations of costs arising.</p> <p>A monthly report should be provided to senior care management staff with regards to the financial state of the joint funded cases.</p> <p>(Priority 2)</p>
Reference	Total	LBB	CCG																
Sample 1	£2,959.74	£1,424.45	£941.74																
Sample 2	£1,295.00	£1,082.00	£213.00																
Sample 3	£2,856.00	£1,456.66	£1,399.44																

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	A training record should be produced and maintained to ensure that all relevant staff have adequate training to carry out their duties.	2	All staff will be provided with training and a guidance to refer to and this will be mandatory training. L&D will be included in the planning and venue of training days so a formal record will be kept. All staff attending the CHC training have been logged and we can identify them - all staff have attended at least one session	Director of Adult Social Care and Head of Assessment and Care Management	Sept 2018
3	The Council should ensure that both the CHC Panel and the Joint Funded Panel have finalised their terms of reference. The terms of reference should include the date these were approved and who by, as well as the quorum requirements.	3	This is in process. The Joint Funding CHC Panel Terms of Reference are owned by the CCG and this will be raised at the next meeting.	Director of Adult Social Care and Head of Assessment and Care Management	October 2018

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Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p>The identified cases should be followed up and the outstanding documentation obtained.</p> <p>Where appropriate, Care Managers should record on the case management system a note confirming they have checked with the CCG that the required assessments were carried out by them even though a copy is not required to be on file.</p>	2	<p>As in 1 above</p> <p>As in 1 above</p>	Director of Adult Social Care and Head of Assessment and Care Management	Sept 2018
5	Staff should ensure all checklists are passed over to CCG as soon as practicably possible. The date these are communicated to the CCG should be clearly recorded on the case management system for completeness of records.	3	As in 1 above	Director of Adult Social Care and Head of Assessment and Care Management	October 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p>The identified case should be investigated further to determine whether the costs should be recovered from the CCG or not.</p> <p>Clear and accurate records of beginning and end dates should be put on the case management system for any CHC funding to ensure all appropriate costs are recovered.</p>	2	<p>Cases will be looked at as a priority as part of the CHC iBCF Project</p> <p>As in 1 above</p>	<p>Head of Assessment and Care Management and Strategic Commissioner,</p> <p>Head of Assessment and Care Management</p>	<p>July 2018</p> <p>Sept 2018</p>
7	<p>A decision sheet should be completed for all joint funded cases decided at the Panel to confirm the agreed split of costs.</p>	2	As in 1 above	Head of Assessment and Care Management	July 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
8	<p>Details of the care plan for each joint funded individual should be put on the case management system to confirm that the Council is aware of care they are contributing towards.</p> <p>The Individual Service Agreement signed by all parties involved should be put uploaded onto the case management system to confirm the agreed payment plan and funding arrangements.</p>	2	<p>This will be looked at during the actions of finding 1 above to ensure a clear and user friendly system is in place for staff to follow with up to date guidance.</p>	<p>Head of Assessment and Care Management and Strategic Commissioner</p>	<p>Sept 2018</p>

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
9	<p>The Council should ensure the CCG is invoiced in a timely manner for all costs due to be recovered. Where this cannot be achieved due to any outstanding issues that need to be resolved before an invoice can be sent out, proactive action should be taken to resolves those as soon as possible to avoid an accumulations of costs arising.</p> <p>A monthly report should be provided to senior care management staff with regards to the financial state of the joint funded cases.</p>	2	This will be included in the actions in finding 1 above.	Head of Assessment and Care Management with Strategic Commissioner	Sept 2018

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

OPINION DEFINITIONS

APPENDIX C

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.



FINAL INTERNAL AUDIT REPORT
CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF COUNCIL TAX FOR 2017-18

Issued to: John Nightingale, Head of Revenues and Benefits

Cc: Peter Turner, Director of Finance (final report only)

Prepared by: Senior Internal Auditor (Mazars LLP) and Principal Auditor, London Borough of Bromley

Reviewed by: Audit Manager (Mazars LLP) and Head of Internal Audit, London Borough of Bromley

Date of Issue: 17 September 2018

Report No.: CEX/01/2017/AU

REVIEW OF COUNCIL TAX FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Council Tax for 2017-18. The audit was carried out in quarter 1 of 2018-19 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. For the financial year 2017-18, the Council Tax collection rate was 98.04%.

AUDIT SCOPE

4. The scope of the audit was outlined in the Terms of Reference issued on 20 March 2018.

AUDIT OPINION

5. Overall, the conclusion of this audit was that Substantial Assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

6. Controls noted to be in place and working well, based on the sample testing conducted, included:
 - Policies and procedures were in place and available to staff via Knowledge Hub, with any changes in legislation being notified to all Council Tax Knowledge Hub users.
 - Revenue Service Review meetings take place on a monthly basis to discuss the performance of the Exchequer contractor in addition to any other Council Tax matters. The Exchequer contractor representatives are in attendance at these meetings.

Project Code: CEX/01/2017/AU

REVIEW OF COUNCIL TAX FOR 2017-18

- Monitoring reports are provided by the Exchequer contractor on a monthly basis with agreed Key Performance Indicators (KPI's). KPIs are measured against the previous year's performance at the same point in time.
- A sample of 10 support payments tested for the 2017-18 financial year identified that all had appropriate documentation retained and decisions on whether to provide support payments were reasonable.
- The collection rate of 98.04% for the 2017-18 financial year had increased from 97.9% for the 2016-17 financial year.
- For a sample of 20 accounts in arrears, it was identified that where bailiffs were engaged, monies were being routinely recovered from those persons in arrears. Additionally, in some cases covering more than one year, monies were being paid direct to the bailiffs and the Council.
- One bankruptcy case tested identified that appropriate action and reasoning had been undertaken. The amount owed to the Council in this case was over £13,000.

7. However, we would like to bring to management attention the following issues:

- Evidence of how complaints are dealt with was not fully evidenced and provided.
- Examination of discretionary Council Tax payments identified one instance (out of 10) where the reason for the discretionary payment could not be evidenced and there was also no revised letter on the system. The value of the payment was £190.72.
- The Discretionary Council Tax Support claim form is not Data Protection Act 2018 compliant.
- Examination of 10 refunds identified one instance where there was no evidence of the refund being requested by the claimant.
- Examination of 20 accounts in arrears identified one instance where we were unable to locate the final demand letter.
- Examination of 10 write-offs identified one instance where the case had not been sent to the bailiffs. This was for a total value of £1,319.20.
- Examination of 10 discounts awarded identified one instance where there was a lack of evidence for the discount being provided. The discount was for £57.72.

SIGNIFICANT FINDINGS (PRIORITY 1)

8. There were no priority one recommendations raised as part of this audit.

Project Code: CEX/01/2017/AU

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

10. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

REVIEW OF COUNCIL TAX FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation																
1	<p><u>Complaints</u></p> <p>When a complaint is made, this is sent to the Revenues and Benefits team. The Head of Service (HoS) advised that each case will then be fully assessed by a LBB Revenues and Benefits staff member and subsequently communications will be held between LBB and the Exchequer contractor to check that any decisions that were taken were appropriate. In this manner, checks are undertaken on work performed by the Exchequer contractor. Discussions regarding the Exchequer contractor's performance are undertaken at monthly Revenue Services Review meetings.</p> <p>We obtained the following information from the aforementioned minutes for December 2017, January 2018 and February 2018.</p> <table border="1" data-bbox="282 927 1182 1257"> <thead> <tr> <th>Month</th> <th>Justified Complaints</th> <th>Un-Justified Complaints</th> <th>Total complaints</th> </tr> </thead> <tbody> <tr> <td>December 2017</td> <td>3</td> <td>24</td> <td>27</td> </tr> <tr> <td>January 2018</td> <td>7</td> <td>20</td> <td>27</td> </tr> <tr> <td>February 2018</td> <td>2</td> <td>22</td> <td>24</td> </tr> </tbody> </table> <p>Whilst the above statistics on complaints had been provided, we were unable to see evidence that discussions about individual cases had occurred or that checks carried out by the</p>	Month	Justified Complaints	Un-Justified Complaints	Total complaints	December 2017	3	24	27	January 2018	7	20	27	February 2018	2	22	24	<p>Where there is no evidence to support how complaints are dealt with, there is a risk that all complaints are not dealt with appropriately, which could mean that any cases of poor decision making by the contractor are not recognised.</p> <p>This can result in continual poor decision making by the contractor if not identified in addition to individuals paying the incorrect amount of Council Tax.</p>	<p>Evidence should be retained by the contractor to support how complaints have been dealt with and by the client team to confirm that the contractor's performance for handling complaints is satisfactory. (Priority 2)</p>
Month	Justified Complaints	Un-Justified Complaints	Total complaints																
December 2017	3	24	27																
January 2018	7	20	27																
February 2018	2	22	24																

REVIEW OF COUNCIL TAX FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>Exchequer contractor had then been verified by management in each case.</p>		
2	<p><u>Discretionary Council Tax Benefits</u> Discretionary Council Tax benefits may be given in circumstances where claimants:</p> <ul style="list-style-type: none"> • claim support payments but still require further monetary assistance; • for claimants who do not receive support payments and need monetary assistance; or • for individuals who are affected by the 2013 Welfare Reform changes. <p>Examination of a sample of 10 claimant accounts that had been awarded discretionary council tax support payments over the 2017-18 financial year identified one case (reference; 5667932) where the 'request document' (document requesting discretionary council tax payments) could not be located.</p> <p>In addition, there was no evidence of a revised letter being sent once the payment had been made to the claimant's account. The revised letter would detail the new council tax liability taking into account the discretionary council tax payment made.</p>	<p>Where there is no evidence of the reason for the discretionary council tax payment, there is a risk that money is awarded to persons who are not in need of additional support.</p> <p>Where 'revised council tax due' letters are not sent to individuals, there is a risk that individuals are not aware of their current council tax liability which can lead to further issues with payments.</p>	<p>Evidence of all discretionary council tax payments and support payments awarded should be retained on file, including revised letters sent out to claimants. (Priority 2).</p>

REVIEW OF COUNCIL TAX FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
3.	<p><u>Data Protection Act 2018 Compliance</u></p> <p>A copy of the most up to date Discretionary Claim form was obtained from the Council’s website. The Form currently does not comply with the latest version of the Data Protection Act 2018. For example the form does not indicate how information provided will be used, how long it will be kept for nor who else will have access to the information provided.</p> <p>The Benefits Manager advised us that the Revenues and Benefits Team are aware of this and they are working to update all forms to be Data Protection Act 2018 compliant.</p>	<p>Where the Council is not Data Protection Act 2018 compliant, there is a risk of a breach of legislation, imposed fines and reputational damage.</p>	<p>The Council should aim to update all claim forms in line with the Data Protection Act 2018 as soon as possible. (Priority 2)</p>
4.	<p><u>Refunds</u></p> <p>A sample of 10 refunds was selected covering the period April 2017 until March 2018.</p> <p>A refund request is required to be made by the tenant or an appropriate person/body where a refund is believed to be due. It was identified from the sample of 10 selected that there was one instance, reference 5002172, where there was no evidence of the refund request form on the system.</p>	<p>Where evidence of the refund request forms cannot be located, there is a risk that the Council are refunding money that is not due or has not been requested, which can lead to an unnecessary strain on resources.</p>	<p>In council tax cases where refunds are given, the refund request form or email should be maintained on the system as evidence. (Priority 2).</p>

REVIEW OF COUNCIL TAX FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
5.	<p><u>Arrears</u></p> <p>Individuals fall into arrears where they do not make their council tax payments in a timely manner. Where payments are not made in a timely manner, debt recovery action is taken. In the first instance, a reminder letter is sent giving the individual 14 days to make payment. Where payment is still not made, either a second reminder is sent (if it's the first time the individual is in arrears) or a final demand letter is sent to try and prompt payment from the individual.</p> <p>It was identified through testing a sample of 20 individuals who fell into arrears in the 2017-18 financial year that there was one instance, reference 5645287 of £1,245.00 where there was no evidence of a final demand letter being sent to the individual.</p> <p>This case has been since been sent to the bailiffs for collection and then subsequently to the Council's debt recovery and enforcement contactor. This case is still ongoing.</p>	<p>Where evidence of final demand letters being sent to individuals cannot be located, there is a risk that appropriate recovery procedures have not been followed. This can result in unnecessary court actions and the action of bailiffs taking place which are unnecessary.</p>	<p>All demand letters and other correspondence relating to individuals should be retained on client files. (Priority 2).</p>
6.	<p><u>Write-Offs</u></p> <p>The Council is able to write-off some of the debts owed immediately (for example where the value is £0.01) without taking recovery action. In other instances, money is only written off once all other recovery avenues have been exhausted.</p> <p>We tested a sample of 10 writes-off cases for the financial year 2017-18. There was one instance, ref 5646920 for the amount</p>	<p>Where monies owed to the Council are written-off prior to all debt recovery avenues being exhausted, there is a risk that money due is not recovered, resulting in a loss of income for the</p>	<p>Management should ensure that there is evidence that all debt recovery channels have been exhausted before debts are written-off. (Priority 2).</p>

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<p>of £1,319.20 where there was no evidence that the debt had been sent to the bailiffs to recover the money due. Approval for this amount to be written off was given on 30 August 2017.</p>	<p>Council.</p>	
<p>7.</p>	<p><u>Discounts</u> Discounts may be applicable to persons depending on their situation. Discounts include but are not exclusive to:</p> <ul style="list-style-type: none"> • single persons discount; • student discount; and • Severe mental impairment discount. <p>We tested a sample of 10 individuals receiving discounts on their council tax liability. Of these 10 discounts, there was one instance, reference 5654932 with a discount of £57.72 being applied, however there was no backing documentation to verify the reason for the discount being awarded.</p>	<p>Where evidence / supporting documentation is not retained, there is a risk that a discount may have been incorrectly awarded, leading to a loss in revenue for the Council.</p>	<p>Supporting documentation for council tax discounts given should be retained on file. (Priority 2).</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1.	Evidence should be retained by the contractor to support how complaints have been dealt with and by the client team to confirm that the contractor's performance for handling complaints is satisfactory.	2	The Head of Revenues & Benefits has raised with Legal Services that he did not believe the corporate complaints procedure to be "fit for purpose" in respect of contracted-out services. The procedure is currently being reviewed by Legal Services and the new process will be implemented following the review.	Head of Revenues & Benefits	Following review of corporate complaints procedure by Legal Services.
2.	Evidence of all discretionary council tax payments and support payments awarded should be retained on file, including revised letters sent out to claimants.	2	Evidence of awards are entered on the Academy screen and customer notification is automatically produced. It is accepted that this was not the case on one occasion. Monitoring will be undertaken to ensure that this does not remain an ongoing issue.	Head of Revenues & Benefits	Implemented

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3.	The Council should aim to update all claim forms in line with the Data Protection Act 2018 as soon as possible.	2	All forms should now be in accordance with GDPR 2018. However, monitoring will continue to ensure old stock and/or missed templates are not being used.	Head of Revenues & Benefits	Implemented
4.	In council tax cases where refunds are given, the refund request form or email should be maintained on the system as evidence.	2	Refund requests are retained on file. On the case identified where this did not happen, a legitimate decision was made to process the refund without the said paperwork. Officers will be asked to document where decisions of this type are taken in future.	Head of Revenues & Benefits	31 October 2018
5.	All demand letters and other correspondence relating to individuals should be retained on client files.	2	Monitoring will continue to be undertaken to ensure that all communications detailed in the recovery process are issued and copies retained.	Head of Revenues & Benefits	Implemented

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6.	Management should ensure that there is evidence that all debt recovery channels have been exhausted before debts are written-off.	2	Agreed. The case identified is believed to be an isolated incident and did not change the end result.	Head of Revenues & Benefits	Implemented
7.	Supporting documentation for council tax discounts given should be retained on file.	2	Agreed. On the case identified where this did not happen, a legitimate decision was made to process the refund without the said paperwork. Officers will be asked to document where decisions of this type are taken in future.	Head of Revenues & Benefits	31 October 2018

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT
EDUCATION CARE & HEALTH DEPARTMENT

REVIEW OF DIRECT PAYMENTS AUDIT FOR 2017-18

Issued to: Stephen John, Director, Adult Social Care,
Tricia Wennell, Head of Assessment & Care Management,
Stephen Ohrmann, Interim Team Manager, Adult Learning Disabilities Team,
Wendy Norman, Head of Contract Compliance & Monitoring,
Paul Feven, Director of Programmes,
Claudine Douglas Brown, Assistant Director, Exchequer Services,
Olwyn Avery, Contract Compliance Officer,
David Bradshaw, Head of ECHS Finance,
Naheed Chaudhry, Assistant Director, Strategy, Performance and Business Support.

Cc Ade Adetosoye, Deputy Chief Executive & Executive Director ECHS (Final Only),

Prepared by: Principal Auditor,

Date of Issue: September 10th 2018

Report No: ECHS/10/2017/AU

REVIEW OF DIRECT PAYMENTS AUDIT 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Direct Payments for 2017-18. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017/18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. Direct payments are payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly. A separate bank account is set up for the direct payments and service users have to provide evidence of expenditure that complies with the terms and conditions of the direct payment. The monitoring function is undertaken by Contractor A in conjunction with care management. Contractor C service user balances are monitored by the Exchequer Team.
4. Service users who are unable to manage their direct payments will have a managed service and this is undertaken by Contractor C. A new contract with Contractor C commenced on 8/4/17 for the provision of the direct payment support and payroll service and expires on 7/4/19 with option to extend. The value for this two year contract is £259,375.32 and separate costs for the payroll and managed accounts, which is based on client numbers. The previous provider was Contractor B.
5. Performance payments received by the contractor are made based on the number of clients utilising particular services on a monthly basis. These were reviewed as part of the audit testing.
6. At the Care Services Policy and Development Committee on 14/3/18, the committee considered the key findings of the ADASS Peer review on the use of resources in adult social care in Bromley. It was highlighted that 'a direct payment project is in the process of being launched which is geared to improve Bromley Council's performance in this area. The project will review the service user experience in using direct payments and will seek to simplify and make more attractive the direct

REVIEW OF DIRECT PAYMENTS AUDIT 2017-18

payment offer to Bromley's residents, as well as increase the range of personal assistants available to service users and self-funders.' This project is due to be completed by March 2019.

7. Direct payment Champions have been identified in each department and there is also attendance at the Self Directed Support meetings (SDS meetings). There is the Direct Payments Project that is underway.
8. It was found when reviewing the quarterly returns from Contractor C that there were some service user groups that had no direct payment users or very low numbers. There were no direct payments for mental health service users, carers and low numbers within learning disability services.
9. The Head of Assessment & Care Management advised the Auditor that there are now Direct Payment champions in every team and there are also Direct Payment champion team meetings. This includes LD and Mental Health teams.
10. A report of all current adult direct payment users was requested from the Performance & Information team which detailed that as at 15/1/18 there were 1267 active service agreements for direct payments on System 1. A random sample of 30 was selected for review. This included a split between Contractor C clients and Contractor A clients.

AUDIT SCOPE

11. The scope of the audit was outlined in the Terms of Reference issued on 28/2/2018. The audit also included following up the recommendations of the Investigation Report.

AUDIT OPINION

12. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

13. Our testing identified the following issues which we would like to draw to management's attention:-

- Reviews to confirm that the direct payment is being used in accordance with the support plan.
- Support Plans were found to be draft in some cases and Statement of Needs had not been completed for some cases.
- Direct Payment Terms and Conditions were found not to have been met.
- Service User account balances for Contractor C clients.
- Performance data cannot be verified and reconciled to the performance payments based on client numbers. Performance measures not met.
- Payments found not to have the relevant supporting documentation. Incorrect payment levels resulting in overpayments.
- Lack of monitoring information in some cases for years.
- DP5 documentation not found and in one case two siblings shared the same form.
- Lack of ownership of the documentation.
- Lack of number in mental health, carers and Learning Disabilities requiring a change in process.

14. The contract specifies six performance measures which were reviewed as part of the audit. The current measures are: -

- 95% clients visited within one week of referral
- 95% recruitment completed within 8 weeks
- 90% level of client satisfaction
- 95% accuracy level for all payroll including returns to HMRC
- 100% number of pensions on auto enrolment completed within legislative timelines.
- 98% complaints dealt with contractors' internal QA systems and procedures.

15. These were reviewed as part of the audit.

SIGNIFICANT FINDINGS (PRIORITY 1)

16. There are four significant findings relating to DP5 documentation, direct payment terms and conditions and payments.
17. **DP5 Documentation**
The DP5 is the legal agreement between the service user and the Authority, whereby both parties sign to confirm that the direct payment will be used in accordance with the terms of and conditions of the DP5 agreement.
18. Unlike other DP forms, which are embedded within System 1 the DP5 is issued by Contractor C and a scanned copy of the signed form should be held on System 2 for each service user. Audit testing showed that the DP5 could not be located within System 2 for 20 of the thirty cases reviewed at the time of testing.
19. **Direct Payment Terms and Conditions not met**
It was found that issues arose with 3 cases whereby terms and conditions of the direct payment were found not to have been complied with.
- Samples 15 and 16 (siblings) both received a one off amount of £4,000 for the year to enable respite provision. There are other direct payments totalling circa £1,500 per week additionally. It was found that no monitoring information has been provided since 2015 and it has not been confirmed whether the client contributions have been paid into the account and whether the monies have been used for respite services. Contractor A advised the Auditor that 'Email sent to Senior Accountant on 26/10/2017 advising that receipts for respite not received. Letter was sent 21/3/2018 regarding both clients to parent this is scanned onto Care Store under Finance Direct Payments. Email was sent to three officers on 17/4/2018 no response received.
 - Sample 27 statements from Contractor C shows that individuals with the same surname are potentially providing the service user with care and the approval for this was not seen at the time of testing.
20. **Payments**
Payments in place at the time of testing were cross referenced to supporting documentation. Issues arose in 2 cases.

REVIEW OF DIRECT PAYMENTS AUDIT 2017-18

21. For Sample 9, it was found that this service user had 4 direct payment service agreements on System 1 all commencing on 5/5/14 and totalled £4,358.20 per week. The service agreement selected for testing was the night wake service which stated that it should be 8 hours (1 person) x £13.28 per hour = £106.24. This equates to £743.63 per week, however, £804.16 has been paid per week instead. Enquiries have been made with the Interim Group Manager for LD and the Senior Care Manager.
22. It was confirmed by the Interim Team Manager, that the service agreement should be 8 hours x £13.28 x 7 days a week. This should have been at a weekly cost of £743.68. This has resulted in an overpayment of circa £12,500 from May 2014 to May 2018. The service agreements have since been closed off as at 2/4/18 as the service user is now within a supported living placement. It should be noted that for this service user the DP5 could not be located at the time of testing. The DP7 was completed on 22/5/18.
23. Sample 17 has a current direct payment that commenced on 27/10/14 for 21 hours per week @ £11.78 per hour = £247.38 but £264.39 has been paid weekly to date. This is an overpayment of £17.01 per week and circa £3,000 in total to the end of March 2018. The DP1 (start-up form) dated 30/10/14 confirms the rate should be £247.38.
24. **Ownership of Documents For Update & Review Including Appointed Person Form**
25. During the audit enquiries were made in relation to the location of the Direct Payment documentation. It could not be determined which officer was responsible for the review and update of the direct payment documentation and also where the latest copy resided such as the DP5, which is the legal document that is signed by all parties.
26. A contact at Contractor C provided the latest copy of the DP5 to the Auditor. Enquiries have been made to determine what happens once the DP has been signed by all parties as a number of the completed DP5 documents could not be located. In relation to the Nominated / Appointed Person form, it could not be determined where these forms are located. This form was discussed at the Contractor C contract monitoring meeting on 23/10/17. The minutes state in relation to the Authorised Person Form "It was agreed that this would be used instead of the DP5 and that there needs to be clear instruction in the referral stating who needs to sign the form during the DP set up visit".

REVIEW OF DIRECT PAYMENTS AUDIT 2017-18

27. System 1 and System 2 were searched to locate all relevant documentation in respect of appropriate person documentation. It is unclear where these forms are located as these also could not be located during testing, for the 15 samples where it was detailed that there was a lack of mental capacity to manage finances.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

28. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

29. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>Reviews</u></p> <p>From sample testing of 30 cases it was found that issues arose in six cases at the time of testing. Sample 5 was last reviewed on 5/1/17. Sample 6 was last reviewed on 6/3/18 but was not yet completed. Sample 12 was last reviewed on 11/7/16. Sample 13 was last reviewed on 18/3/16. Sample 20 was last reviewed on 5/9/16. Sample 30 was last reviewed on 19/10/16.</p>	<p>Direct payments may not be utilised in accordance with the support plan.</p>	<p>Reviews should be undertaken to determine whether the service users are using the direct payment in line with the support plan and that service user is managing with the direct payment.</p> <p>[Priority 2]</p>
2	<p><u>Support Plans & Statement of Needs</u></p> <p>Through testing it was found that issues arose with support plans for six samples out of thirty cases :-</p> <ul style="list-style-type: none"> • Sample 9 Support Plan was Draft dated 12/4/17 • Sample 15 Support Plan was Draft dated 21/6/17 • Sample 16 Support Plan was Draft dated 21/6/17 • Sample 23 Support Plan was not current • It was noted that the support plans were both current for Samples 14 and 18 who died on 4/8/17 and 13/6/17 respectively. 		

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>It was found that in relation to the Statement of Needs issues arose with seven samples:-</p> <ul style="list-style-type: none"> • Sample 4 – No Record • Sample 5 – No Record • Sample 6 – No record • Sample 12 – No Record • Sample 23 Classified as substantial but was not current. • Sample 24 – No Record • Sample 29 Not complete. No assessment of needs and dated 8/7/09. 	<p>Assessments may not be up to date and match care currently being provided.</p>	<p>The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.</p> <p>[Priority 2]</p>
3	<p><u>Direct Payment Terms and Conditions not met</u></p> <p>It was found that issues arose with 3 cases whereby terms and conditions of the direct payment were found not to have been complied with.</p> <ul style="list-style-type: none"> • Samples 15 and 16 (siblings) both received a one off amount of £4,000 for the year to enable respite provision. There are other direct payments totalling circa £1,500 per week additionally. It was found that no monitoring information has been provided since 2015 and it has not been confirmed whether the client contributions have been paid into the account and whether the monies have been used for respite services. Contractor A advised the Auditor that ‘Email 		

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>from sent to Senior Accountant on 26/10/2017 advising that receipts for respite not received. Letter was sent 21/3/2018 regarding both clients to parent this is scanned onto Care Store under Finance Direct Payments. Email was sent to three officers on 17/4/2018 no response received.</p> <ul style="list-style-type: none"> • Sample 27 statement from Contractor C shows that individuals with the same surname are potentially providing the service user with care. Confirmation that prior approval has been given is required. 	<p>Monies may not be recovered by the Authority for unauthorised expenditure.</p>	<p>Cases identified should be investigated without delay. Internal Audit should be notified of the outcome of individual cases.</p> <p>[Priority 1]</p>
4	<p><u>Balances on Direct Payment Account (Contractor A)</u></p> <ul style="list-style-type: none"> • For Sample 12, the Auditor was advised by the contractor that confirmed ‘monitoring was not able to be completed for this service user since December 2016 due to missing information. Adult Early Intervention team were informed that monitoring for October to December 2017 not received. A suspension letter was sent to the client’. The last closing balance available for this period to 30/9/17 showed through monitoring that the closing balance was £10,762.10. This exceeds the 8 weeks direct payment balance by £4,517.46. 	<p>Clients may not be receiving the levels of care they are assessed as needing.</p>	<p>Client balances that exceed 8 weeks payments should be clawed back or queried why money is not being spent.</p> <p>[Priority 2*]</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
5	<p><u>Performance Measures</u></p> <p>Although the contract with Contractor C commenced on 8/4/17 and so has been running for just over a year, the current performance measures are those in place with the previous provider Contractor B and have not been fully reviewed in relation to the effectiveness. There are six agreed current performance measures agreed with the contractor :-</p> <ul style="list-style-type: none"> i. 95% of clients visited within one week of referral. Not achieved. ii. 95% recruitment completed within less than 8 weeks. It is unclear if this has been achieved or not. iii. 90% level of client satisfaction This has yet to be measured as it is annually although the survey has been issued. iv. 95% accuracy level for all payrolls processed including HMRC Met in Q3 and Q4 but not In Q1 93% or Q2 94%. v. 100% pension auto enrolment completed within legislative timelines. Met in Q1 and Q3 but not Q2 99% or Q4 98%. vi. 98% complaints dealt with in compliance with the contractors' internal QA systems and procedures. It is unclear if this has been achieved or not. <p>As there is a policy to significantly increase the number of</p>	<p>Contractors may not deliver responsibilities under the contract terms.</p> <p>Contractor may not deliver responsibilities under the contract terms.</p>	<p>Performance measures have not been fully met for some of the six measures. It is not always clear some targets have been met.</p> <p>Performance measures should be reviewed to determine whether they remain relevant for the effective performance of this contract.</p> <p>[Priority 2]</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>direct payments in Bromley, it is unclear why there is not a specific performance measure to monitor the increase in direct payment cases. This is in light of the fact that there are no referrals to date for Q1-Q3 for carers or mental health clients. In addition, the number of referrals for learning disability service users remain low.</p>		
6	<p><u>Payments</u></p> <p>Payments in place at the time of testing were cross referenced to supporting documentation. Issues arose in 2 cases.</p> <ul style="list-style-type: none"> • Sample 9 it was found that this service user had 4 direct payment service agreements on System 1 all commencing on 5/5/14 and totalled £4,358.20 per week. The service agreement selected for testing was the night wake service which stated that it should be 8 hours (1 person) x £13.28 per hour = £106.24. However, £804.16 has been paid per week instead. Senior management have stated that the service lines should be 8 hours per week at £13.28 which comes to a weekly cost of £743.68. This has resulted in an overpayment of circa £9,000. The service agreements have since been closed off as at 2/4/18 as the service user is now within a supported living placement. The DP5 could not be located at the time of testing. The DP7 was completed on 22/5/18. 		

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> Sample 17 has a current direct payment that commenced on 27/10/14 for 21 hours per week @ £11.78 per hour = £247.38 but £264.39 has been paid weekly to date. This is an overpayment of £17.01 per week and circa £3,000 in total to the end of March 2018. The DP1 dated 30/10/14 confirms the rate should be £247.38. 	<p>Monies may not be recovered by the Authority.</p>	<p>Cases highlighted should be investigated and overpayments recovered without delay. Cases should be amended to the correct rates. The direct payment process should be scrutinised to ensure that these overpayments do not continue to arise.</p> <p>[Priority 1]</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
7	<p><u>Direct Payment Monitoring Information</u> Monitoring information was reviewed up to the last available data set which was December 2017 for all relevant clients. These related to non Contractor C clients.</p> <p>Sample 12 – It was confirmed by Contractor A that ‘not been able to complete monitoring for this client since December 2016 due to missing information. AEI (Adult Early Intervention) were informed, monitoring for October to December 17 not received and a suspension letter sent to client and care management advised’.</p>	<p>Money intended for client care is spent on inappropriate items.</p>	<p>Procedures for ensuring clients return monitoring information should be reviewed and staff reminded of the procedures.</p> <p>[Priority 2*]</p>
8	<p><u>DP5 Documentation</u></p> <p>The DP5 is the legal agreement between the service user and the Authority, whereby the both parties sign to confirm that the direct payment will be used in accordance with the terms of and conditions of the DP5 agreement.</p> <p>Unlike other DP forms, which are embedded within System 1 the DP5 is issued by Contractor C and a scanned copy of the signed form should be held on System 2 for each service user. Audit testing showed that the DP5 could not be located within System 2 for 20 cases.</p> <p>Samples 1,2,6,7,8,9,10,12,13,14,17,18,20,21,23,24, 27 (the scanned copy was unsigned) 28 and 30.</p>		

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Also it was found that Sample 15 and 16 (siblings) had a joint DP5.</p>	<p>Monies may not be recovered if the terms and conditions of the direct payment are not met.</p>	<p>The DP5 document should be in place for all service users in receipt of direct payments. Signed copies of the DP5 form should be held securely and retained on System 2.</p> <p>[Priority 1]</p>
<p>9</p>	<p><u>Ownership of Documents For Update & Review Including Appointed Person Form</u></p> <p>During the audit enquiries were made in relation to the location of the Direct Payment documentation. It could not be determined which officer was responsible for the review and update of the direct payment documentation and also where the latest copy resided such as the DP5. A contact at Contractor C provided the latest copy of the DP5 to the Auditor. Enquiries have been made to determine what happens once the DP has been signed by all parties as a number of the completed DP5 documents could not be located. In relation to the Nominated / Appointed Person form, it could not be determined where these forms are located. This form was discussed at the Contractor C contract monitoring meeting on 23/10/17. The minutes state in relation to the Authorised</p>	<p>Staff may be operating to different working practices as current version of documentation is not readily available.</p>	<p>All documentation should be owned by a designated officer, Documents such as the DP5 and the Appointed Person Form should be readily available and regularly reviewed.</p>

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Person Form “It was agreed that this would be used instead of the DP5 and that there needs to be clear instruction in the referral stating who needs to sign the form during the DP set up visit”.</p> <p>System 1 and System 2 were searched to locate all relevant documentation in respect of appropriate person documentation. It is unclear where these forms are located as these also could not be located during testing, especially as there were 15 samples where it was detailed that there was a lack of mental capacity to manage finances.</p> <p>It should be noted that a Policy Officer has recently been appointed.</p>	<p>Staff may not complete the DP5 due to this instruction.</p>	<p>Any change in documentation should be detailed within the direct payment procedures and once approved made available to all staff.</p> <p>[Priority 1]</p>
10	<p><u>Direct Payment Service User Groups</u></p> <p>It was found when reviewing the Quarterly returns from Contractor C that there were some service user groups that had no direct payment users or very low numbers. There were no direct payments for mental health service users, carers and low numbers within learning disability services.</p>	<p>Direct payments levels achieved in Bromley will not be in line with that being achieved nationally.</p>	<p>The direct payment processes should be reviewed to ensure direct payments are made accessible to all service user groups.</p> <p>[Priority 2]</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p><u>Reviews</u></p> <p>Reviews should be undertaken to determine whether the service users are using the direct payment in line with the support plan and that service user is managing with the direct payment.</p>	2	<p>ASC are taking steps to ensure all reviews are completed. The overdue DP reviews will be included in that work.</p> <hr/> <p>ALDT is working on all reviews to be completed. Extra efforts are currently undertaken. DP reviews included.</p>	<p>Head of Assessment & Care Management/Head of Learning Disability</p> <hr/> <p>Service Lead - Adult Learning Disabilities</p>	<p>November 30th 2018</p> <hr/> <p>December 31st 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p><u>Support Plans & Statement of Needs</u></p> <p>The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.</p>	2	<p>As above with all support plans in place.</p> <p>Staff will be reminded to complete Support Plans and Statements of needs correctly.</p> <p>PRG will audit this as part of PRG using the mini Case file audit tool.</p> <hr/> <p>Alongside all reviews support plans to be completed. Majority are in place; outstanding SP being done. Staff has been told to complete all together with review. Recent IT report shows most are done.</p>	<p>Head of Assessment & Care Management/Head of Learning Disability</p> <hr/> <p>Service Lead - Adult Learning Disabilities</p>	<p>November 30th 2018</p> <hr/> <p>November 30th 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Direct Payment Terms and Conditions not met</u></p> <p>Cases identified should be investigated without delay. Internal Audit should be notified of the outcome of individual cases.</p>	1	<p>These cases will be reviewed within three months.</p> <hr/> <p>Specific case has been looked in judicial review. Special DP arrangement for family PA was authorised as in some other cases. Should be recorded in support plan. Needs to be looked at.</p>	<p>Head of Assessment & Care Management / Head of learning Disability.</p> <hr/> <p>Service Lead - Adult Learning Disabilities</p>	<p>October 31st 2018.</p> <hr/> <p>October 31st 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p><u>Balances on Direct Payment Account (Contractor A)</u></p> <p>Client balances that exceed 8 weeks payments should be clawed back or queried why money is not being spent.</p>	2*	<p>Contractor A has been reminded of the requirement to request surplus funds notwithstanding any outstanding monitoring queries.</p> <p>Contractor A will request payment of the £4,517.46 excess that was identified on the 30/09/17 monitoring however as no further monitoring has been received and the direct payment is still ongoing there may no longer be any excess funds to recover.</p>	<p>Assistant Director, Exchequer Services</p> <p>Operations Manager, Contractor A</p>	<p>Completed</p> <p>31st July 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p><u>Performance Measures</u></p> <p>Performance measures have not been fully met for some of the six measures. It is not always clear some targets have been met.</p> <p>Performance measures should be reviewed to determine whether they remain relevant for the effective performance of this contract.</p>	2	<p>Performance measures are currently being reviewed in light of contract management experience. This will ensure that the current KPI's are relevant, robust and effective in managing the performance of the contract.</p> <p>A new performance framework will be developed and in place as a core part of contract management.</p>	Director of Programmes	Sept 30 th 2018

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p><u>Payments</u></p> <p>Cases highlighted should be investigated and overpayments recovered without delay. Cases should be amended to the correct rates. The direct payment process should be scrutinised to ensure that these overpayments do not continue to arise. Service agreements should be closed off in a timely manner.</p>	1	<p>First case completed. Second case to be reviewed.</p> <p>Staff to be reminded that they must follow the process.</p> <p>A report for all open service agreements is in place will all be checked by management.</p>	<p>Senior Care Manager / Interim Manager LD</p> <p>Operational Managers and LD Management</p>	<p>Two weeks</p> <p>July 24th 2018</p> <p>ongoing</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
7	<p><u>Direct Payment Monitoring Information</u> Procedures for ensuring clients return monitoring information should be reviewed and staff reminded of the procedures.</p>	2*	<p>DP monitoring and procedures will be reviewed by CM along with Finance Management.</p> <hr/> <p>First case has been completed. DP monitoring to be intensified and looked at in review and PRG.</p>	<p>Head of Assessment and Care Management</p> <p>Head of Learning Disability/ Assistant Director, Exchequer Services</p> <hr/> <p>Service Lead - Adult Learning Disabilities/Senior Care Manager LD</p>	<p>September 30th</p> <p>October 31st 2018</p> <hr/> <p>September 30th 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
8	<p><u>DP5 Documentation</u> The DP5 document should be in place for all service users in receipt of direct payments. Signed copies of the DP5 form should be held securely and retained on System 2.</p>	1	<p>Process for storage of DP5 will be reviewed along with all DP Policy and Procedures</p> <p>DP5's are scanned in to System 2 but are not easily located. Staff will be reminded to scan all DP5s in to System 2 and informed of where this should be for consistency.</p> <hr/> <p>DP 5 to be stored consistently on same section in System 2.</p> <p>Specific case has been looked at and reviewed. Family and LBB agree on current arrangement.</p>	<p>Head of Assessment & Care Management /Head of Learning Disability.</p> <hr/> <p>Service Lead - Adult Learning Disabilities</p>	<p>30th November 2018</p> <p>September 30th 2018</p> <hr/> <p>November 30th 2018</p> <p>September 30th 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
9	<p><u>Ownership of Documents For Update & Review including the Appointed Person Form</u> All documentation should be owned by a designated officer, Documents such as the DP5 and the Appointed Person Form should be readily available and regularly reviewed.</p> <p>Any change in documentation should be detailed within the direct payment procedures and once approved made available to all staff.</p>	1	<p>The process and guidance for the appointed person is in its final draft stage. The terminology has been changed in line with the language used in the Care Act 2014. The Suitable Person and Nominee are clear in the process and guidance. The Head of Assessment and Care Management will circulate the documents as soon as they are signed off and will be visiting teams to ensure all staff are clear about the requirements. They will be stored on one-bromley for ease of access to all staff.</p> <hr/> <p>As above.</p>	<p>Head of Assessment & Care Management / Head of Learning Disability.</p> <hr/> <p>Service Lead - Adult Learning Disabilities</p>	<p>September 30th 2018</p> <hr/> <p>September 30th 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
10	<p><u>Direct Payment Service User Groups</u></p> <p>The direct payment processes should be reviewed to ensure direct payments are made accessible to all service user groups.</p>	2	<p>A review of the direct payments process is a core part of the current service review being undertaken within ECHS.</p> <p>The service review will:</p> <ul style="list-style-type: none"> • Review the Direct Payments business process • Identify areas for improvement and greater efficiency. • Recommend a revised DP process that is more accessible and easier for service users to navigate. This would include an easy read version. • Implement the required changes. 	Director of Programmes via Direct Payment Project	<p>Review of process – August 31st 18</p> <p>Revised process - Sept 30th 18</p> <p>New guidance based on revised process (including easy read) – October 30th 18</p>

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE AND HEALTH SERVICES

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

Issued to: Janet Bailey, Director Children's Social Care
Vicky West, Head of Fostering, Adoption and Resources
Ruth Wood, Head of Service, Placements and Brokerage

Cc: Ade Adetosoye, Deputy Chief Executive, Executive Director, ECHS (final only)
David Bradshaw, Head of Finance ECHS
Naheed Chaudhry, Assistant Director Strategy Performance and Business Support

Prepared by: Senior Internal Auditor (Mazars LLP).
Principal Auditor

Date of Issue: 20th August 2018

Report No.: ECHS/03/2017/AU

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Family Placements for 2017/18. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 22 February 2018.
4. Within Fostering and Adoption there are numerous arrangements available. As part of this audit we tested Special Guardianship Orders (SGO), Child Arrangement Orders (CAO), Connected Persons Arrangements (CP) and Adoption Placements (AP).

AUDIT SCOPE

5. The scope of the audit is detailed in the Terms of Reference.

AUDIT OPINION

6. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

7. Controls noted to be in place and working well based on audit testing conducted included:
 - Policies and procedures were in place and reviewed on a periodic basis;

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

- For a sample of 10 Connected Person Placements, Connected Person Authorisation forms were completed prior to the placement and reviews were found to be completed after 16 weeks where required; and
 - For a sample of 10 Special Guardianship Orders (SGO) Initial Assessments were completed.
8. However, we would like to bring to management attention the following issues:
- There had been no uplift to the carer's allowances, paid in line with DfE thresholds, for 2017 or 2018. 19/20 CAO and CP sampled were being paid at the 2016/17 DfE rate.
 - Financial Regulations training had not been completed recently by the respective staff with financial responsibility.
 - Family Placement Officers were storing information in different locations on the case management system. The classification for children has not been updated on the case management system when the placement has changed. Accountancy and Placements are therefore using data sourced from the case management system which is out of date and not consistent with actual case numbers monitored by the Family Placements Team.
 - The means test reviews for 2/10 adopters sampled exceeded 12 months and for 4/10 cases the value paid did not equate to the means test completed.
 - For 2/10 SGO assessments the Group Manager had not dated the review when authorising the document and for 1/10 the reviewer had not signed as authorised.
 - For 3/10 SGO cases the annual means test review was not evidenced on the case management system.

SIGNIFICANT FINDINGS (PRIORITY 1)

9. There was one priority one recommendation raised as part of this audit.
10. A sample of 10 CAO was selected for audit examination. In the first instance the court order and supporting legal documentation available on the case management system was checked to confirm that no specific funding had been agreed and therefore the allowances for these cases would be the standard rate for the age of the child. A sample of 10 CP cases was selected for audit examination.
11. For 19/20 cases the allowances being paid at the time of testing (Feb/March 2018) were not in line with the 2017/18 DfE rates that had been provided by the Finance Officer Family Placements Team (FPT)

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

12. Discussions with the Finance Officer (FPT) identified that she was aware of this issue and that the Head of Service was in the process of reviewing allowances and distributing letters to guardians.
13. Further investigation by Internal Audit and interviews with Finance and the Head of Service Placement & Brokerage (HoS P&B) highlighted several issues with regard to the payment of allowances:-
 - Before September 2016 all foster carers, SGO's, CP and CAO had been paid according to locally agreed Bromley rates which were higher than the DfE rates.
 - A report to Executive in May 2016 resolved to transfer all foster carers to the DfE rates with immediate effect for new carers and 1st September 2016 for existing foster carers and pertinent to this audit:-
.
“The Department for Education maintenance allowances be used as the core allowance in the calculation for connected person, special guardianship, adoption and child arrangement financial assessments from 1st July 2016 for all new carers”
 - The Service Accountant evidenced the 2014/15 Bromley rates that had been taken to Committee. The HoS P&B evidenced the same report template but for 2016/17 and these are the DfE rates that are currently being paid.
 - The source of the 2016/17 allowances template evidenced by the HoS P&B could not be confirmed but thought to be the previous Head of Service who left the Authority in February 2017.
 - There is no evidence that following the May 2016 Executive report LBB rates have been reviewed and uplifted to pay allowances to existing carers at the July 2016 cut-off date.
 - The cases selected for audit testing agreed to the 2016/17 DfE rates in 19/20 cases. It should be noted that the 10 CAO cases all predated the July 2016 cut off and should therefore, according to the May 2016 Executive report, be paid at local rates rather than the DfE allowances.
 - No uplift had been applied to the foster carer, Connected Person or Child Arrangement Order for 2017/18 or 2018/19.
 - The DfE thresholds are a minimum to be paid, Bromley are currently paying carers below that minimum for maintenance.
 - The Finance Officer (FPT) arranged to meet with the HoS P&B and the System Support Officer on the 6th June 2018 to discuss the uplift and to potentially back date to December 17 for the 2017-18 rates however at this time there was no evidence that this decision had any authorisation or management consideration.

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

- There is a further complication given the DfE rates have an additional banding of 0-2 years old whereas Bromley have 0-4. Carers for 0-2 children in Bromley are currently being paid at the higher rate. To implement the same bandings as the DfE rate, **0-2, 2-4**, 5-10, 11-12, 13-15 and 16+ will take significant work on the case management system to cancel all service agreements, amend the set up and then re-enter all cases.
 - The end of audit meeting held on the 7th June with the Head of Service confirmed that the uplift for 2018/19 should have been actioned as it had been discussed at budget monitoring in December 2017. The Head of Service was not aware that the 2018/19 uplift was still outstanding or that the current rates were the 2016/17 rates and therefore the 2017/18 uplift had also, not been actioned.
14. At a meeting with the Director of Children's Social Care on the 3rd July 2018 it was confirmed that an external agency had written to the Authority in December 2017 highlighting that data collated in a recent survey identified that the Bromley rates were lower than the current DfE rates. In an exchange of e-mails between the 8th and the 11th December 2017 the Director of Children's Social Care agreed that the rates should be moved up as identified by this agency and the Head of Service instructed the Finance Officer to action this effective from week beginning the 18th December 2017 if possible.
 15. The reason for the delay or oversight will be considered by management. However going forward any training needs or skill gaps should be assessed and facilitate access to Finance colleagues and peers for the Finance Officer (FPT). The priority is to address the underpayment, assess the financial impact for 2017-18 and 2018-19 and execute the uplift with the 2018/19 DfE rates. The financial impact and sensitivity of the service area will warrant careful consideration and authorisation at the appropriate level.
 16. The audit testing has shown that the rates for 19/20 cases is incorrect compared to current rates however the values are consistent with the 2016/17 DfE rates. The significant finding is that the DfE allowances have not been uplifted for 2017-18 and 2018-19.

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

17. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

18. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1.	<p>Payments – Department for Education Guidelines</p> <p>Child Arrangement Order funding is paid in line with the thresholds agreed by the Department for Education dependant on the child's age. Connected Persons Funding is also paid in line with the thresholds agreed by the Department for Education dependant on the child's age.</p> <p>A sample of 10 CAO's was selected for audit examination. In the first instance the court order and supporting legal documentation available on the case management system was checked to confirm that no specific funding had been agreed and therefore the allowances for these cases would be the standard rate for the age of the child. A sample of 10 CP cases was selected for audit examination.</p> <p>For 19/20 CP and CAO cases the allowances being paid at the time of testing (Feb/March 2018) were not in line with the 2017/18 DfE rates that had been provided by the Finance Officer Family Placements Team (FPT)</p> <p>Discussions with the Finance Officer (FPT) identified that she was aware of this issue and that the Head of Service was in the process of reviewing allowances and distributing letters to guardians to confirm that the child was still at the placement.</p> <p>Further investigation by Internal Audit and interviews with Finance and the Head of Service Placement & Brokerage (HoS P&B) highlighted several issues with regard to the payment of allowances:-</p> <ul style="list-style-type: none"> • Before September 2016 all foster carers, SGO's, CP's and CAO's had been paid according to locally agreed Bromley 	<p>Where payments are not made in line with the Department for Education guidelines in accordance with the child's age, there is a risk that incorrect payments are being made.</p> <p>This could lead to financial loss for the Council if overpayments are being made, or dissatisfied carers/guardians where underpayments are being made.</p> <p>The Authority may be in breach of their agreement with carers if the allowances have not been uplifted.</p> <p>Reputational risk to the Authority from underpayment of allowances</p>	

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1. cont	<p>rates which were higher than the DfE rates.</p> <ul style="list-style-type: none"> • A report to Executive in May 2016 resolved to transfer all foster carers to the DfE rates with immediate effect for new carers and 1st September 2016 for existing foster carers and pertinent to this audit:- <i>. “The Department for Education maintenance allowances be used as the core allowance in the calculation for connected person, special guardianship, adoption and child arrangement financial assessments from 1st July 2016 for all new carers”</i> • The Service Accountant evidenced the 2014/15 Bromley rates that had been taken to Committee. The HoS P&B evidenced the same report template but for 2016/17 and these are the DfE rates that are currently being paid. • The source of the 2016/17 allowances template evidenced by the HoS P&B could not be confirmed but thought to be the previous Head of Service who left the Authority in February 2017. • There is no evidence that following the May 2016 Executive report LBB rates have been reviewed and uplifted to pay allowances to existing carers at the July 2016 cut-off date. • The cases selected for audit testing agreed to the 2016/17 rates in 19/20 cases. It should be noted that the 10 CAO cases all predated the July 2016 cut off and should therefore be paid at local rates rather than the DfE allowances. • No uplift has been applied to the foster carer, CP or CAO for 2017/18 or 2018/19. 		

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1. cont	<ul style="list-style-type: none"> • The DfE thresholds are a minimum to be paid, Bromley are currently paying carers below that minimum for maintenance. • The Finance Officer (FPT) arranged to meet with the HoS P&B and the System Support Officer on the 6th June 2018 to discuss the uplift and to potentially back date to December 17 for the 2017/18 rates however there is no evidence that this decision had any authorisation or management consideration. • There is a further complication given the DfE rates have an additional banding of 0-2 years old whereas Bromley have 0-4. Carers for 0-2 children in Bromley are currently being paid at the higher rate. To implement the same bandings as the DfE rate, 0-2, 2-4, 5-10,11-12,13-15 and 16+ will take significant work on the case management system to cancel all service agreements, amend the set up and then re-enter all cases. • The end of audit meeting held on the 7th June with the Head of Service confirmed that the uplift for 2018/19 should have been actioned as it had been discussed at budget monitoring in December 2017. The Head of Service was not aware that the 2018/19 uplift was still outstanding or that the current rates were 2016/17 and therefore the 2017/18 uplift had also not been actioned. <p>At a meeting with the Director of Children’s Social Care on the 3rd July 2018 it was confirmed that an external agency had written to the Authority in December 2017 highlighting that the published Bromley rates were lower than the current DfE rates. In an exchange of e-mails between the 8th and the 11th December 2017 the Director of</p>		<p>The Department must urgently review the application of DfE allowances and the need to action 2017/18 and 2018/19 uplifts.</p> <p>The financial and political impact must be managed with regard to backdating underpayments.</p> <p>The payment of locally agreed rates for CAO, CP and SGO cases pre-dating July 2016 should be formalised or resolved to transfer to DfE rates.</p> <p>Annual uplifts must be communicated to the system help desk in a timely manner once the appropriate authorisation has been evidenced.</p> <p>Management will need to consider the reason for the delay and why the uplift was not actioned. Similarly any training issues and skill gaps should be addressed to ensure</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1. cont	<p>Children’s Social Care agreed that the rates should be moved up as identified by an external agency and the Head of Service instructed the Finance Officer to action this effective from week beginning the 18th December 2017 if possible.</p> <p>The priority is to address the underpayment, assess the financial impact for 2017-18 and 2018-19 and execute the uplift with the 2018/19 DfE rates. The financial impact and sensitivity of the service area will warrant careful consideration and authorisation at the appropriate level.</p> <p>The audit testing has shown that the rates for 19/20 cases is incorrect compared to current rates however the values are consistent with the 2016/17 DfE rates. The significant finding is that the DfE allowances have not been uplifted for 2017-18 and 2018-19.</p> <p>Following the issue of the initial draft audit report in July, the FO and Head of Service evidenced a chronology of e-mails and calls to the system Help Desk to uplift the rates from December 2017 when the service were first alerted that current rates were lower than DfE rates. The original Request for Work form to uplift the rates, submitted in January 2018 could not be actioned as the service was requesting a new age band to be introduced in line with DfE rates. This would require a significant amount of work to restructure the records and an undertaking from the service to allocate a resource to cancel and reset service agreements. There is a trail of e-mail exchanges and undocumented phone calls to resolve the issue but as at February 2018 the Help Desk had put the work request on hold and was awaiting further direction from the service. There is a two month period between February and April with no activity then at a</p>		<p>that the annual uplift is actioned in a timely manner.</p> <p>Staff are to be reminded of the process to request work from the system help desk. It is the service area that must instruct the system support team of what work is to be done, formalised through the Request for Work forms.</p> <p>Facilitate access to finance colleagues in other ECHS service areas to exchange good practice and support for the Finance Officer (FPT).</p> <p>(Priority 1)</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
1. cont	<p>meeting on the 6/6/18 between System Help Team, FO and the HoS P&B it was agreed to retain the existing age bands and therefore a straightforward uplift was ordered in a revised Request for Work form submitted 18/6/18. This has been a protracted exercise that should have been escalated sooner to the Head of Service and the Contract Monitoring ISD Manager to resolve.</p>		
2	<p>Financial Regulations Training</p> <p>Staff who have financial responsibility are required to complete financial regulations training.</p> <p>Examination of the training records indicated that there are five staff members within the Fostering and Adoption Team who have financial responsibility but have not completed the financial regulations training for the London Borough of Bromley.</p>	<p>Where financial regulations training is not completed on a periodic basis, there is a risk that staff do not act in line with current financial regulations. This could result in financial loss.</p>	<p>All staff within the Fostering and Adoption Team who have financial responsibility should complete financial regulations training.</p> <p>(Priority 2).</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
3	<p>Use of the Case Management System</p> <p>Audit tested a sample of SGO's, CAO's, CP's and AP's. It was identified whilst testing these, that staff members were storing information in different locations on the case management system. As a result, this made it difficult to identify where information would be stored; locating documentation was a time consuming process.</p> <p>During the course of the audit the Service Accountant and Head of Service, Placements and Brokerage (HoS P&B) provided the number of cases for each classification as at May 2018 sourced from the case management system:-</p> <p>Foster carers 130,SGO 147,CPA 25 and CP 25 Total 327</p> <p>At the post draft report meeting the Head of Service highlighted that these values were incorrect and confirmed that the team consult with the Senior Performance and Information Officer (SP&IO) to monitor the number of current cases in each category. The SP&IO provided audit with the cases as at 31/5/18 sourced from information provided by the Fostering and Adoption Team:-</p> <p>Foster carers mainstream 95,respice 9, SGO 173, CPA 25 and CP 28 Total 330</p> <p>The discrepancy in numbers is due to the classification not being updated to the system when the circumstances and placement change. The front line children's team have the child as the primary record but the Fostering and Adoption Team work with the carers.</p> <p>Finance should have access to the current case numbers and the primary case management system should reflect actual service delivery.</p>	<p>Where staff members store information in different locations, there is a risk that this information will not be easily accessible if required. This could result in duplication of work or work not being completed.</p>	<p>Consideration should be given to reviewing procedures and including details of where information should be stored on the case management system.</p> <p>The information shown in the case management system should reflect actual service delivery.</p> <p>The responsibility to update the classification in the case management system when a child is placed should be considered and assigned.</p> <p>The discrepancy between the case management system and current case numbers should be corrected.</p> <p>(Priority 2)</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
4	<p>Adoption Information</p> <p>Where a child is going into an adoption placement, an adoption support plan is developed, approved by the Adoption Panel for the adopted child, which are required to be stored on the care management system..</p> <p>Testing of a sample of 10 adopted children receiving adoption allowances identified that in all cases, there was no documentation stored on the case management system. This was because previously the team had used paper files and information, including the means tests, have not all been scanned on to the system. The FO is in the process of reviewing previous documentation for adopters, available in paper form and uploading to the system.</p> <p>Adopters can request that the Council consider payment of an adoption allowance but this is means tested on receipt of financial documentation. The Finance Officer will complete a means test to identify the allowance that can be granted (if any).</p> <p>Follow up testing in June identified that for the original sample of 10 adoption cases the most recent means tested had been completed in the previous 12 months for 7 cases. For 1 case the family received a protected allowance but for 2 cases the means test exceeded 12 months.</p> <p>For the sample of 10, allowances were checked to the means test. The main issues arising were:-</p> <ul style="list-style-type: none"> For 2 cases the amount paid is higher than the means test value. In both cases £216.92 has been paid per week but the rate should be £183.11 and £203.73 respectively. 	<p>Where financial means tests are not being completed on a periodic basis in line with financial information provided by guardians/adopters, there is a risk the incorrect payments are being made to guardians/adopters. This could lead to financial loss for the Council if overpayments are being made.</p>	<p>The Finance Officer is continuing to upload information to the care management system. The Finance Officer will then review all financial means tests to confirm that these are being completed annually.</p> <p>The Finance Officer will need to evidence the current financial position of the two cases identified in the audit review.</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • For 1 case the weekly payment has been £82.30 but the means test outcome was £109.16 • For 1 case the weekly payment has been £44.44 but the means test outcome was £55.14. It was also noted that the DoB is 15.9.1999 and was 18 in 2017. There was no evidence on the system to support payments beyond 18th birthday. <p>The testing had been completed with the Finance Officer (FPT) and agreed that there was no documentation or notation on the case management system to support the differences. For 1 case there was no means test on file to complete the test and verify the payment.</p>		<p>The Finance Officer will need to resolve the four cases identified where the payment does not agree to the current means test and the one case with no current means test available.</p> <p>(Priority 2)</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
5	<p>SGO Assessment Review</p> <p>SGO assessments are reviewed on an annual basis, with the completed reviews uploaded and stored on the case management system for three years post order.</p> <p>For the sample of 10 SGOs selected, it was identified that there were three cases where a review has not been completed in the last 12 months, or a review has been completed but we were unable to evidence this at the time of the audit.</p> <p>Following the end of audit meeting the Group Manager (Connected Persons Team) has now checked the three cases and found that the assessments for two of the cases had been stored on the adults file rather than the child's folder.</p> <p>For two of the three cases rechecked the Group Manager had not dated their review and in one case not authorised the review.</p>	<p>Where the required monitoring is not completed and uploaded onto the case management system, there is a risk that the Council are unaware of any changes in circumstances or issues within a placement.</p>	<p>Staff should be reminded that annual reviews should be completed in line with procedures and stored on the case management system in an agreed consistent location.</p> <p>The reviewer should date their authorisation to allow verification that the review is completed in a timely manner.</p> <p>(Priority 2).</p>

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

DETAILED FINDINGS

APPENDIX A

No.	Findings	Risk	Recommendation
6	<p>Payments – Means Tests</p> <p>A financial means test is completed by the Finance Officer for SGOs. This is then reviewed on an annual basis. The review is completed by the Finance Officer who will complete a new financial means test based on financial information requested and provided by the Guardian.</p> <p>Evidence of a review in the last 12 months on the case management system could not be located for three of the sample of 10 SGO’s tested.</p> <p>We are aware that the Finance Officer is relatively new in post and that there is a backlog in means assessment reviews.</p>	<p>Where financial means tests are not being completed on a periodic basis in line with financial information provided by guardians/adopters, there is a risk that the incorrect payments are being made to guardians/adopters.</p>	<p>The Finance Officer should ensure that financial means assessments are completed in a timely manner using the log to identify when cases are due.</p> <p>(Priority 2)</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p><u>Payments – Department for Education Guidelines</u></p> <p>The Department must urgently review the application of DfE allowances and the need to action 2017/18 and 2018/19 uplifts.</p> <p>The financial and political impact must be managed with regard to backdating underpayments.</p> <p>The payment of locally agreed rates for CAO, CP and SGO cases pre-dating July 2016 should be formalised or resolved to transfer to DfE rates.</p> <p>Annual uplifts must be communicated to the system help desk in a timely manner once the appropriate authorisation has been evidenced.</p> <p>Management will need to consider the reason for the delay and why the uplift was not actioned. Similarly any training issues and skill gaps should be addressed to</p>	1	<p>The allowances have now been uplifted. The 2017/18 rates were back dated to December 17 and paid to carers on the 20/7/18.</p> <p>The 2018/19 rates have also been uplifted, backdated to April 2018 and paid to carers 3/8/18.</p> <p>No uplift has been applied to the CAO cases as the HoS is currently reviewing Bromley’s policy to pay any allowance to this category of carer.</p> <p>The DfE confirmed that a payment to CAO carers is at the discretion of the Local Authority.</p>	Head of Service Fostering and Adoption/Finance Officer, Family Placements Team	1 st October 18

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>ensure that the annual uplift is actioned in a timely manner.</p> <p>Staff are to be reminded of the process to request work from the system help desk. It is the service area that must instruct the system support team of what work is to be done, formalised through the Request for Work forms.</p> <p>Facilitate access to finance colleagues in other ECHS service areas to exchange good practice and support for the Finance Officer (FPT).</p>		<p>Due to the postponement of a planned new system and all work in the current case management system ceased for Children Social Care.</p> <p>Decision to review workflows in the case management system by Change Control group chaired by AD Strategic and Business Support Services.</p> <p>Agreed, to be considered</p>	<p>Head of Service, Fostering and Adoption/ AD Strategic and Business Support Services</p> <p>Head of Service, Fostering and Adoption</p>	<p>1st September 2018</p> <p>1st October 2018</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p><u>Financial Regulations Training</u> All staff within the Fostering and Adoption Team who have financial responsibility should complete financial regulations training.</p>	2	Agreed, it is clear that the service would benefit from training on these matters.	Head of Service Fostering and Adoption	1 st October 2018

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Use of the Case Management System</u></p> <p>Consideration should be given to reviewing procedures and including details of where information should be stored on the case management system.</p> <p>The information shown in the case management system should reflect actual service delivery.</p> <p>The responsibility to update the classification in the case management system when a child is placed should be considered and assigned.</p> <p>The discrepancy between the system and current case numbers should be corrected.</p>	2	<p>Classifications of children placements are not completed by the Fostering and Adoption Team but will be done by the Central Placement Team which forms part of the Programmes Division.</p> <p>The Central Placement Team rely on timely notification from the Children's Teams when the placement classification or legal status for the child changes.</p> <p>The current case numbers and classification held by the Fostering and Adoption Team will be forwarded to the Placement Team to allow reconciliation to the system and resolution on the identified discrepancies.</p>	<p>Head of Service Placements and Brokerage</p> <p>Heads of Service, Children's Social Care</p> <p>Head of Service Fostering and Adoption/Head of Service Placement and Brokerage</p>	<p>1st September 18</p> <p>1st October 18</p>

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p><u>Adoption Information</u></p> <p>The Finance Officer is continuing to upload information to the case management system.</p> <p>The Finance Officer will then review all financial means tests to confirm that these are being completed annually.</p> <p>The Finance Officer will need to evidence the current financial position of the two cases identified in the audit review.</p> <p>The Finance Officer will need to resolve the four cases identified where the payment does not agree to the current means test and the one case with no current means test available.</p>	2	<p>The Finance officer will continue to upload the information onto the case management system and will continue with the annual reviews.</p> <p>The cases identified will be scrutinised to ensure the carers are receiving the correct monies in line with the DFE base rate.</p>	<p>Finance Officer, Family Placements Team</p> <p>Head of Service Fostering and Adoption/Finance Officer, Family Placements Team</p>	1 st October 18

REVIEW OF FAMILY PLACEMENTS FOR 2017-18

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p><u>SGO Assessment Review</u></p> <p>Staff should be reminded that annual reviews should be completed in line with procedures and stored on the case management system in an agreed consistent location.</p> <p>The reviewer should date their authorisation to allow verification that the review is completed in a timely manner.</p>	2	<p>The Finance Officer is now storing the signed review to both the adults and child's folder under Finance on the case management system and this will be included in procedures as standard practice.</p> <p>The Group Manager will date her signature on all reviews. Staff will be reminded to upload the signed copy of the review to the system.</p>	Head of Service Fostering and Adoption/Finance Officer, Family Placements Team	1 st December 18
6	<p><u>Payments – Means Tests</u></p> <p>The Finance Officer should ensure that financial means assessments are completed in a timely manner using the log to identify when cases are due.</p>	2	For the cases identified, the review had been completed but had not been uploaded to the system. All three means test reviews have now been uploaded.	Head of Service Fostering and Adoption/Finance Officer, Family Placements Team	1 st October 2018

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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FINAL INTERNAL AUDIT REPORT
CHIEF EXECUTIVE'S DEPARTMENT

FOLLOW UP REVIEW OF HOUSING BENEFIT
2017/18

Issued to: John Nightingale, Head of Revenues & Benefits,

Cc Jayne Carpenter, Benefits Operations Manager,
Claudine Douglas-Brown, Assistant Director Exchequer Services,
Peter Turner, Director of Finance, (Final Report only)

Prepared by: Clare Newby, Principal Auditor

Date of Issue: September 10th 2018

Report No.: CEX/04/2017/FU

INTRODUCTION

1. This report sets out the results of our systems based follow up audit of Housing Benefit for 2017-18. The audit commenced in quarter 3 as part of the programmed work specified in the 2017/18 Internal Audit Plan, agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The Benefits Service Monitoring Report went to the Executive on July 5th 2018 and provided an update on Universal Credit. The Universal Credit 'Full Service' starts in Bromley on July 25th 2018. This means from that date the majority of working age claimants commencing a claim for assistance with their rent will receive Universal Credit rather than Housing Benefit. Existing working age Housing Benefit recipients will transfer over to Universal Credit on a change in their circumstances.

AUDIT SCOPE

4. This follow up review considered the Internal Audit report issued on 24th March 2017 and the progress made to implement the five recommendations.

MANAGEMENT SUMMARY

5. We carried out sample testing and analysis of relevant documentation to confirm the extent to which the recommendations made in our original report had been implemented. We found that out of the 5 original recommendations 2 had been implemented and 3 remained outstanding.

SIGNIFICANT FINDINGS (PRIORITY 1)

6. None.

DETAILED FINDINGS/MANAGEMENT ACTION PLAN

7. Appendix A provides information on the recommendations that are being followed-up and the status following the audit review. Any new findings and re recommendations are detailed in Appendix B of this report and require management comment. Appendix B also gives definitions of the priority categories.

ACKNOWLEDGEMENT

8. We would like to thank all staff contacted during this review for their help and co-operation.

FOLLOW UP REVIEW OF HOUSING BENEFITS 2017-18

No	Original recommendation (Internal Audit report 24/3/2017)	Priority	Management comment	Responsibility	Agreed timescale	Follow-up comments	Status
1	The contract monitoring team should ensure stated processing times are accurate.	2	Checking accuracy of processing times forms part of the function of random sampling of HB assessments.	Benefits Operations Manager	Ongoing	<p>No issues were identified with processing times recorded on the system. Testing of a sample of 20 claims showed that 15 claims were not processed within 13 days as expected.</p> <p>Claim A 41 days Claim B 30 days Claim C 24 days Claim D 33 days Claim E 36 days Claim F 31 days Claim G 35 days Claim H 22 days Claim I 25 days Claim J 45 days Claim K 15 days Claim L 47 days Claim M 15 days Claim N 41 days</p> <p>An average figure is taken over the month under the Right Time Indicator, the annual target being 13 days.</p>	Implemented.

FOLLOW UP REVIEW OF HOUSING BENEFITS 2017-18

No	Original recommendation (Internal Audit report 24/3/2017)	Priority	Management comment	Responsibility	Agreed timescale	Follow-up comments	Status
						A report went to the Executive on 5/7/18 - Benefits Service Monitoring Report.	
2	The contractor should make sure action is taken on debts that are returned from the solicitor and where no action is taken after a month on hold. All recovery action taken on debts should be recorded on System A.	2	Agreed. Staff will be reminded of the importance of recording recovery action on System A.	Benefits Operations Manager	April 2017	A sample of twenty overpayments were selected for review. No issues arising were found in relation to the samples selected relating to recording on System A.	Implemented.
3	A process should be put in place to ensure part time and self-employed claims are reviewed on a regular basis.	2	Agreed. A process will be adopted in 2017/18 to ensure that all part-time self-employed claims are reviewed regularly.	Benefits Operations Manager	June 2017	A copy of the process has been provided to the Auditor on 11/7/18. Sample testing of five cases on System A showed the following :- Claim 1 – next review due 8/4/19. A review for 2017/18 could not be found. Claim 2 - No review detailed. Claim 3 - No review detailed. Claim 4 – No review detailed.	Outstanding

FOLLOW UP REVIEW OF HOUSING BENEFITS 2017-18

No	Original recommendation (Internal Audit report 24/3/2017)	Priority	Management comment	Responsibility	Agreed timescale	Follow-up comments	Status
						The contractor confirmed on 17/7/18 that only 58% of the 466 self-employed cases had diaries set. There were also system issues identified with 71 cases so no diary document was added and as a result cases have not been reviewed.	
4	In achieving the key objective of maximising recovery the annual target needs to be set carefully, bearing in mind the effects of RTI.	2*	The impending changes by HMRC/DWP need to be evaluated before considering the effectiveness of setting a target.	Head of Revenues and Benefits	On-going	The target has not been re-set.	Outstanding
5	Where appeals are approaching the target date, actions should be taken to ensure that these are reviewed within the 3 month target suggested by the DWP.	3*	Agreed.	Benefits Operations Manager	On-going	The appeals spreadsheet was reviewed and it was found that for 2017-18 there were 46 appeals that had not met the three month target. The contractor advised that at the start of Q1 2018-19 they had carried over	Outstanding

FOLLOW UP REVIEW OF HOUSING BENEFITS 2017-18

No	Original recommendation (Internal Audit report 24/3/2017)	Priority	Management comment	Responsibility	Agreed timescale	Follow-up comments	Status
						<p>approximately 135 appeals work items from 2017-18 with an average age profile of 40+ days.</p> <p>During the last 2 quarters of 2018-19, and into the first quarter of 2018-19, a number of measures were put in place to refine the process:</p> <ul style="list-style-type: none"> • A weekly report for escalation of any significant age appeal awaiting a client decision • Review of the pending process • Implementation of evidence upload facility • Additional screening of work at the allocation stage • Additional resource for the appeals work <p>The effect of this has been gradual over Q1 but is cumulative and is starting to yield results.</p>	

No	Re-recommendation	Priority	Management Comment	Responsibility	Target Date
Original rec no. 3	A process should be put in place to ensure part time and self-employed claims are reviewed on a regular basis.	2*	A process was adopted to review self-employed cases but unfortunately technical issues were experienced. This has now been rectified and the 71 cases identified will be reviewed by 31.10.18. However, review of self-employment cases will be done on a rolling review basis.	Benefits Operations Manager.	31.10.18 – annual thereafter
Original rec no. 4	In achieving the key objective of maximising recovery the annual target needs to be set carefully, bearing in mind the effects of RTI	2*	Target has not been re-set as agreed by PDS. There are significant functional implications if the target was reset.	Head of Revenues & Benefits.	On-going
Original rec no. 5	Where appeals are approaching the target date, actions should be taken to ensure that these are reviewed within the 3 month target suggested by the DWP.	3*	Significant improvements have been made to the process during Quarter 1 of 2018/19 which have had positive effect on the percentage of claims reviewed in line with DWP suggested timescales. This is being monitored.	Benefits Operations Manager.	On-going

Definition of priority categories.

Priority 1

**Required to address major weaknesses
and should be implemented as soon as
possible**

Priority 2

**Required to address issues which
do not represent good practice**

Priority 3

**Identification of suggested
areas for improvement**

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FINAL INTERNAL AUDIT REPORT
EDUCATION, CARE & HEALTH DEPARTMENT

REVIEW OF LEAVING CARE AUDIT FOR 2017-18

Issued to: Aneesa Kaprie, Interim Head of Service, CLA & Care Leavers,
Kevin Merrison, Group Manager, Leaving Care,
Janet Bailey, Director, Children's Social Care,
David Bradshaw, Head of ECHS Finance,
Naheed Chaudhry, Assistant Director, Strategy, Performance and Business Support,

Cc : Ade Adetosoye, Executive Director of ECHS & Deputy Chief Executive,
(Final Report Only).

Prepared by: Principal Auditor

Date of Issue: October 15th 2018

Report No: ECHS/01/2017/AU

REVIEW OF LEAVING CARE AUDIT 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of Leaving Care for 2017-18. The audit was carried out in quarter 4 as part of the programmed work specified in the 2017/18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations. Any Priority 1 recommendations or Nil/Limited Assurance opinions must be considered for inclusion in the Department's Risk Register.
3. The 16+ Leaving care team provides help and support to children and young people who have been looked after by our social services and are leaving care.
4. The revised net budget for CLA and Care Leavers for 2017-18 was £3,329,220 and the year to date actuals was £3,722,832 a variance of £393,612. For 2018-19 the revised net budget for CLA and Care Leavers was £4,084,580 and the year to date actuals was £864,647.

AUDIT SCOPE

5. The scope of the audit was outlined in the Terms of Reference issued on 27/3/18. The review did not cover any petty cash testing.

AUDIT OPINION

6. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

7. Our testing identified the following issues which we would like to draw to management's attention:-

- Leaving Care Procedures were found to be out of date and in need of review.
- Documentation was found not to always be in place to support payments to service users.
- Payment request forms could not be located in some cases.
- Pathway Plans had not been reviewed within 6 months as expected.
- Individual finance records were found to be incomplete.
- Grant sheets (central log) did not reconcile to the finance records held.
- T accounts were found not to have been reconciled. The process of making payments to care leavers needs to be fully reviewed.
- Service agreements had not been completed or authorised in a timely manner.
- Staying Put Allowances were not in line with the DFE rates and had not been uplifted for 2017/18 and 2018/19.
- It was confirmed that none of the staff within the Leaving Care Team with finance responsibilities had completed the mandatory financial regulations training.
- The Asset Register was found to be incomplete, undated and had no review date.

SIGNIFICANT FINDINGS (PRIORITY 1)

8. There are six priority one findings made within this report.

Documentation to support payments to Service Users

9. Issues arose in six cases concerning the supporting documentation and substantiating the payments currently being paid:-
- For Sample 1 no documentation could be located to verify the amount of £1,337 per week.

REVIEW OF LEAVING CARE AUDIT 2017-18

- For Sample 2 – A Living Together agreement was located for this service user at the weekly rate of £155.75. The current service agreement is £255.75 from 24/8/16. The Group Manager advised that the rate that should actually be paid is the staying put rate of £376.45 per week.
- For Sample 6 – A service agreement from 5/3/18 to 25/11/18. This service user turned 18 on 23/11/18 but it is unclear why the payment was not ended on 23/11/18. An overpayment of £16.54 has arisen.
- For Sample 13 a service agreement commenced on 21/12/17 to 19/5/18 for £100 per week. This was a staying put retainer payment for term time only while the service user attended education. It was found that the period related to term time and non term time, so the incorrect rates had been paid.
- For Sample 16 a service agreement commenced on 8/7/16 for £1,800 per week and remains current. No agreement has been located to support this placement. The Finance & Monitoring Officer confirmed that the service agreement should have been closed as the service user is no longer there and the service agreement ended on 15/12/16 retrospectively.
- For Sample 19 a service agreement commenced on 4/4/18 and ended on 4/4/18 for £699.01 for the carer whilst the service user returned home for 13 days. This was a one of payment. The rate is not correct.

Pathway Plans

10. Issues arose with Pathway Plans for 12 cases in relation the pathway plans not being reviewed every 6 months as expected. The Group Manager explained that the pathway plans due to be reviewed are detailed within a BOXI report on Carefirst.

Individual Service User Finance Record

11. Payment records were reviewed and were found not to be up to date and complete. These related to the Setting up Home Allowance (SUHA), travel reimbursement, clothing allowances food vouchers and sundry items.

Grant Sheet (Central Log)

12. It was found that when reconciling the grant sheet to the finance records, issues arose in seventeen of the cases sampled for testing.

REVIEW OF LEAVING CARE AUDIT 2017-18

Reconciliation to Oracle – T accounts

13. A FBM report was run of all transactions under accounting code 807***4076 for 2017-18. It was found that for 3 samples Setting Up Home Allowances (SUHA) transactions appeared on the finance records but not on the grant record and were unallocated to the individual T account. Other transactions on the FBM report remained unallocated that went back to 31/7/17.

Staying Put Allowances

14. Staying Put allowances are included within the agreed Fostering Allowances. In May 2016, a report went to the Executive Committee to approve a change whereby rates were to be brought in line with the DFE rates. It was confirmed by officers that this was to be from December 2017. The Auditor was informed that the Staying Put Rates were linked to the Fostering rates.
15. It was found that the Staying Put rates had not been subject to any uplift for 2017/18 and 2018/19. This should be read in conjunction with the Family Placements Audit for 2017-18.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

16. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

17. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>16+ Leaving Care Procedures</u> The 16+ Leaving Care Procedures were provided to the Auditor. It was found that the 16+ Leaving care procedures were out of date and the rates have since changed.</p> <p>There is no version control, date of review and the document is undated.</p> <p>It was confirmed by the Group Manager that the procedures are likely to be out of date.</p> <p>Procedures need to detail a process to prevent the Setting Up Home Allowance being exceeded.</p>	<p>Staff may not be aware of Policies and Procedures resulting in inconsistent practices being undertaken and payments being exceeded.</p>	<p>Leaving Care procedures should be fully reviewed and updated, stating the responsible officer and be version controlled and dated. A review date should also be added. On completion, procedures should be made available to all staff.</p> <p>[Priority 2]</p>
2	<p><u>Documentation to Support Payments to service users</u></p> <p><u>This is linked to recommendation 8</u></p> <p><u>Issues arose in 6 samples :-</u></p> <ul style="list-style-type: none"> • Sample 1 – No documentation has been seen to verify this service agreement of £1,337 per week. 		

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • Sample 2 – A Living Together agreement was located for this service user at the weekly rate of £155.75. The current service agreement is £255.75 from 24/8/16. The Group Manager advised that the rate that should actually be paid is the staying put rate of £376.45 per week. • Sample 6 – A service agreement from 5/3/18 to 25/11/18. This service user turned 18 on 23/11/18 but it is unclear why the payment was not ended on 23/11/18. An overpayment of £16.54 has arisen. • For Sample 13 a service agreement commenced on 21/12/17 to 19/5/18 for £100 per week. This was a staying put retainer payment for term time while the service user attended education. It was found that the period related to term time and non term time, so the incorrect rates had been paid. • For Sample 16 a service agreement commenced on 8/7/16 for £1,800 per week and remains current. No agreement has been located to support this placement. The Finance & Monitoring Officer confirmed that the service agreement should have been closed as the service user is no longer there and the service agreement ended on 15/12/16 retrospectively. 		

Project Code: ECHS/01/2017/AU

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Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> For Sample 19 a service agreement commenced on 4/4/18 and ended on 4/4/18 for £699.01 for the carer whilst the service user returned home for 13 days. This was a one off payment and the rate is not correct. 	Lack of robust monitoring could lead to incorrect payments being made.	<p>Documentation should be readily available to support payments continuing to be made in respect of service users. All agreements should be current and complete.</p> <p>[Priority 1]</p>
3	<p><u>Payment Request Forms</u> It was found that Payment requests forms could not be located for Samples 4, 12 and 19.</p>	Payments are not authorised or appropriate.	<p>Payment request forms should be completed as required.</p> <p>[Priority 2]</p>
4	<p><u>Pathway Plans</u> Issues arose with Pathway Plans for 12 cases in relation to the pathway plans not being reviewed every 6 months. Sample 1 – 7 month gap Sample 3 – Last one dated 29/6/11-5/7/11. A closure record started 5/8/13 but remains incomplete. Sample 4 – 7 month gap</p>		

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Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Sample 5 – 8 month gap Sample 7 – 8 month gap Sample 9 – Last one 14/2/11-29/6/11. A closure record started on 28/9/12 but remains incomplete. Sample 10 – 9 month gap. Sample 11 – 7 month gap. Sample 12 – 7 month gap Sample 14 – 1 year gap (should have been closed). Sample 15 – 8 month gap Sample 16 – 7 month gap The Group Manager explained that the pathway plans due to be reviewed are detailed within a BOXI report on Carefirst.</p>	<p>Pathway Plans are not reviewed within expected timescales. (Children & Social Work Act 2017 & Children’s Act 1989).</p> <p>Non-compliance with Children & Young People Service Safeguarding and Social Care Division Procedures Manual.</p>	<p>Ensure that completed Pathway Plans are in place and reviewed as appropriate and compliant with legislation.</p> <p>[Priority 1]</p>
5	<p><u>Individual Service User Finance Records</u></p> <p>Payment records were reviewed and were found not to be up to date and complete. The following issues arose:-</p> <p><u>Clothing allowances</u> Sample 6 totalling £300 not detailed.</p> <p><u>Birthday Allowances not always listed.</u> Incorrect payment made Sample 6. Not detailed for Sample 15,</p>		

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>and Sample 20. For Sample 17 service user is aged 26 and was paid £30 birthday money 8/2/17.</p> <p><u>Travel Allowances</u> Not listed for the following:- Sample 4 (21/5/18 £15, 26/3/18 £15), Sample 5 21/11/17 £90, Sample 11 (17/4/17 £21.20 5/6/17 £21.20), Sample 14 (30/5/17 £22.00), Sample 15 18/4/17 £21.20 5/6/17 £21.20), Sample 18 23/10/17 £10. The Auditor requested evidence in relation to these travel reimbursements and it was confirmed that there are no receipts available.</p> <p><u>Food Vouchers</u> For Sample 12 £20 8/9/17 and 15/11/17 and Sample 16 £20 25/7/17. Sample 18 on 25/1/18 £40 and 8/3/18 £20.00.</p> <p><u>Setting Up Home Allowance</u> Not listed for Sample 14 £300 8/9/17, Sample 18 £145.06.</p> <p><u>Sundry items</u> Sample 4 laptop, Gym membership Sample 5 £76 total, Sample 10 (glasses and stationery), Sample 15 laptop £400 12/12/17, Sample 17 rent £250, Sample 18 rent arrears £966.73, Sample 19 Passport reimbursement £75.50 15/3/18, Sample 20 driving test theory £23.</p>		

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Service agreements for items may appear on Carefirst but are not updated onto the individual finance record.</p> <p>For Sample 7 the date of birth differs from the details recorded on Carefirst and seems to be the wrong finance record belonging to another service user</p> <p>For Sample 10 there are recent transactions for October and November 2017 and the Setting Up Home allowance is overspent by £88.69.</p> <p>For Sample 17 the last transaction was in June 2017 relating to rent arrears. The SUHA was overspent by £737.36.</p>	<p>There is a risk that payments made to a young person exceed their entitlement.</p>	<p>A comprehensive record should be readily available to detail all payments made to support each individual leaving care service user.</p> <p>[Priority 1]</p>
6	<p><u>Grant Sheet (Central Log)</u></p> <p>It was found that when reconciling the grant sheet to the finance records issues arose in the following cases –</p> <ul style="list-style-type: none"> • Sample 1 Clothing total shows as £335 but payment record shows £395. • Sample 2 not listed on grant sheet. • Sample 3 not listed on grant sheet • Sample 4 queries with SUHA balance and clothing. 		

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Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • Sample 6 Clothing total shows £350 but the payment record shows £100. • Sample 7 cannot be tested as payment record refers to another service user. • Sample 10 SUHA total shows as £2,463.10 but finance records shows as £88.69 over. Clothing shows as £70 but nothing detailed on finance record. • Sample 11 clothing total shows as £295 but finance record says £180. • Sample 12 SUHA total shows as £741 balance remaining but finance record shows £774.17. Clothing shows as £480.03 but finance record shows £145 • Sample 14 SUHA balance £1827.24 but finance records shows £827.24 • Sample 15 SUHA shows £2,030.52 but the finance record shows £58.59 balance, • Sample 18 SUHA shows as £503.56 but finance record shows £145.06. Clothing shows as £50 but finance record shows £250. • Sample 19 SUHA no transactions but the finance record shows a balance of £2,150 balance, after a transaction of £350. 	<p>There is a risk that payments made to a young person exceed their entitlement.</p>	<p>All service user finance records should be fully reviewed to ensure that all payments and allowances are up to date accurate and complete. Payments should not be made unless there are sufficient funds.</p> <p>[Priority 1]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> Sample 20 SUHA shows as £ 1,501.01 but shows full grant of £2,800 spent. Samples 3, 8, 9, grant records were not listed on the grant sheet. Sample 17 was also not listed and showed that the SUHA balance was over by £737.36. 		
7	<p><u>Reconciliation to Oracle – T account</u></p> <p>In order to assist monitoring, under the leaving care account code 807***4076 all transactions in respect of the Setting Up Home Allowance (SUHA) should be recorded in each individual T account which is a sub code. Reconciliations are undertaken monthly.</p> <p>A FBM report was run of all transactions under accounting code 807***4076 for 2017-18. It was found that for :-</p> <ul style="list-style-type: none"> Sample 1 £150 SUHA 27/7/17 appears on finance record but does not appear on the Grant Record and could not be matched to a T8673. The Finance Monitoring officer confirmed that the this transaction went to T7220 account. Sample 8 £50 SUHA on 12/3/18 does not appear on the Grant Record and could not be matched to T8626. 	<p>There is a risk that payments made to a young person exceed their entitlement.</p> <p>The stand alone monitoring system maintained by the service does not reconcile to the Authority’s accounts.</p>	

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> Sample 11 £2,500 (5 individual transactions) appears on finance record but only 3 could be found on the FBM report and remain unallocated.T8494 Sample 12 the SUHA balance on the finance sheet is £774.17 but the grant sheet states £741. The Finance Monitoring Officer confirmed that there was an error on the spreadsheet formula. Sample 14 the SUHA balance on the finance sheet is £827.24 but the grant sheet states £1,827.24. This was an error on the spreadsheet. Sample 18 the SUHA balance on the finance sheet is £145.06 but the grant sheet states £503.56. The Finance Monitoring Officer identified it was likely to be the purchasing card transactions and team members complete entries which may or may not include VAT. Sample 19 Transactions on Carefirst do not link to individual T codes and therefore these are picked up on reconciliation. Transactions are processed and authorised without having prior knowledge of the actual funds available. 	<p>The Authority’s accounts are not a true and fair reflection of the service delivery for the team.</p> <p>Allowances are likely to be exceeded as there is no comprehensive record available at a given time.</p>	<p>All transactions specific to the leaving care team should be allocated to the individual T accounts. Accounts should be reconciled on a regular basis.</p> <p>The whole process for making payments to care leavers needs to be fully reviewed as the current system is not fit for purpose.</p> <p>[Priority 1]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
8	<p><u>Service Agreements on Carefirst</u> <u>(See Recommendation2)</u></p> <p>It was found that there were issues with five service agreements.</p> <ul style="list-style-type: none"> • Sample 3 – A service agreement commenced on 20/01/2004 and remained current at the time of testing. The Finance & Monitoring Officer confirmed that the Carefirst team had been contacted for cancellation of this agreement • For Sample 8 the service commenced on 14/6/10 for £79.66 per week. It was queried with officers whether this service agreement should still be open. A service agreement commenced on 14/6/10 and the Finance & Monitoring Officer emailed the case worker to confirm closure. • For Sample 9 the service commenced on 30/4/09 for £210 per week. It was queried with officers whether this service agreement should still be open. It was confirmed that this had been passed back to Placements & Brokerage to confirm whether the service agreement should be closed. 	<p>Delayed payments to service users and providers budget implications and inaccurate commitment shown within the budget. Lack of accurate management information.</p>	<p>Service agreements should be authorised in a timely manner to ensure that payments are made on time and commitments are accurately reflected in the budget. Service agreements should be closed in a timely manner and authorised for closure to prevent any potential overpayments arising. Service agreements for the Leaving Care team need to be reviewed to confirm that they are all current and that the correct rates are currently being paid.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> For Sample 13 a service agreement commenced on 21/12/17 to 19/5/18 for £100 per week. This was a staying put retainer payment for term time while the service user attended education. It was found that the period related to term time and non term time, so the incorrect rates had been paid. For Sample 14 the service commenced on 30/9/16 for £562.50. When reviewing this service agreement, it was noted that the service user moved out of the property on 20/8/17. The Finance Monitoring officer confirmed that the service agreement was closed on 14/9/17. 		

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 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
9	<p><u>Staying Put Allowances</u></p> <p>Staying Put allowances are included within the agreed Fostering Allowances. In May 2016, a report went to the Executive Committee to approve a change to the rates which were to be brought in line with the DFE rates. It was confirmed by officers that this was to be from December 2017. The Auditor was informed that the Staying Put Rates were linked to the Fostering rates. It was found that the Staying Put rates had not been subject to any uplift for 2017/18 and 2018/19.</p> <p>This should be read in conjunction with the Family Placements Audit for 2017-18.</p>	<p>Where payments are not made in line with the Department for Education guidelines in accordance with the child’s age, there is a risk that incorrect payments are being made. This could lead to financial loss for the Council if overpayments are being made, or dissatisfied residents where underpayments are being made.</p> <p>The Authority may be in breach of their agreement with carers if the allowances have not been uplifted.</p> <p>Reputational risk to the Authority from underpayment of allowances.</p>	<p>The Department must review the application of DFE allowances for staying put and the need to action both the 2017/18 and 2018/19 uplifts. Annual uplifts must be communicated to the CareFirst Team in a timely manner once the appropriate authorisation has been evidenced.</p> <p>[Priority 1]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
10	<p><u>Mandatory Financial Regulations Training</u></p> <p>It was confirmed by the Group Manager that none of the Leaving Care team had completed the mandatory Financial Regulations training.</p>	<p>Where financial regulations training are not completed, there is a risk that staff do not act in line with current financial regulations. This could result in financial loss.</p>	<p>All staff within the Leaving Care Team who have financial responsibilities, should complete financial regulations training.</p> <p>[Priority 2]</p>
11	<p><u>Asset Register</u></p> <p>The asset register was supplied on 2/7/18 by the Group Manager. This detailed Blackberry's and Laptop's allocated to the Leaving Care Team. The document was undated and had no review date. The register had not been signed off as correct.</p> <p>It was found that no equipment is detailed for the previous Head of Service of the current post holder.</p>	<p>Ineffective control over assets.</p>	<p>The Leaving Care service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded and reviewed.</p> <p>[Priority 2]</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p><u>16+ Leaving Care Procedures</u></p> <p>Leaving Care procedures should be fully reviewed and updated, stating the responsible officer and be version controlled and dated. A review date should also be added. On completion, procedures should be made available to all staff.</p>	2	<p>The review of leaving care financial policy should be undertaken but there are significant interdependencies with other sources of income, and review dates should be driven by these changes. (eg benefit rates, apprenticeship bursaries etc)</p> <p>A discussion will need to take place with the finance team to agree who is best placed to re-write this policy. The current capacity within the service does not allow for this to take place within the service. A meeting will be set up with the finance team to agree a way forward.</p>	Interim Head of Service, CLA & CT, Group Manager, Leaving Care.	Meeting to take place in October 2018. Finance procedure to be reviewed by end of December

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p><u>Documentation to Support Payments to service users</u></p> <p>Documentation should be readily available to support payments being made to service users. All agreements should be current and complete.</p>	1	<p>All service users have a clear eligibility criteria and allowance rates are set. Discretionary payments are signed off by the Group Manager or HOS.</p> <p>This action will be considered as part of the review of the financial policy as noted above.</p> <p>All Leaving Care Cases are currently being reviewed and financial agreements will be checked for accuracy.</p>	Interim Head of Service, CLA & CT, Group Manager, Leaving Care.	December 2018
3	<p><u>Payment Request Forms</u></p> <p>Payment request forms should be completed as required.</p>	2	Agreed. This is already in place.	Interim Head of Service, CLA & CT, Group Manager, Leaving Care.	Completed

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<u>Pathway Plans</u> Ensure that completed Pathway Plans are in place and reviewed as appropriate and compliant with legislation.	1	This is undertaken already and there is regular monitoring of performance in this area. Weekly monitoring of compliance and quality is currently in place. There is an overall improvement in the timeliness of completion and where plans are out of timescales, management reviews are undertaken and exception reporting with reasons are provided to the Director of CSC.	Interim Head of Service, CLA & CT, Group Manager, Leaving Care.	Completed (all outstanding PP have been reviewed and updated) Ongoing monitoring of timeliness.
5	<u>Individual Service User Finance Records</u> A comprehensive record should be readily available to detail all payments made to support each individual leaving care service user.	1	As part of the review process the development and investment in suitable record management tools should be considered. A single workflow is desirable, linking across systems to minimise the administrative overhead and foster increased accuracy.		

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Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>The capacity to manage these records in the light of a projected 40% growth in the cohort should be assessed.</p> <p>All current finance records per young person will be updated to accurately reflect current payments. Each case to be reviewed by the responsible team manager.</p> <p>Procurement of new case recording system to include tracking of finance for Care.</p>	<p>Group Manager/Care Leaver Team Managers.</p> <p>Interim Head of Service, CLA & CT/ Director, Children’s Social Care.</p>	<p>December 2018</p> <p>Date to be confirmed for procurement of the new system.</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p><u>Grant Sheet (Central Log)</u> All service user finance records should be fully reviewed to ensure that all payments and allowances are up to date accurate and complete. Payments should not be made unless there are sufficient funds.</p>	1	<p>Agreed. As above. Team Managers will undertake this review over the next 3 months. Given the nature of the service user group, at times young people may require additional payments. This will be agreed by the head of service.</p>	<p>Interim Head of Service, CLA & CT / Group Manager /Care Leaver Team Managers</p>	<p>December 2018</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
7	<p><u>Reconciliation to Oracle – T accounts</u></p> <p>All transactions specific to the leaving care team should be allocated to the individual T accounts. Accounts should be reconciled on a regular basis.</p> <p>The whole process for making payments to care leavers needs to be fully reviewed as the current system is not fit for purpose.</p>	1	Finance processes to be reviewed including reconciliations. This will be part of the review of the full process.	Interim Head of Service, CLA & CT/ Head of Finance.	December 2018

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 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
8	<p>Service Agreements on Carefirst Service agreements should be authorised in a timely manner to ensure that payments are made on time and commitments are accurately reflected in the budget. Service agreements should be closed in a timely manner and authorised for closure to prevent any potential overpayments arising.</p> <p>Service agreements for the Leaving Care team need to be reviewed to confirm that they are all current and that the correct rates are currently being paid.</p>	2	<p>Agreed.</p> <p>All current service agreements to be reviewed by the end of January 2019.</p>	Group Manager.	Ongoing. This is part of the core business of the team.

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
9	<p><u>Staying Put Allowances</u> The Department must review the application of DFE allowances for staying put and the need to action both the 2017/18 and 2018/19 uplifts. Annual uplifts must be communicated to the CareFirst Team in a timely manner once the appropriate authorisation has been evidenced.</p>	1	<p>Agreed. Annual uplifts are communicated to CareFirst team. Current Staying Put payments to be reviewed for accuracy.</p>	Group Manager/Project Manager	<p>Ongoing January 2019</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
10	<p><u>Mandatory Financial Regulations Training</u></p> <p>All staff within the Leaving Care Team who have financial responsibilities, should complete financial regulations training.</p>	2	Agreed. All staff will be encouraged to attend the relevant training when this becomes available.	Interim Head of Service, CLA & CT/ Group Manager.	Timescale to be confirmed (dependant on availability of training)
11	<p><u>Asset Register</u></p> <p>The Leaving Care service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded and reviewed.</p>	2	As part of a full service review due to undertaken between November 2018 –January 2019 – all posts numbers and assets linked to the post will be recorded.	Interim Head of Service, CLA & CT.	January 2019

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As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

Issued to: Richard Haines, Head of Direct Care Services,
Joy Bennett, Group Manager, Reablement,
Tricia Wennell, Head of Service, Assessment & Care Management,
Carole Brown, Operations Manager, Short Term Intervention,
Stephen John, Director, Adult Social Care,

Cc: Angela Buchanan, Acting Assistant Director, Strategic Development & Performance,
David Bradshaw, Head of ECHS Finance,
Alicia Munday, Programme Manager, Commissioning,
Ade Adetosoye, Executive Director of ECHS (Final Only).

Prepared by: Principal Auditor,

Date of Issue: March 9th 2017

Report No.: ECH/036/01/2016

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

INTRODUCTION

1. This report sets out the results of our systems based audit of **Reablement Team Service Audit for 2016-17**. The audit was carried out in quarter 3 as part of the programmed work specified in the 2016-17 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 9/11/16. The period covered by this report is from **April 2016 to January 2017**.
4. The budget for Reablement also includes the Community Assessment & Rehabilitation Team (CART's) and the Direct Care Management. For 2016/17, the budget is £842,460 and the actual spend is £655,472 (as at August). This was provided to Internal Audit in November 2016. For 2015/16, the budget was £844,500 and the actual spend at year end was £694,648. The Better Care Fund and how this was spent was not reviewed as part of this audit review.
5. The Reablement Services help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement Services may be offered to someone who has recently come out of hospital. Reablement should be provided free of charge by the local authority for up to six weeks. Reablement is one of councils' main tools in managing the costs of an ageing population and will be important as Authorities face cuts in government funding. Since the Care Act 2014, there is more of a responsibility for prevention and to enable people to remain independent.
7. Referrals for reablement or new service requests are made via a number of sources such as the Hospital Care Manager or the Reablement Care Management. An assessment is undertaken and as part of this, an outcome measurement tool is used to determine suitability for the service following which the Reablement Service will commence the home visits for the service user.

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

8. It is proposed that the Council tender this service jointly with Provider A.
9. The Reablement Service was inspected on the 22/11/16 by the Care Qualities Commission. The overall rating for the service was that the service 'requires improvement'.

AUDIT SCOPE

10. The scope of the audit is detailed in the Terms of Reference. In addition to this, coverage of the understanding of reablement tasks was requested by the Director, Adult Social Care.
11. The CARTS team were not reviewed.

AUDIT OPINION

12. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

13. The findings within this report are split between the Reablement Team and the Reablement Assessment Team. Internal Audit wish to bring the following to management's attention :-

Reablement Team

- A definitive number of clients cannot be accurately identified at present.
- Concerns relate to the accuracy and robustness of performance management data.
- An asset register was not maintained and signed off by a senior manager.
- Reablement Policies and Procedures had not been updated since May 2016, despite a change in processes.

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

- Insurance certificates to confirm that staff are insured for business use were found in have expired in some cases.

Reablement Assessment Team

- The Outcome Measurement Tool was found not to be used by all staff to assess suitability for the service.
- Current support plans were found not to be in place in some cases.
- Service agreements on Carefirst were not updated in a timely manner and queries arose with the dates of the service.
- Reablement Reviews had not been undertaken in some cases.
- Reablement Assessment Policy & Procedures were found to require an update.

14. Enquiries were made in respect of the understanding of reablement tasks by staff who were able to provide details as applicable. The service undertook some functions that were more akin to a homecare service, such as shopping. These non-reablement functions have since ceased immediately under the direction and supervision of the Director of Adult Social Care.

SIGNIFICANT FINDINGS (PRIORITY 1)

15. Priority 1 findings are also listed here:

Performance Management Data

16. The main performance area is also the information recorded within Ezitracker. This records the contracted hours, available hours (after leave and any training or sickness), hours allocated to Ezitracker, office time, contact time with clients and the travelling time. These are shown as percentages. Any variances are highlighted.

17. For weeks commencing 11/7/18 and 18/7/18 (combined) the performance measures outcomes are detailed below;-

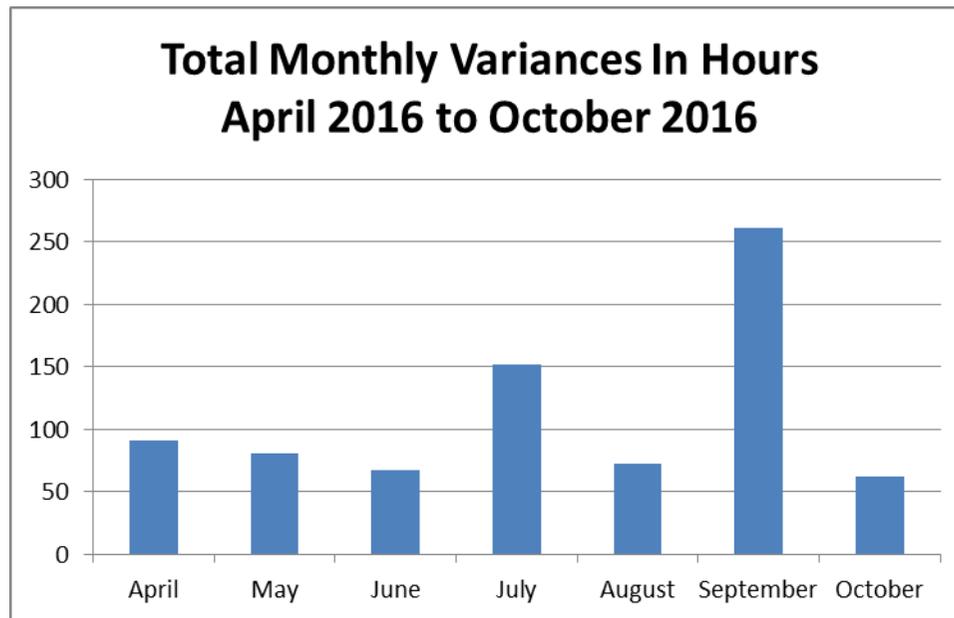
- Eight staff exceeded the 10% office time measure.(Samples D,E,F,J,K,O,S and W)
- Six staff had not met the 65% contact time measure. (Samples B, D, E, F, K and V).
- Six staff had not delivered their contracted hours /available hours. (Samples B,D,E,K,R & T)
- Two staff claimed additional hours or overtime in respect of the month of July 2016 that was paid in August 2016. For Sample R, 0.5 hours extra hours were paid and according to the Ezitracker data there was a shortfall of 3.25 hours. For Sample P, the Ezitracker data highlights that there was a variance of 12.75 hours (shortfall) but 2.58 hours were paid.

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

- In total, there are 80 hours in variance for this time period that cannot be accounted for by management.
18. For week commencing 31/10/16 the performance measures results are detailed below:-
- Eight staff exceeded the 10% office time measure (Samples C, E, F, G, K, L, N and Q).
 - Nine staff had not met the 65% contact time measure. (Samples B, E, F, I, K, L, O, P and U).
 - Nine staff had exceeded the travel time measure of 25%. (Samples E, F, G, I, K, L, M, Q and U).
 - Five staff had not delivered their contracted hours/ available hours. (Samples B, E, I P and W).
 - One staff member (Sample B) claimed additional hours in respect of the month of October 2016 that was paid in November 2016, Ezitracker shows that there was a shortfall of hours of 3.5 hours in October 2016 and 6.75 hours were paid in November 2016. For Sample P, the Ezitracker data highlights that there was an additional 4.5 hours but 2.17 hours were paid.
 - In total there are 25 hours in variance for this time period that cannot be accounted for by management.

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

19. The chart below shows the number of hours that cannot be accounted for the period of April 2016 – October 2016, according to the services performance data on Ezitracker. The total number of hours that cannot be accounted for over this seven month period is 788.42, which represents 5% of the available hours that facilitators should have delivered for the period. Therefore, it is likely that hours have been overpaid but this cannot be quantified comprehensively.



20. It is highlighted within a committee reported dated 14/9/16, that 'Performance management information is not adequately captured and reported on, which means that the service cannot be confident in its current budget monitoring. This is being addressed through establishing weekly reconciliation reports between finance, the service, and care management'.

REVIEW OF REABLEMENT TEAM SERVICE AUDIT FOR 2016-17

Outcome Measurement Tool

21. For 11 samples, it was found that the outcome tool had not been completed. Therefore, it was not possible to confirm whether the eligibility criteria had been satisfied.
(Samples 4,9,11,14,19,23,24,27,28,30 and 32).
22. Additionally, it was found that when applying the outcome measurement tool scoring index, although the scoring had been applied it was found that 9 service users that received the reablement service had not met the criteria. (Samples 1, 3, 7, 12, 16, 17, 22, 25, and 29).
23. Discussions with management identified that there was a lack of confidence that all staff completed the tool as they should and suggested that a decision should be made on whether the completion of the measurement tool should continue.
24. Discussions with the Operations Manager, Short Term Intervention on 30/01/2017, confirmed that the Outcome Measurement Tool should continue to be completed and there has been no directive issued to the contrary.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

25. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

26. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p><u>Number of Clients in the Reablement Service</u></p> <p>Referred clients eligible for reablement care are assessed and then set up on Carefirst with a service agreement.</p> <p>Strategy and Performance (ECHS) provided a report of all open and closed reablement service users for the period April 1st 2016 to 9th November 2016. It could be seen that there were a total number of 437 service users during this period of which of which 47 were open, 390 were closed and 48 of these cases were actually deceased</p> <p>The Reablement Service itself used to monitor the number of clients by means of the Reablement Client list which detailed the client, start and end dates, hours of weekly care over a period of time within or in excess of 6 weeks. However, this is no longer available due to a lack of resources and instead the weekly Reablement Performance Data is now prepared, which shows the number of clients in the service each week. It does not drill down to individual service users or detail the number of terminations or discharges from the service each week. The reliability of this data was not tested during the audit.</p>		

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Delays occur in updating Carefirst in a timely manner when services are ended. An update is provided by the Group Manager periodically to ensure that Carefirst is up to date. The start and end date of the reablement service sometimes differs in reality to that recorded on Carefirst.</p> <p>Concerns have been raised with the Head of Direct Care by other senior officers in respect of the reliability of this data for clients in receipt of reablement as this cannot be given as a definitive figure at a point in time. This will directly impact on business planning, budget monitoring and the completion of statutory returns.</p> <p>The number of clients is circa 500 per year as highlighted within a committee report dated 14/9/16. The report highlights that ‘the absence of accurate data means it is difficult to measure the success of the current services, and therefore accurately measure the impact the services is having on the overall objectives of reducing or delaying long term social care intervention. Through the weekly reconciliation meetings this will be improved and monitored’.</p>	<p>Records currently held do not allow sufficient reconciliation or information to make informed decisions.</p>	<p>The Department should consider the need for a more comprehensive way of identifying and detailing the current reablement users.</p> <p>CareFirst reports identifying service users should be reconciled to the records held to ensure that the information held on CareFirst is accurate and complete.</p> <p>[Priority 2]</p>

Priority 1
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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p><u>Performance Management Data</u></p> <p>The main source of performance data for the service is recorded within Ezitracker. Performance reports are also produced separately and additional data collection is undertaken on open and closed cases, which is duplicating work.</p> <p>Ezitracker records key data such as the facilitators contracted hours, available hours (after leave and any training or sickness), hours allocated to Ezitracker, office time, contact time with clients and the travelling time. There are three main performance measures that are required to be met; Office time 10%, Contact Time 65% and Travelling Time 25%. Any variances are highlighted.</p> <p>In some cases fields are not completed and some contain errors.</p> <p>Sample weeks of Ezitracker date were selected for review and it was found that having reviewed the performance data for weeks commencing 11/7/16 and 18/7/16 (combined) it can be seen that :-</p> <ul style="list-style-type: none"> • Eight staff exceeded the 10% office time measure. 	<p>Performance data is inaccurate and misleading. If data is incorrect and misleading service data, budget monitoring and government returns will also be incorrect.</p>	<p>Robust and accurate performance data should be available, accessible and provide useful management information. This data for the identified and agreed measures must be regularly reviewed, variances investigated and reconciled to staff claims on a monthly basis.</p>

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Priority 1
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Priority 2
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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>(Samples D,E,F,J,K,O,S and W)</p> <ul style="list-style-type: none"> • Six staff had not met the 65% contact time measure. (Samples B, D, E, F, K and V). • Six staff had not delivered their contracted hours or available hours. (Samples B, D, E, K, R & T). • Two staff claimed additional hours or overtime in respect of the month of July 2016 that was paid in August 2016. For Sample R, 0.5 hours extra hours were paid and according to the Ezitracker data there was a shortfall of - 3.25 hours. • For Sample P, the Ezitracker data highlights that there additional hours of 4.5 hours but 2.17 hours were paid. • In total, there are 80 hours in variance for this time period that cannot be accounted for by management. <p>For week commencing 31/10/16 the performance measures results are detailed below:-</p> <ul style="list-style-type: none"> • Eight staff exceeded the 10% office time measure. (Samples C, E, F, G, K, L, N and Q). • Nine staff had not met the 65% contact time measure. (Samples B, E, F, I, K, L, O, P and U). 	<p>Staff do not delivering their contracted hours.</p>	<p>Management must ensure that contracted hours are being delivered by staff and that all performance data is accurate and complete.</p>

Priority 1
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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> • Nine staff had exceeded the travel time measure of 25%. (Samples E, F, G, I, K, L, M, Q and U). • Five staff had not delivered their contracted hours or available hours (Samples B, E, I, P and W). • There was no data completed for K and there is a query with the data for R. • One staff claimed additional hours in respect of the month of October 2016 that was paid in November 2016. For Sample B, Ezitracker shows that there was a shortfall of hours of 3.5 hours and 6.75 hours were paid. For Sample P, the Ezitracker data highlights that there was an additional 4.5 hours but 2.17 hours were paid. • In total there are 25 hours in variance for this time period that cannot be accounted for by management. <p>The performance measures do not seem to be reported anywhere and are used within the service area only. It was confirmed that at the budget monitoring meeting held on 27/10/16, copies were handed out but collected back in at the end of the meeting.</p> <p>It is highlighted within a committee reported dated 14/9/16, that</p>		

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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>'Performance management information is not adequately captured and reported on, which means that the service cannot be confident in its current budget monitoring. This is being addressed through establishing weekly reconciliation reports between finance, the service, and care management'.</p>	<p>There is also no supporting evidence to confirm that management monitor the weekly performance data and investigate variances.</p>	<p>Management must monitor and investigate the reasons why performance measures are not being satisfied.</p> <p>[Priority 1]</p>
<p>3</p>	<p><u>Reablement Asset Register</u> A copy of the Reablement Asset Register was requested. The Group Manager confirmed that there was no reablement asset register, as they did not own any equipment.</p> <p>The stock or equipment such as protective clothing etc was not detailed and log of mobile phone users provided to the Auditor detailing the 25 mobile phones currently in use by staff and managers had not be signed off or dated.</p>	<p>Ineffective control over assets.</p>	<p>The Reablement Service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded. The stock list should be reviewed and signed off by a senior officer.</p> <p>[Priority 2]</p>

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Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4	<p><u>Reablement Service Policies & Procedures</u> The current procedure manual was requested from the Group Manager on 16/11/16. The auditor was advised that this had previously been sent on 27/5/16. The manual has not been updated since this time.</p> <p>It was found that the change in process of moving away from the completion of the reablement client list to the Reablement Performance Data spreadsheet had not been reflected within the procedure manual.</p> <p>The details of the performance measures for the service are also not included within the procedures.</p>	<p>Staff may be working to different working practices.</p>	<p>Policies & Procedures for the reablement service should be fully reviewed and updated, stating the responsible officer and be version controlled. The areas discussed in this report should be considered and included if appropriate. On completion, procedures should be made available to all staff.</p> <p>[Priority 2]</p>

Priority 1
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Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
5	<p><u>Insurance Certificates for Business Use</u> Insurance certificates were reviewed for facilitators sampled to confirm that the necessary insurance was in place for business use if staff used their own vehicles. Queries arose in 3 cases.(Samples K, R and T).</p> <p>Sample K - Insurance expired on 4/12/16. Sample R - Insurance expired on 25/11/16. Sample T - Insurance expired on 2/10/16. This facilitator left employment on 16/10/16.</p>	<p>Employees will not be insured whilst on business journeys in the event of a claim.</p>	<p>All current staff using their vehicles for business journeys should be insured for business use.</p> <p>[Priority 2]</p>
6	<p><u>Outcome Measurement Tool</u></p> <p>For 11 samples, it was found that the outcome tool had not been completed. Therefore, it was not possible to confirm whether the eligibility criteria had been satisfied. (Samples 4,9,11,14,19,23,24,27,28,30 and 32).</p> <p>Additionally, it was found that when applying the outcome measurement tool scoring index, although the scoring had been applied it was found that 9 service users that received the reablement service had not met the criteria. (Samples 1, 3, 7, 12, 16, 17, 22, 25, and 29).</p>	<p>The correct service may not be provided in the first instance.</p>	<p>Staff need to be reminded that the outcome measurement tool to assess suitability for the service must be completed until a decision is made to the contrary. The scoring index must be applied consistently.</p>

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Priority 3
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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>Discussions with management identified that there was a lack of confidence that all staff completed the tool as they should and suggested that a decision should be made on whether the completion of the measurement tool should continue.</p> <p>Discussions with the Operations Manager, Short Term Intervention on 30/01/2017, confirmed that the Outcome Measurement Tool should continue to be completed and there has been no directive issued to the contrary.</p>	<p>Services may be provided with a service that is not appropriate based on the service users assessment.</p>	<p>Management should determine whether the Outcome Measurement Tool should continue to be used to determine the service user’s suitability for the reablement service, as is detailed within the current procedural guidance. Cases highlighted within this audit should be investigated.</p> <p>[Priority 1]</p>

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Priority 3
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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
7	<p>Support Plans Audit testing showed that out of the 32 service agreements tested,</p> <ul style="list-style-type: none"> • Two service users had draft support plans only (Samples 3 and 8). • Eight current service users only had historic support plans. (Samples 15, 16,19, 20, 21,22,24,25) <p>A Care and Support Plan should be completed within 4 weeks of the assessment being finished.</p>	<p>Assessments may not be up to date and match care currently being provided.</p>	<p>The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.</p> <p>[Priority 2]</p>

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Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
8	<p><u>Service Agreements</u></p> <p>From the 32 reablement service agreements reviewed, it was found that there were 4 service agreements that were open or closed at 11/1/17 but remained unauthorised (Samples 1, 2, 6 a deceased service user, 11, 12, 15 and 19). The remaining sample was incomplete at the time of testing. (Sample 4).</p> <p>Dates of start and end dates were also found to be different when comparing data on Staffplan (which details the individual staff visits to the service user) to Carefirst. (Samples 1, 8, and 19).</p>	<p>Service agreements are not updated or authorised onto Carefirst correctly resulting in incorrect and misleading service data, budget monitoring and government returns.</p>	<p>Service agreements should be updated and authorised in a timely manner. Cases should be investigated and updated as necessary.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
9	<p><u>Reablement Reviews</u></p> <p>Audit testing showed that out of the 32 service agreements tested (31 service users), it was found that some Reablement Reviews were not recorded/fully recorded on Carefirst at the time of testing.(Samples 4,5,8,12,27 and 31).</p>	<p>If Reablement Reviews are not undertaken, then identifying any changes in the client's needs may not be possible.</p>	<p>Reablement Reviews should be undertaken to determine whether the service users still require the service over the full period of up to six weeks or if there is the possibility of setting up a care package due to ongoing needs, or whether the service can be terminated.</p> <p>[Priority 2]</p>

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Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
10	<p><u>Reablement Assessment Policies & Procedures</u> The procedure document Operational Procedures for Reablement version 3, refers to the early adopter site and the assessment Process for Reablement version 3, were both undated. On discussions with the Senior Practitioner, the Auditor was informed that these procedures were no longer relevant and were no longer applicable.</p>	<p>Staff may be operating to different practices.</p>	<p>Policies & Procedures for the Reablement Assessment team should be revised in full and should reflect the Care Act and not Fair Access to Care, stating the responsible officer and be version controlled and made available to all staff.</p> <p>The areas discussed in this report should be considered and included if appropriate.</p> <p>[Priority 2]</p>

Priority 1
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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
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Reablement Team					
1	<p><u>Number of Clients in the Reablement Service</u></p> <p>The Department should consider the need for a more comprehensive way of identifying and detailing the current reablement users.</p> <p>CareFirst reports identifying service users should be reconciled to the records held to ensure that the information held on CareFirst is accurate and complete.</p>	2	<p>The Re-ablement provider service has its own weekly record of how many clients are in the service measured on a daily basis.</p> <p>This information is made available to finance allowing them to cross check the information held in Carefirst.</p> <p>The provision of a more detailed list of SU's will be discussed with the Director.</p>	Group Manager, Re-ablement.	The new system started July 16 and will be reviewed following the market testing of the service or 31 st March 2018.
2	<p><u>Performance Management Data</u></p> <p>Robust and accurate performance data should be available, accessible and</p>	1	<p>The KPI's are monitored on a weekly basis by the Head of Service and the Re-ablement Management Team.</p>		

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Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>provide useful management information. This data for the identified and agreed measures must be regularly reviewed, variances investigated and reconciled to staff claims on a monthly basis.</p> <p>Management must ensure that contracted hours are being delivered by staff and that all performance data is accurate and complete.</p> <p>Management must monitor and investigate the reasons why performance measures are not being satisfied.</p>		<p>Current figures for the 13 weeks up to and including week commencing 6th Feb are;</p> <p>Contact Time – 63% Office Time – 10% Travel Time – 28%</p> <p>The monitoring will continue and staff are constantly reminded about the need to be accurate with their timing and reporting.</p> <p>Following discussions with HR all staff will be informed that overtime/additional hours claims will not be authorised if their monthly hours, as identified on Ezitracker, are lower than their contractual hours for the month in question.</p>	<p>Head of Service/Re-ablement management team.</p> <p>Group Manager, Re-ablement</p>	<p>Weekly monitoring started October 2016.</p> <p>March 31st 2017.</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>The three performance indicators referred to were agreed as indicators of the service being provided and were never intended as individual performance indicators for individual staff.</p> <p>Unfortunately, there are a number of factors which make the KPI's unsuitable for individual staff. For example, cancellations of visits, visits that are curtailed due to SU's fatigue, hospital discharges not happening and on occasions SU's not being at home.</p> <p>An example of this is that on 22nd February, between 18:49 and 19:29, one member of staff had three calls cancelled as follows; 1 x Agency already on site. Re-ablement not informed.</p>	<p>Head of Service Re-ablement management team.</p>	<p>Weekly reviews started July 2016 and will continue until the outcome of the market testing tender is known when the KPI's will be reviewed.</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>1 x Already in bed, no help needed. 1 x Daughter on-site, no help needed.</p> <p>The shortfall identified by audit will be investigated but cancellation figures may not be complete as data collection had not started at that point and specific travel time figures for the two periods identified may not be available as Ezitracker data is not kept beyond three months. The possibility for retrieval is being explored but this may be a chargeable service. However the Re-ablement management team believe that the shortfall was the result of the reporting system which allocated an across the board 25% for all</p>	<p>Head of Direct Care/Re-ablement Management Team.</p>	<p>30th of September 2017.</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			<p>staff travel time. This was changed in Sept/Oct 2016 to reflect the actual time the staff spent travelling as it had become clear that a generic travel time missed a significant number of hours as the travel time was in excess of 25% and was therefore no longer accurate enough for monitoring purposes.</p> <p>An example for w/c 3rd October thru to w/c 24th October 2016 there were 1,871 re-ablement hours available. The service could account for 1,859, a shortfall of 11 hours (0.68%).</p> <p>Subsequent monitoring has shown that the Re-ablement service regularly delivers more weekly hours than are actually available.</p>		

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			For example the figures for the service for the 13 weeks up to and including week commencing 6 th Feb show that there were 4,821 available hours and the service accounted for 4,863 (+42 hrs., 0.87%). This period included Christmas and New Year which historically see an increase in cancellations and aborted visits.		

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	<p><u>Reablement Asset Register</u></p> <p>The Reablement service should ensure that they are maintaining an up to date record of assets and that movements of these assets are recorded. The stock list should be regularly reviewed and signed off by a senior officer.</p>	2	Re-ablement has set-up an asset register which has documented the number of mobiles phones and non-disposable PPE items, e.g. Jackets.	Group Manager, Re-ablement	January 31 st 2017.

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Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	<p><u>Reablement Service Procedures</u></p> <p>Policies & Procedures for the reablement service should be fully reviewed and updated, stating the responsible officer and be version controlled. The areas discussed in this report should be considered and included if appropriate. On completion, procedures should be made available to all staff.</p>	2	The Re-ablement Service and Procedures manual will be updated to show the change the service has made to how it records the performance data.	Group Manager, Re-ablement	1 st April 2017.

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Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	<p><u>Insurance Certificates for Business Use</u></p> <p>All current staff using their vehicles for business journeys should be insured for business use.</p>	2	<p>The two Insurances that were found to be out of date were:-</p> <p>1. The staff member was on long term sick and had not been asked for her certificate.</p> <p>2. The staff member was on Annual Leave.</p> <p>These were both updated when the staff returned to work.</p>	Group Manager, Re-ablement	Immediate. Completed as detailed.
Reablement Assessment Team					

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 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	<p><u>Outcome Measurement Tool</u></p> <p>Staff need to be reminded that the outcome measurement tool to assess suitability for the service must be completed until a decision is made to the contrary. The scoring index must be applied consistently.</p> <p>Management should determine whether the Outcome Measurement Tool should continue to be used to determine the service users suitability for the reablement service, as is detailed within the current procedural guidance. Cases highlighted within this audit should be investigated.</p>	1	<p>All Team Leaders have been reminded verbally and in writing to ensure that staff complete the OMT in all cases.</p> <p>The OMT will be reviewed</p>	<p>Operations Manager, Short Term Intervention.</p> <p>Head of Service, Assessment & Care Management / Operations Manager, Short Term Intervention.</p>	<p>Completed</p> <p>September 30th 2017</p>

Priority 1
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Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
7	<u>Support Plans</u> The support plans for the cases identified should be investigated. Current support plans should be in place for all service users currently receiving services.	2	All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to TLs. Staff will be informed and will be required to update the cases	Head of Service, Assessment & Care Management Operations Manager, Short Term Interventions.	Completed March 21 st 2017
8	<u>Service Agreements</u> Service agreements should be updated and authorised in a timely manner. Cases should be investigated and updated as necessary.	2	All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to Team Leaders. Staff will be informed and will be required to update the cases.	Head of Service, Assessment & Care Management. Operations Manager, Short Term Interventions.	Completed March 31 st 2017

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
9	<p><u>Reablement Reviews</u></p> <p>Reablement Reviews should be undertaken to determine whether the service users still require the service over the full period of up to six weeks or if there is the possibility of setting up a care package due to ongoing needs, or whether the service can be terminated.</p>	2	<p>All Team Leaders will be sent a reminder to ensure staff complete support plans as per procedure. PRG will continue to monitor this and feedback to TLs.</p> <p>Staff will be informed and will be required to update the cases</p>	<p>Head of Service, Assessment & Care Management.</p> <p>Operations Manager, Short Term Interventions.</p>	<p>Completed</p> <p>March 31st 2017</p>

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
10	<p><u>Reablement Assessment Policies & Procedures</u></p> <p>Policies & Procedures for the Reablement Assessment team should be revised in full and should reflect the Care Act and not Fair Access to Care, stating the responsible officer and be version controlled and made available to all staff.</p> <p>The areas discussed in this report should be considered and included if appropriate.</p>	2	<p>All documents will be reviewed and updated.</p> <p>Service is subject to future commissioning considerations and the Head of Service will work with any new provider on the development of documents if appropriate.</p>	Head of Service, Assessment & Care Management / Operations Manager, Short Term Intervention.	January 31 st 2018

Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the objectives tested.

Substantial Assurance

While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.



FINAL INTERNAL AUDIT REPORT

EDUCATION CARE & HEALTH SERVICES

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

Issued to: Andrew Rees, Acting Head Teacher
Dr Paul Wright, Chair of Governors (final report only)
Schools Finance Team, (final report only)

Cc: Gillian Palmer, Interim Director of Education (final report only)
Ade Adetosoye, Executive Director of ECHS (final report only)

Prepared by: Principal Auditors

Date of Issue: 8th February 2018
Report No.: ECH/20/2017/AU

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

INTRODUCTION

1. This report sets out the results of our systems based audit of St Olaves School for 2017-18. The audit was carried out in quarter 3 as part of the programmed work specified in the 2017-18 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the school's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.
3. The original scope of the audit was outlined in the Terms of Reference issued on 21/11/17. The period covered by this report is from November 2016 to November 2017.

AUDIT SCOPE

4. The scope of the audit is detailed in the Terms of Reference.

MANAGEMENT SUMMARY

5. Internal Audit visited the school on the 6th and 7th December to complete a programme of testing for expenditure, income, financial management, budget monitoring, payroll, contract monitoring, voluntary fund, safeguarding assets, pecuniary interests, procurement card and lettings. The 6 recommendations raised in the previous audit report finalised on the 21/04/17 were followed up and progress to implement noted.
6. Interviews with the Finance Manager (FM) and the School Business Manager (SBM) and testing on recent data confirmed that the two recommendations relating to the contract register and the scheme of delegation have been implemented; the three recommendations relating to pecuniary interests for staff, cash flow reports and the procurement of the IT support contract are outstanding; the recommendation relating to orders and HMRC is partially implemented as the school have issued reminders

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

to all staff in various communications, staff meetings and the generic policy document signed by all staff at the start of the academic year; the FM has identified payments to individuals and started to complete the HMRC questionnaires. The outstanding and partially implemented recommendations have been re-recommended at Appendix A. Although the contract register and scheme of delegation have been completed and presented to Governors, there are suggestions for both documents. The suggested template shown at Appendix 1 of the Financial Regulations for Schools (2010) details the roles and responsibilities of key officers including the Head Teacher (HT), SBM and FM. The annual value and whole life contract value should be added to the contract register improving the information to Governors to support decisions with regard to procurement and rolled over contracts.

7. The Internal Audit review has identified issues in the following areas that should be considered by the school:-
- Although the IT support contract had been discussed at the Finance Committee, Governors had not acknowledged the potential breach of EU tendering regulations with spend exceeding the threshold of £164,176. The cumulative spend with this company since November 2015 is now £277,967.
 - Business continuity / practice notes for financial procedures were not available
 - FM was not aware when a contract had been awarded to raise the expenditure as a commitment on the FMS system
 - Certified audited accounts for the Voluntary Fund were not presented to Governors. The 2016/17 accounts did not note "Related third party transactions" whereas 2015/16 did and stated that the outstanding balances from the Foundation were nil.
 - Block grant expenses paid from the School Funds and reimbursed from the Voluntary Fund or Foundation coded to I13
 - Goods received could not be reconciled to the ICT asset register as the serial number is not recorded on the invoice. The school do not operate a loans book to record asset items that are temporarily removed off site
 - The contract register does show a list of contractual arrangements but the value of the contract is not completed in all instances and the number of rollover years is not shown
 - HMRC questionnaires had not been completed for all individuals receiving payment.
 - Cash flow statements are not prepared as required by section 2.1.2 Scheme for Financing Schools (2015) and the annual circular issued by the Schools Finance Team. ("*Submission of Budget Plans & Supporting Documents & Request for Budget Monitoring & Final CFR Reports*")
 - Pecuniary interest forms for staff have been drafted but have not yet been distributed and completed.

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

- The Scheme of Delegation does not specify the roles and responsibilities of key officers. The FM had not seen the Scheme of Delegation and was not aware of the financial limits imposed by the scheme
 - The sale of sample test papers to prospective parents/students' needs to be shown as compliant to DfE regulations
 - Confirmation that the school have completed the necessary documentation for any "benefit in kind" payments.
 - The Governor minutes do refer to the three funding streams available to the school in isolation but the information is not shown in one document to give Governors an overview of total funds available.
8. It is acknowledged that the audit visit was undertaken during a period of change for the school following the resignations of the Head Teacher and Chair of Governors. At the start of the audit visit the SBM confirmed that he would be leaving the school at the end of the autumn term. With these changes of key personnel it is timely for the school to review the financial procedures, roles and responsibilities. Paragraph 7 above sets out the main findings of the audit that are shown in detail at Appendix A with a recommendation for the school to consider and implement. The audit review has identified two areas that should be considered by the school to improve financial management and governance as discussed below:-

Budget setting – the SBM was responsible for setting the budget and reporting to Governors. There was no collaboration with the FM prior to the budget being presented and the late timing of the Governor approval delayed the upload to FMS. The budget was also set at a strategic level whereas the FM requires the detail to be at ledger code. It was noted that in previous years the budget was balanced by a contribution from the voluntary fund but at year end the actual draw down was a significantly lower value. There was no apparent revision to the original budget during the year to reflect in year changes despite the recommendation to do so from the Schools Finance Team. Audit examination of the Income and Expenditure report 2017, identified 3 cost centres with a variance spend over 100%. Both the FM and SBM satisfactorily explained the variances but suggested that an in year adjustment could have been made.

Authorisation – The Scheme of Delegation sets out the financial limits for authorisation, setting thresholds for SBM, Head Teacher, Finance Committee and Governing Body. The scheme states that "invoices must be authorised for settlement by the budget holder responsible". With the change of personnel it is timely to remind all authorising officers of their responsibility to comply with section 7 of the Financial Regulations for Schools. Section 7.4.1 of the Regulations state that "*the overriding principle to be adhered to is that the authorisation and certification checks should be meaningful. To this end, they should be carried out and evidenced by those members of staff who are in a position to judge whether goods and services have actually*

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

been received or whether invoice prices are correct. The evidence should also be unambiguous, an isolated signature on an invoice does not make it clear what has been checked or what is being authorised or certified and is therefore unacceptable”
The signature template used for the invoice does not clarify that the authorisation officer has completed the required checks.

SIGNIFICANT FINDINGS (PRIORITY 1)

9. There was one priority one finding relating to the procurement of the IT support.
10. The previous audit finalised in May 2017 identified that the 3 year contract awarded to Contractor A for IT support in September 2016 had not been subject to competitive tendering. The school were advised that with an annual cost of £93K the contract exceeded the UK public contract regulations threshold of £164,176.
11. During the school visit on the 6th and 7th December the SBM confirmed the arrangements for IT support have not changed since the previous audit.
12. The Clerk of Governors confirmed that the Internal Audit report had been included in the Governors pack for the Finance Committee in May 2017 but Governors had not discussed the specific issue relating to compliance to EU tendering. The minutes of this meeting record “the expertise of the current holders of the contract, pricing had been benchmarked with other schools and the quality of the resource provided was very good. The SBM did not propose to make any changes with which the Governors concurred.”
13. From the bank history provided for the audit this year it was shown that £198,787 has been paid to the IT supplier from November 2015 to November 2017 in respect of contract payments; £23,586.29 in respect of non contract expenditure. Combining expenditure from previous bank history records available to Internal Audit, the total net spend with Contractor A is £369,785 since August 2014.
14. At the previous audit the SBM stated that he received calls from other IT suppliers and the incumbent provider was cost effective. The management response to the previous audit disputed that choice should be determined by cost alone and reiterated the need for a quality IT support service dependent on the knowledge and commitment of individuals. The school

REVIEW OF ST OLAVES SCHOOL AUDIT FOR 2017-18

should consider the following issues arising:-

- Included in the final report as an Internal Audit note – the agreement commencing September 2016 with a 90 day termination clause does not avoid EU tendering.
- The cumulative spend with this contractor exceeds the EU threshold of £164,176 and should be subject to the appropriate competitive tendering.
- Section 6 of the Financial Regulations for Schools sets out the procedures that must be complied with for contracts. The Invitation to Tender document would include the award criteria, the cost/quality weighting and other relevant factors.
- IT procurement is a critical area and includes consideration of ownership of data and processes and intellectual property rights of any software developed by the contractor for the school's use. The school must be able to demonstrate that appropriate controls have been put in place to mitigate these risks.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

15. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

AUDIT OPINION

16. Overall, the conclusion of this audit was that limited assurance can be placed on the effectiveness of the overall controls. Opinion definitions are given in Appendix C.

ACKNOWLEDGEMENT

17. We would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p>Procurement of IT Support Contract</p> <p>The SBM confirmed that the arrangements for IT support have not changed since the previous audit.</p> <p>The Clerk of Governors confirmed that the Internal Audit report had been included in the Governors pack for the Finance Committee in May 2017 but Governors had not discussed the specific issue relating to compliance to EU tendering. The minutes of this meeting record <i>“the expertise of the current holders of the contract, pricing had been benchmarked with other schools and the quality of the resource provided was very good The SBM did not propose to make any changes with which the Governors concurred.”</i></p> <p>From the bank history provided for the audit this year it was shown that £198,787 has been paid to the IT supplier from November 2015 to November 2017 in respect of contract payments; £23,586.29 in respect of non contract expenditure.</p> <p>Combining expenditure from previous bank history records available to Internal Audit, the total net spend with Contractor A is £369,785 since August 2014.</p>	<p>There is a risk of damages and costs awarded against the school due to contracts let in breach of UK public contract regulations and the schools own financial regulations. Value for money may not be obtained when procuring goods and services.</p>	<p>The school must ensure that tenders are sought or a procurement framework process is undertaken now for the schools IT support, acknowledging that compliance with EU rules cannot be disregarded.</p> <p>[Priority 1]</p>

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Priority 1
Required to address major weaknesses and should be implemented as soon as possible

Priority 2
Required to address issues which do not represent good practice

Priority 3
Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>At the previous audit the SBM stated that he received calls from other IT suppliers and the incumbent provider was cost effective. The management response to the previous audit disputed that choice should be determined by cost alone and reiterated the need for a quality IT support service dependent on the knowledge and commitment of individuals. The school should consider the following issues arising:-</p> <ul style="list-style-type: none"> • Included in the final report as an Internal Audit note – the agreement commencing September 2016 with a 90 day termination clause does not avoid EU tendering. • The cumulative spend with this contractor exceeds the EU threshold of £164,176 and should be subject to the appropriate competitive tendering. • Section 6 of the Financial Regulations for Schools sets out the procedures that must be complied with for contracts. The Invitation to Tender document would include the award 		

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>criteria, the cost/quality weighting and other relevant factors.</p> <ul style="list-style-type: none"> IT procurement is a critical area and includes consideration of ownership of data and processes and intellectual property rights of any software developed by the contractor for the school's use. The school must be able to demonstrate that appropriate controls have been put in place to mitigate these risks. 		

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p>Procedure Notes/Business Continuity</p> <p>At the start of the audit visit the SBM confirmed that he would be leaving at the end of the Autumn Term. During the fieldwork it was evident that there was limited collaboration between the SBM and the FM and they worked independently.</p> <p>There were no procedures notes available to document the strategic and operational procedures in the school. Similarly new processes such as on line payments were not supported by guidance notes. The FM had requested Finance staff to consider their daily routines and create brief practice notes.</p>	<p>Key financial procedures may not be sustained during periods of absence.</p> <p>Business continuity may be compromised when key officers leave the school.</p>	<p>The Finance Officers should complete the task of writing procedure notes for the financial processes to support business continuity.</p> <p>The school should review the strategic and operational procedures to ensure that the vacant SBM post does not impact on financial management and information to Governors.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
3	<p>Purchase Orders</p> <p>We saw email evidence that the FM and SBM had reminded all staff to raise Purchase Orders (PO) in advance of expenditure being committed.</p> <p>Our testing showed 5 instances where PO's had not been raised. These were :-</p> <ol style="list-style-type: none"> 1) Contractor B, paid 19/10/17, inv no IN2936, £21,084.62 2) Contractor C, paid 8/11/17, inv no 6687, £30,599.99 3) Contractor D, paid 2/11/16, inv no 524/16, £39,876.06 4) Contractor E, 3/5/17, paid 3/5/17, inv no ADVANTAGE, £40,229.43 5) Contractor F, paid 28/7/17, inv no 29420.4306.33, £13,988.20 <p>It transpired that these related to contracts being awarded following a tender process or approval of an annual service arrangement. In each instance the FM had not been made aware of the contract award and amount. Therefore no funds had been committed on the school's financial system.</p>	<p>Payments may not be made in compliance with Financial Regulations and the School's own procedures.</p> <p>The school is not aware of future payments, leading to a risk that the financial position of the school at any given time is not accurate.</p>	<p>The FM should be made aware of the full financial details when contracts are awarded and annual service arrangements are approved; this could be via the relevant Governor's minutes, e-mail, award documentation or PO.</p> <p>[Priority 2]</p>

Priority 1
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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
4	<p>Voluntary Fund</p> <p>The FM presents the voluntary fund accounts at each Finance Committee. The minutes of the 1st November meeting evidence that the total value of unrestricted funds was discussed by Governors and that the Clerk to Governors had confirmed the value of unrestricted funding held by the Foundation.</p> <p>The Schools Finance Team requests a copy of the certified audited accounts annually. As at October 2017, 2015/16 and 2016/17 were outstanding but were received in November prior to the Internal Audit visit. The certified accounts had been signed by the Chair of Governors and Head teacher but had not been reported to either the Finance Committee or Full Governing Body.</p> <p>It should be drawn to the attention of the Governing Body that the 2015/16 accounts detailed Section 13 “Related Party Transactions” stated that “no balances were outstanding to or from the Foundation at 31 March 2016” whereas the Foundation confirmed that the balances owing to the school had not been drawn down and were rolled over each year.</p>	<p>Governors are not informed of the financial position of the school.</p> <p>The accounts have not been independently verified and do not reflect the actual activity through the accounts.</p>	<p>The certified audited accounts for the Voluntary Fund should be presented to Governors.</p> <p>The school should confirm the inclusion of the statement for “Related Party Transactions” and clarify the statement relating to outstanding balances.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>There are no notes to the accounts for Related Party Transactions in the 2016/17 accounts.</p>		
5	<p>Block Grant Expenditure</p> <p>Examination of the bank history and payments to individuals identified expenditure that would be met by the Voluntary Fund or Foundation grant. The expenditure is shown separately on the “Block grant” ledger code, the reimbursement or transfer of funds is shown against the Income code I13 – “donations and/or voluntary funds”. This effectively overstates the expenditure and income codes for transactions that should not be met by the school fund.</p> <p>The processing of invoices and coding to “Block Grant” was based on historic knowledge and previous experience; the collection of income was not formalised during the year. There were no procedure notes to support the payment of block grant invoices or the recovery of income.</p>	<p>Inappropriate expenditure may be met by the school fund.</p> <p>Revenue budgets, income and expenditure are overstated and do not reflect school finances.</p>	<p>The FM should review all payments allocated to “block grant” and consider payment to be made from the voluntary fund or passing the invoices directly to the Foundation.</p> <p>[Priority 3]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
6	<p>Asset Register and Loans Book</p> <p>The asset registers were a comprehensive list of stock that is maintained by the faculty heads with a separate sheet for each item, signed by the responsible officer. The IT provider maintains a register for IT equipment.</p> <p>A sample of 3 invoices was selected from the bank history to test that the items had been updated on the asset registers. The iPads were traced to the faculty asset record but the lap top did not have sufficient details to identify the entry on the IT list.</p> <p>The school do not operate a loans book to record assets that are temporarily removed from site.</p>	<p>Assets lost or stolen may not be easily identified.</p> <p>A register of assets is not maintained and up to date. Assets are not kept secure.</p>	<p>For ICT equipment the receiving officer/budget holder should record the serial number of the item on the invoice to be able to cross reference to the asset register.</p> <p>The school should introduce a loans book to record items that are temporarily taken off site. It may be more appropriate to retain the loans books in the departments where this is likely to occur.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
7	<p>Contracts register and contracts status</p> <p>We noted that the contracts register had been presented to the Finance Committee for approval at the meeting held on 1 February 2017.</p> <p>From our analysis of the register and the information it contained, the main issues arising were that:-</p> <ul style="list-style-type: none"> • The SBM was responsible for the contracts register and as previously discussed had not been in consultation with the FM nor was this a document that the FM had access to. • The contracts register showed a record of past and current contractors, end dates, indicative costs and rolling contracts. The information recorded could be more comprehensive, for example the number of times that a contractor has been extended without competitive tendering. • The contracts register did not show any contracts due for renewal in the next 3 months. 	<p>Contracts may be let without following proper procedures and/or rolled over without proper approval.</p>	<p>The contracts register should be developed to incorporate the issues identified in this audit review; number of years that competitive tendering has been waived or a contract rolled over, indicative costs based on previous years expenditure, updated costs where the contract has been varied.</p> <p>The school should hold a signed copy of all contracts, available for inspection and any officer responsible for payment or monitoring.</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<ul style="list-style-type: none"> The contracts register was reported to the Finance Committee on the 1/2/17. The minutes record that the SBM <i>“highlighted the range of contractual arrangements.....Governors noted the list of contractual arrangements”</i> The annual cost of the contract with the school’s insurance broker is shown as £5,000 per annum. A total of £53,324 for insurance has however been paid to the broker for the period 1 April 2017 to 31 March 2018. The cost of the contract for the SIMS licences is shown on the contracts register as £6,577.50 per annum. The annual contract agreement provided to us by the School Business Manager shows however a total of £18,475.00. A total of £8,341.20 has been paid so far during this financial year. We were unable to evidence a copy of a formal contract for the catering service and the cleaning service. The contracts register shows that the catering service has been rolled over each year since January 2013 with no 		<p>The contract register is a “live” document that should be owned and updated regularly. The document should be used as a planning document and evidence action taken for each contract and the current status.</p> <p>[Priority 2]</p>

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Priority 1
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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>formal tender. It also shows an 'Expiry date/or last renewed' date of August 2015 for the cleaning contract although without evidence of a formal contract it is unclear if the contract was formally renewed.</p> <ul style="list-style-type: none"> The contract register also shows five other contracts which are 'subject to review' although it is unclear whether or not progress has been made reviewing these. 		

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
8	<p>HMRC – IR35</p> <p>From the bank history report (November 2016 to November 2017) there were 18 named individuals that had received payments. The FM had started to process the information held for certain payees and access the HMRC questionnaire, but at the time of our audit visit this was a work in progress. There was a range of tasks undertaken by these providers; one-off visits and regular service delivery but the school should be advised that the assessment should be carried out for all instances.</p>	<p>Non-compliance with HMRC regulations resulting in a financial penalty. As a voluntary aided school the Governors are the engaging Authority and the penalty would therefore have to be met by the school.</p>	<p>The school must complete an online questionnaire for all individuals providing services to the school or via an intermediary such as a Public Service Company or partnership. The completed questionnaire will need to be kept with the orders and invoice to support the payment.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
9	<p>Cash flow statements</p> <p>The FM confirmed that the cash flow statements had not been produced and the realistic target date would now be April 2018.</p> <p>The FM accepted that the need for a cash flow statement which is a requirement of “Scheme for Financing Schools December 2015” section 2.1.2 and the annual circular sent by the Bromley Schools Finance Team requesting “a cash flow analysis forecast for the financial year”</p>	<p>The school may not be aware of their ability to meet all liabilities</p>	<p>Ensure that cash flow statements are produced periodically and any variances to the projected cash flow are investigated and actioned.</p> <p>[Priority 2*]</p>
10	<p>Pecuniary Interests</p> <p>The FM confirmed that although a pecuniary interest template had been created for staff, the recommendation was still outstanding as the forms had not been distributed.</p> <p>The Clerk to the Governing Body provided a list of Governors as at the start of term in September 2017. Pecuniary interest forms had been completed for all.</p>	<p>Staff with financial responsibilities may be involved in making financial and/or business decisions relating to organisations which they have a pecuniary interest without the school knowing.</p>	<p>A form declaring pecuniary interests should be completed by each member of staff with financial and procurement responsibilities for the school.</p> <p>[Priority 2*]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
11	<p>Scheme of Delegation</p> <p>The previous Internal Audit report was discussed at the May 2017 Finance Committee. The minutes show that the SBM would produce a Scheme of Delegation and that he was trying to source a template.</p> <p>At this audit visit the FM did not have a copy of the Scheme of Delegation and was not aware that the SBM had taken a draft copy to the Governing Body meeting in June 2017. The FM should have access to the Scheme of Delegation as this document stipulates the financial limits for authorisation in the expenditure process.</p> <p>The Scheme of Delegation, agreed by Governors in June 2017, is ‘basic’ and does not include all the elements suggested in the template shown at Appendix 1 of the Schools’ Financial Regulations. There is no explanation of responsibilities or task specific roles; delegation is discussed in general terms, for example the Head and SBM having authority to “pursue additional opportunities to generate revenue for the school.”</p>	<p>Delegated duties and financial limits agreed by Governors may not be adhered to</p>	<p>The school should review the agreed Scheme of Delegation to reflect the changes in personnel.</p> <p>The scheme should be extended in line with the template shown at Appendix 1 of the Financial Regulations for Schools.</p> <p>The financial limits and the application of the authorisation controls should be revised in line with accepted practice.</p> <p>[Priority 2]</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>There were 4 invoice payments in the expenditure sample which were over £15,000. The invoices had not been authorised by the Finance Committee or Governing Body as set out in the school's Scheme of Delegation. The SBM opined that, as approval had already been given for these services (building refurbishments, extensions and annual insurance) at a previous meeting of the Finance Committee or Governing Body, they did not need to be referred for appropriate authorisation. The scheme should therefore be revised accordingly.</p>		

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
12	<p>Mock Tests</p> <p>The previous audit had raised the issue of the school receiving income from mock tests which seemed to conflict with the DfE guidelines regarding the admissions process. Last year, the SBM commented that the mock tests were organised by the PTA, including collection of income. The school received a donation from the PTA as with other fund raising activities. Audit examination of the income received by the school this year has shown that sample test papers are sold from the school reception on the open day and the income banked directly to the school account.</p> <p>Internal Audit has sought legal advice from the Borough solicitors to ensure that the school is acting within statutory guidelines and will update the school accordingly.</p>	<p>Failure to comply with DfE regulations</p>	<p>The school should confirm that the sale of sample test papers is within DfE guidelines.</p> <p>Priority 2</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
13	<p>Benefits in Kind</p> <p>It was noted that there are members of staff who receive private medical cover paid directly by the Foundation and that the Head Teacher resides in the Headmaster’s house on the school site with all costs met by the Foundation. The Chief Executive of the Foundation has advised Internal Audit that he writes to all recipients each April informing them of the amount they need to declare. However it is the responsibility of the employer to complete a P11D for each employee receiving a “benefit in kind”.</p>	<p>The school may incur financial penalties for non-disclosure of benefits in kind</p>	<p>The school are advised to consult with HR to ensure that all declarations have been made to HMRC in the correct format and in a timely manner as failure to comply will result in financial penalties.</p> <p>Priority2</p>

Priority 1
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Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
14	<p>Income Streams</p> <p>The school receives funding from three sources; the school budget share, voluntary fund and an annual grant from the Foundation. Given the recent focus on the school and concerns raised about spending it is important to clarify these income streams and the scope of this review. Internal Audit is concerned with the financial management and probity of the Government funds paid to the school, monthly, from Bromley. This funding is shown in the school accounts and the budget share is monitored by the Schools Finance Team at the Council.</p> <p>The voluntary fund receives income from parent’s monthly contributions and other donations to the school, the school visits are processed through this fund. In accordance with the DfE “Schemes for Financing Schools” statutory guidance “Audit of voluntary and private funds” (section 2.8) which states “<i>Authorities must not seek to impose through the scheme a right to audit such funds themselves or otherwise access the accounts of private funds</i>” Internal Audit does not check the operational management of the voluntary fund but do verify that the account is independently audited annually. It</p>	<p>The Governing Body may not be fully aware of the total financial resources, commitments and liabilities when making decisions.</p> <p>There may be a lack of transparency</p>	<p>For effective governance and decision making purposes the Governors should be aware of all funding available to the school; the source of that income should be clearly defined and any restrictions on spend or commitments presented.</p> <p>Priority 2</p>

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DETAILED FINDINGS

No.	Findings	Risk	Recommendation
	<p>is also verified that a copy of the certified accounts has been sent to the Schools Finance Team.</p> <p>The Foundation grant allocated to the school and any commitments from this grant is outside of the scope of Internal Audit.</p> <p>The Finance Committee and Governing Body minutes refer to all income streams in isolation but there is no summary document to inform Governors of the total funds available. For effective governance and decision making purposes the Governors should be aware of all funding available to the school; the source of that income should be clearly defined and any restrictions on spend or commitments presented.</p>		

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Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	The school should ensure that tenders are sought or a procurement framework process is undertaken now for the schools IT support, acknowledging that compliance with EU rules cannot be disregarded.	1	Initial discussions have already taken place with Contractor A and a meeting is being arranged between their CEO and the Acting Headmaster informing them that we intend to go to tender. The process of tendering will begin as soon as a SBM is appointed.	School Business Manager	When Appointed – April 2018
2	The Finance Officers should complete the task of writing procedure notes for the financial processes to support business continuity. The school should review the strategic and operational procedures to ensure that the vacant SBM post does not impact on financial management and information to Governors.	2	Underway Finance manager produced all the routine reports to the Finance Committee. Deputy Head has responsibility for LCVAP funding, contracts, Data Protection	Finance Manager Senior Leadership Team	Summer/ Autumn Immediate

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Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			Legislation. School has purchased support from Bromley's Exchequer Contractor for Human Resources and Finance to include software for budgeting and training for cash flow		
3	The FM should be made aware of the full financial details when contracts are awarded and annual service arrangements are approved; this could be via the relevant Governor's minutes, e-mail, award documentation or PO.	2	Procedures to be put in place to ensure information is passed to the Finance Manager in an appropriate and timely fashion.	School Business Manager	When appointed
4	The certified audited accounts for the Voluntary Fund should be presented to Governors.	2	These have been put before the Finance Committee on 31/1/18	School Business Manager	Ongoing

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	<p>The school should confirm the inclusion of the statement for “Related Party Transactions” and clarify the statement relating to outstanding balances</p>		<p>The school have been advised that the note regarding 3rd party transactions first appeared in the 2014/15 accounts when the Foundation paid the School, £250000 towards the new science laboratories. The note remained in the 2015/16 accounts as it related to the 2014/15 figures but it was removed from the 2016/17 report as no related transactions between the Foundation and the School had been made in either year’s figures per the Schools accounts. As the school is not a charity the sorp rules relating to the declaration of money held for the school by the Foundation do not apply. The accountants will make this clear in the Management letter to the 2017/18 accounts.</p>		

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 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	The FM should review all payments allocated to “block grant” and consider payment to be made from the voluntary fund or passing the invoices directly to the Foundation.	3	All payments made in Block Grant codes to be reviewed. All payments that are not curriculum related to be put through the Voluntary Fund	Finance Manager	From April 2018
6	For ICT equipment the receiving officer/budget holder should record the serial number of the item on the invoice to be able to cross reference to the asset register. The school should introduce a loans book to record items that are temporarily taken off site. It may be more appropriate to retain the loans books in the departments where this is likely to occur.	2	The IT Manager will put serial numbers on all ICT equipment invoices to enable cross reference to the ICT asset register. Departments to set up a system of loan books as and when items are taken off site.	IT Manager/ Finance Manager Acting Assistant Headteacher	Immediate and ongoing Immediate

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Priority 3
Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
7	<p>The contracts register should be developed to incorporate the issues identified in this audit review; number of years that competitive tendering has been waived or a contract rolled over, indicative costs based on previous years expenditure, updated costs where the contract has been varied.</p> <p>The school should hold a signed copy of all contracts, available for inspection and any officer responsible for payment or monitoring.</p> <p>The contract register is a “live” document that should be owned and updated regularly. The document should be used as a</p>	2	This will be part of the remit for the new School Business Manager	School Business Manager	When Appointed

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Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	planning document and evidence action taken for each contract and the current status.				
8	The school must complete an online questionnaire for all individuals providing services to the school or via an intermediary such as a Public Service Company or partnership. The completed questionnaire will need to be kept with the orders and invoice to support the payment.	2	Completed questionnaires will be held on file and can easily be cross referenced with the invoices relating to the individual or Public Service company.	Finance Manager	Immediate and ongoing
9	Ensure that cash flow statements are produced periodically and any variances to the projected cash flow are investigated and actioned.	2*	Bromley's Exchequer Contractor has been asked and has agreed to provide support and training	Finance Manager	Summer 2018

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Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
10	<p>A form declaring pecuniary interests should be completed by each member of staff with financial and procurement responsibilities for the school.</p>	2*	This has been done	Finance Manager	Immediate and then annually in September
11	<p>The school should review the agreed Scheme of Delegation to reflect the changes in personnel.</p> <p>The scheme should be extended in line with the template shown at Appendix 1 of the Financial Regulations for Schools.</p> <p>The financial limits and the application of the authorisation controls should be revised in line with accepted practice.</p>	2	This will be revised and resubmitted to the Finance Committee.	School Business Manager	When appointed

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Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
12	The school should confirm that the sale of sample test papers is within DfE guidelines.	2	The sale of the sample test papers will be taken over by the PA and become independent of the school. Also the school is waiting for further LA advice.	Deputy Headmaster	June 2018
13	The school are advised to consult with HR to ensure that all declarations have been made to HMRC in the correct format and in a timely manner as failure to comply will result in financial penalties.	2	The Foundation gives the private medical benefit to staff employed before a cut-off date and not the school. It is outside the scope of the School as an employer. The Foundation pays class 1A National Insurance contributions on the this benefit and writes to the staff annually to let them know the value of the benefit. It is the responsibility of the member of staff to declare the benefit in kind to HMRC. The Headmaster's House is not a benefit in kind it is a requirement		

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MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
			for work as per his contract. The Foundation have taken advice on this and will revisit this on the appointment of a new Headmaster.		
14	For effective governance and decision making purposes the Governors should be aware of all funding available to the school; the source of that income should be clearly defined and any restrictions on spend or commitments presented.	2	The Finance Manager produced a summary for the Finance Committee 31/1/18 showing the Schools available funding from all sources after restrictions and commitments had been accounted for. This will be further developed in discussion with Governors.	School Business Manager	When appointed

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
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 Identification of suggested areas for improvement

SCHOOLS OPINION DEFINITIONS

As a result of their audit work auditors should form an overall opinion on the extent that actual controls within the school provide reasonable assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level

Definition

Full Assurance

There is a sound system of control designed to achieve all the system and school procedures objectives tested.

Substantial Assurance

While there is a basically sound system and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the schools finances. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to Governors, material income losses.

Limited Assurance

Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.

No Assurance

Control is generally weak leaving the systems and procedures open to significant error or abuse.

INTERNAL AUDIT FINAL REPORT

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

**INTERNAL AUDIT REVIEW OF THE TROUBLED FAMILIES CLAIM
FOR THE PERIOD 1 APRIL 2018 TO 30 SEPTEMBER 2018**

Issued to: Rachel Dunley, Head of Service, Early Intervention & Family Support
Kokui Binns, Intelligence & Operations Lead
Neil Dilkes, Intelligence & Operations Co-ordinator

Cc Ade Adetosoye, Executive Director of ECHS and Deputy Chief Executive (final report only)
Janet Bailey, Interim Director of Social Care (final report only)
David Bradshaw, Head of Finance, ECHS (final report only)
Dave Hogan, Head of Audit

Prepared by: Principal Auditor

Date of Issue: 22 October 2018

Audit ref: ECHS/14/2018/AU

INTRODUCTION

1. This report sets out the results of our audit testing of a sample of individual claims for the claim period between 1 April 2018 and 30 September 2018.
2. We have agreed with the Early Intervention and Family Support Team that checks on a sample of individual claims will be carried out every six months, in September and March of each financial year. These compliance checks seek to confirm that the sample of individual claims to be submitted at the end of those periods meet the employment or significant and sustained criteria, enabling a claim to be made.
3. The Financial Framework for the Troubled Families Programme issued in January 2018 by the Department for Communities and Local Government (now the Ministry of Housing, Communities and Local Government) sets out the 'Principles for Internal Audit'. Following these principles, we selected a sample of 10% of claims submitted for the six month period commencing 1 April 2018. This was to ensure continuity of testing from the previous claim period.

METHODOLOGY

4. There were 84 individual claims closed between 1 April 2018 and 30 September 2018. Our sample for checking consisted of eight claims. Two of the claims examined were where a client had gained employment, enabling a claim to be made. The other six claims in our sample were where the Early Intervention and Family Support Team considered that the national and/or local criteria as set out in the London Borough of Bromley's Outcome Plan had been met and significant and sustained progress had been made, resulting in the family no longer being attached to the programme.

SUMMARY OF FINDINGS

5. Our review of these claims found that the two employment claims met the relevant criteria for a claim to be made and the six other claims showed evidence that significant and sustained progress had been made. We also confirmed that these families had not been claimed for previously under the Troubled Families programme.
6. We also confirmed that the total amount claimed for payment by results for the 84 individual claims submitted between the period 1 April 2018 and 30 September 2018 was £67,200. As a result of our testing there are no significant findings and there are no recommendations arising from this review.
7. Finally, we would like to thank all the staff contacted during this review for their help and co-operation.

FINAL INTERNAL AUDIT REPORT
ENVIRONMENT AND COMMUNITY SERVICES DEPARTMENT

REVIEW OF WINTER MAINTENANCE SERVICE AUDIT FOR 2018-19

Issued to: Garry Warner, Assistant Director (Highways)
Alistair Berry, Highways Project Engineer

Cc
(Final only) Nigel Davies, Executive Director, Environment and Community Services
Claire Martin, Head of Finance, Environment and Community Services and Corporate
Sarah Foster, Head of Performance Management and Business Support

Prepared by: Principal Auditor

Date of Issue: 17th October 2018

Report No: ECS/3/2018/AU

REVIEW OF WINTER MAINTENANCE SERVICE AUDIT 2018/19

INTRODUCTION

1. This report sets out the results of our systems based audit of the Winter Maintenance Service. The audit commenced in quarter two as part of the programmed work specified in the 2018/19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee.
2. The controls we expect to see in place are designed to minimise the department's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be corrected to assist overall effective operations.

AUDIT SCOPE

3. The scope of the audit was outlined in the Terms of Reference issued on 13th August 2018.

AUDIT OPINION

4. Overall, the conclusion of this audit was that Substantial Assurance can be placed on the effectiveness of the overall controls. Definitions of the audit opinions can be found in Appendix C.

MANAGEMENT SUMMARY

5. The Winter Maintenance Service formed part of the Minor and Reactive Works contract which, from 2010 until 30th June 2018 was operated by Contractor A. Its remit also included day to day reactive maintenance works including repairs to pot holes, footway maintenance and carriageway resurfacing. The recommendation for the award of the new contract for Highway Maintenance (Major and Minor), for a term of eight years from 1st July 2018 to Contractor B, was approved by the Executive on 20th April 2018. The audit covers a time period for which Contractor A was responsible for delivery of the contract and any references to 'the contractor' should be read as 'Contractor A' unless otherwise stated.
6. The Council has a responsibility under the Highway Act 1980 to maintain the highway. To assist in meeting this responsibility, a Winter Service is provided to allow, as far as reasonably practicable, for the safe movement of traffic on roads throughout

REVIEW OF WINTER MAINTENANCE SERVICE AUDIT 2018/19

the Borough at all times. In October 2003, Section 41A was added to the Act introducing a duty to ensure, as far as is reasonably practicable, that safe passage along a highway is not endangered by snow and ice.

7. National Guidance and recommendations for Winter Service delivery are detailed in Section 13 of 'Well-maintained Highways, Code of Practice for Highway Maintenance Management' and more recently Section B7 of the 'Well-managed Highway Infrastructure: A Code of Practice'.
8. The Winter Service normally operates for 21 weeks of the year; from the first week of November to the first week of April, although weather conditions may necessitate extending the season at either end from the first week of October and/or to the last week of April.
9. The Council's Priority carriageway treatment network, excluding Red Routes which are the responsibility of Transport for London, constitutes 196 miles (40%) of the Borough's carriageway network. The Secondary treatment routes and other locations, including a Tertiary network (steep inclines), cover a further 16% of the network. Salt bins are provided across the borough to allow local residents to assist in the winter service by spreading salt on carriageways and footways affected by snow and ice.
10. The Winter Service consists of two elements:-
 - Pre planned precautionary salting to prevent the formation of ice
 - Snow clearing and post treatment salting to melt snow and ice already formed.
11. Between 1st September 2017 and 31st August 2018, Contractor A was paid £187k for delivery of the Winter Maintenance Service, with the detail depicted in Table 1 below:-

Table 1

Cost Centre	Total Paid
Salting/Gritting/Carriageways/Footways	£110k
Snow Fences/Salt Bins	£18k
Standby/Training/ Annual Set Up	£59k
Total	£187k

REVIEW OF WINTER MAINTENANCE SERVICE AUDIT 2018/19

12. Our testing identified the following issues which we would like to draw to management's attention:-

Policy and Plan

- The Policy and Plan for 2017/18 contained out of date information in terms of the schools listed, an E mail In box which, whilst still open is not regularly monitored and post season reporting undertaken.

Public Liability Insurance

- Additional snow clearance support is provided by local farmers on pre determined routes as required. For one individual to whom payment was made for the 2017/18 season, whilst they had provided the name and address of their insurer, a copy of their Public Liability Insurance certificate could not be located.

SIGNIFICANT FINDINGS (PRIORITY 1)

13. There are no significant findings.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

14. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised at Appendix B.

ACKNOWLEDGEMENT

15. Internal Audit would like to thank all staff contacted during this review for their help and co-operation.

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
1	<p>Process and Procedures Whilst a Winter Service Policy and Plan was in place for the 2017/18 season, information contained therein was not up to date in terms of school listed, E mail addresses monitored and post season reporting undertaken.</p> <p>i) The list of schools did not contain all those open at the beginning of the 2017/18 season or reflect changes of name which have taken place.</p> <p>ii) Guidance used by the Customer Service Centre to respond to queries received in relation to the Winter Service includes an E mail address which, whilst still open, is not regularly monitored.</p> <p>iii) Paragraphs 2.10 (Policy Statement) and 3.16 (Operational Plan) are both headed up 'Performance Monitoring' and contain conflicting information as to how often reports will be produced on the performance of the Winter Service operation, for whom, and the areas to be covered.</p>	<p>Out of date information within the Winter Service Policy and Plan may lead to:-</p> <p>i) Inequity of School footway access areas treated</p> <p>ii) Correspondence received via E mail not being actioned in a timely manner</p> <p>iii) End of season reporting not being carried out as stated.</p>	<p>A review of the Winter Service Policy and Plan should be undertaken ahead of the 2018/19 season ensuring that all elements of the document reflect the up to date position.</p> <p>Priority 2</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

DETAILED FINDINGS

No.	Findings	Risk	Recommendation
2	<p><u>Public Liability Insurance</u> Additional snow clearance support is provided by local farmers on pre determined routes as required. For one individual to whom payment was made for the 2017/18 season (£945), whilst they had provided the name and address of their insurer, a copy of the Public Liability Insurance certificate could not be located.</p>	<p>In the event of a claim being received, lack of recourse to a Contractor’s Public Liability Insurer would increase the Authority’s financial exposure.</p>	<p>A copy of the Public Liability Insurance Certificate, covering the whole of the time period for which the Winter Service may be operational, should be held on file.</p> <p>Priority 2</p>

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
 Required to address issues which do not represent good practice

Priority 3
 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	<p><u>Process and Procedures</u> A review of the Winter Service Policy and Plan should be undertaken ahead of the 2018/19 season ensuring that all elements of the document reflect the up to date position.</p>	2	<p>The policy and plan will be updated;</p> <p>i) list of schools to be updated</p> <p>ii) reference to ESD winter service review email to be removed</p> <p>iii) ESD winter service review email account to be closed</p> <p>iv) end of season reporting to be as required</p>	<p>Highway Area Manager & Neighbourhood Manager</p> <p>Highways Project Engineer</p> <p>Assistant Director, Highways</p> <p>Highways Project Engineer</p>	<p>1st Nov 2018</p> <p>1st Nov 2018</p> <p>1st Nov 2018</p> <p>1st Nov 2018</p>

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 Identification of suggested areas for improvement

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	<p><u>Public Liability Insurance</u> A copy of the Public Liability Insurance Certificate, covering the whole of the time period for which the Winter Service may be operational, should be held on file.</p>	2	Confirmation of public liability insurance to be obtained from all farmers employed of winter service	Highways Project Engineer	1 st Nov 2018

Priority 1
 Required to address major weaknesses and should be implemented as soon as possible

Priority 2
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Priority 3
 Identification of suggested areas for improvement

OPINION DEFINITIONS

APPENDIX C

As a result of their audit work auditors should form an overall opinion on the extent that actual controls in existence provide assurance that significant risks are being managed. They grade the control system accordingly. Absolute assurance cannot be given as internal control systems, no matter how sophisticated, cannot prevent or detect all errors or irregularities.

Assurance Level	Definition
Full Assurance	There is a sound system of control designed to achieve all the objectives tested.
Substantial Assurance	While there is a basically sound systems and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a priority one recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.
Limited Assurance	Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are priority one recommendations considered to be fundamental control system weaknesses and/or several priority two recommendations relating to control and procedural weaknesses.
No Assurance	Control is generally weak leaving the systems and procedures open to significant error or abuse. There will be a number of fundamental control weaknesses highlighted.

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