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DATE: 10 October 2019

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Thursday 17 October 2019

QUESTIONS ON THE INFORMATION BRIEFING

The Briefing comprises:

11 REVIEW OF ECHS CAPITAL SCHEMES (Pages 139 - 148)

12 REVIEW OF FOSTERING (Pages 149 - 156)

13 REVIEW OF LICENSING (Pages 157 - 168)

14 POST IMPLEMENTATION REVIEW OF THE LIBRARIES CONTRACT (Pages 169 - 176)

15 REVIEW OF STARTERS AND LEAVERS (Pages 177 - 192)

16 REVIEW OF WORKFORCE PLANNING AUDIT (Pages 193 - 202)

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

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FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

Issued to:	**Kim Carey, Interim Director of Adult Services**
	Tricia Wennell, Head of Assessment and Care Management
	Colin Lusted, Head of Service, Complex and Long Term Commissioning
	Kelly Sylvester, Head of service, Community Living Commissioning
	Naheed Chaudhry, Assistant Director Strategy, Performance and Corporate Transformation
	James Mullender, Head of Finance Adult Social Care Health and Housing
Prepared by:	**Assistant Manager and Senior Manager (for LBB Internal Audit)**
Reviewed by:	**Principal Auditor and Head of Audit and Assurance**
Date of Issue:	**2nd September 2019**
Report No.:	**ECHS/01/2019/AU**

REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

INTRODUCTION

1. This report sets out the results of our audit of Adults Health and Social Care Integration. The audit was carried out as part of the work specified in the 2019-20 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. We would like to thank all staff contacted during this review for their help and co-operation.
3. The Health and Social Care Act 2012 resulted in the creation of Health and Wellbeing Boards, which were tasked with increasing the integration of health and care services. The Care Act 2014 then placed a duty on local authorities to promote the integration of care and support services with health services.
4. Corporate Risk No.3, recorded on the Council's Corporate Risk Register (as at April 2019), has two elements: *'Failure to achieve partial implementation of Health and Social Care Integration'* and *'Plans are not in place to deliver partial integration by 2020'*. The impact of non-achievement would be that the Council may fail to deliver its statutory duties or fail to achieve its priorities.
5. The audit therefore looked to review the key controls linked to the risks identified in the Corporate Risk Register around the management of ECHS Health and Social Care Integration. This was a high level (strategic) review of the existing controls in place, used to help provide assurance over the achievement of statutory duties, including secure joint working across the Health and Social Care economy (particularly looking at the use of Delayed Transfer of Care (DToC), Better Care Fund (BCF) and Improved Better Care Fund (iBCF)).
6. The BCF grant is ring fenced for the purpose of pooling budgets and integrating services between Clinical Commissioning Groups (CCGs) and local authorities, for the benefit of local residents using health and care services. The Council's BCF Plan for 2017-19 has annual budgets for BCF schemes of £22.125m for 2017/18 and £22.670m for 2018/19.

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference issued on 25 April 2019.

8. The following were considered to be the key risks inherent to Adults Health and Social Care Integration:

- In the absence of clear Implementation Plans and/or Strategies, agreed with partners such as the Bromley Clinical Commissioning Group (CCG), the Council may experience difficulties in achieving the rapid change required in a system as complex as Health and Social Care.
- If the Council fails to work effectively with health partners to deliver the main transformation programmes (per the Council's Risk Register), there is an increased risk that the Council may not adapt effectively to the rising social care costs caused by an ageing population and people living longer with increasingly complex needs.
- If the Council does not embed effective governance mechanisms to control and manage its integration strategy (such as through the activity of the Integrated Commissioning Board (ICB)), there is an increased risk that the Council may have difficulties in agreeing budgets (given the likely funding reductions going forward) and embedding complex governance arrangements and/or workforce planning structures.
- If the Council fails to think and work collaboratively, there is an increased risk that cultural differences may materialise, which prevents the implementation of the intended levels of integration. This could also result in an inability to respond to the pressures being placed on Social Care, which expect services to be made accessible seven days a week (both in terms of the Council's own workforce and in respect of its contracts with external providers).
- There is an increased risk that the Council may not have access to the resources it needs, to effectively deliver the services it is responsible for, if it does not engage with system reviews designed to help ensure that funding follows the patient.

REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

AUDIT OPINION

9. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**4**	**0**

SUMMARY OF FINDINGS

10. Controls noted to be in place and working well, based on the audit testing conducted, included:

- A Bromley Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in November 2018.
- An Integrated Commissioning Board with formal Terms of Reference meets every two months.
- The Integrated Commissioning Board has a detailed work programme and receives regular reports on progress made on completion of tasks.

- The Health and Wellbeing Board receives quarterly performance reports for Better Care Fund and Improved Better Care Fund workstreams, which include updates on integration of health and social care and detailed budget monitoring information.
- Integrated Care Networks (ICNs) have been in place in Bromley since 2016, enabling shared health and social care services to be delivered to individuals by local multi-disciplinary teams.
- Bromley CCG is leading the One Bromley Partnership, which consists of local health providers, Bromley Council and representation from the voluntary sector. The partnership is designed to deliver seamless joined-up services to individuals.
- Bromley Council and Bromley CCG are developing an integrated commissioning unit, which covers joint procurement arrangements, sharing of expertise, service development, oversight of quality and safety and performance management (to be in place by April 2020).
- The Council and Bromley CCG are working on a 'digital roadmap' in conjunction with other local authorities and CCGs in south east London to enable care records for individual service users to be viewed by all health and social care professionals.

11. We would like to bring to management attention the following issues:

- Outstanding actions in the superseded 2020 Bromley Action Plan need to be transferred to the Integrated Commissioning Board's Work Programme.
- The draft Joint Mental Health and Wellbeing Strategy was not approved by the Council's Adult Care and Health Policy Development and Scrutiny Committee because more work needed to be done in several areas (e.g. interface with Child and Adolescent Mental Health Services and accessing of services by people with limited access to the internet).
- Performance statistics for ICNs reported to the Health and Wellbeing Board for 2018/19 did not relate to agreed performance indicators and require further development.
- The latest revised version of the Section 75 Agreement between Bromley Council and Bromley CCG (which governs the administration of the pooled fund for integrated services) has not yet been signed off.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

12. 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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

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REVIEW OF REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

DETAILED FINDINGS AND ACTION PLAN

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	<u>2020 Bromley Action Plan</u> The draft Bromley 2020 Integration Strategy contained a detailed action plan. It was established that the Strategy has not been formally adopted by Bromley Council and Bromley CCG and is now out of date. However, the Bromley 2020 Action Plan contains actions, which do not appear in any other action plan and still appear to be valid (e.g. completion of a self-assessment against the vision for integration and objectives for health and social care integration, and production of a workforce development plan).	Where actions identified as necessary are not carried out in a timely manner, there is a risk of failure to achieve objectives.	Outstanding actions in the 2020 Bromley Action Plan, appended to the superseded Bromley 2020 Integration Strategy, should be transferred to the Integrated Commissioning Board's Work Programme. **Priority 2**	The launch of the Self-assessment was postponed from the last ICB as key officers were on leave. This item is on the next agenda for the meeting on 16th September. Workforce development plan to be considered when new Director of Integrated Commissioning is in post – target date January 2020 subject to member approval.	16th September 2019 to launch – Assistant Director Strategy. Performance and Corporate Transformation February 2020 – Director of Integrated Commissioning
2	<u>Joint Commissioning Strategies</u> A draft Joint Mental Health and Wellbeing Strategy was submitted to Bromley's Adult Care and Health and PDS Committee for approval on 7th March 2019, but was not	Where joint commissioning strategies are produced without sufficient consultations with groups of service users and elected	The development of future joint commissioning strategies should involve increased consultations with groups of service users and elected members. **Priority 2**	Task and finish group set up by Bromley's Adult Care and Health PDS due to meet for final time on 4.9.19. Final report to be signed off at PDS on 17.9.19.	17th September 2019 Head of Service,Complex and Long Term Commissioning

REVIEW OF REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

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DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	approved due to concerns about lack of clarity in certain areas including: • Interface between Adult Mental Health Services and Child and Adolescent Mental Health Services (CAMHS); • Re-entry of service users who do not permanently recover; • Cultural and language barriers experienced by people in minority communities trying to access services; and • Access to services by people who have limited access to the internet. Comments made by members of the Committee highlighted a lack of public consultation and stakeholder engagement and a lack of involvement by members in the production of the draft strategy.	members, there is a risk that they will not be fit for purpose.		Further engagement with those with living experience and key stakeholders to inform the development of the action plan that falls out of the Strategy.	

REVIEW OF REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

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DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	Integrated Care Networks The quarterly Better Care Fund performance reports to the Health and Wellbeing Board for 2018/19 included statistics for Integrated Care Networks, but they were activity statistics, which did not relate to any performance indicators. For example, the report for Quarters 3 and 4 of 2018/19 refers to a "speedier response to referrals and assessment and turnover of cases" (paragraph 4.93), but the statistics in paragraph 4.94 do not cover the timeliness of responses to referrals and assessments of cases. It is noted that work on developing performance management systems for Integrated Care Networks is currently ongoing.	Where performance statistics for Integrated Care Networks do not include comparisons with targets, there is a risk that the effectiveness of Integrated Care Networks will not be clearly established.	Performance statistics for Integrated Care Networks submitted to the Health and Wellbeing Board should include comparisons of actual performance with targets. **Priority 2**	To be addressed at next reporting round.	Quarter 3 2019/20 Head of Service, Community Living Commissioning

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REVIEW OF REVIEW OF ADULTS HEALTH AND SOCIAL CARE INTEGRATION

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
4	Section 75 Agreement The Section 75 Agreement between the Council and Bromley CCG is due to be refreshed every Autumn, but it was established that the latest refreshed version of the Agreement had not yet been formally signed off by the two parties.	Where the current signed version of the Section 75 Agreement is out of date, there is a risk that any disputes between the two parties may not be resolved in an efficient and effective manner.	The latest revised version of the Section 75 Agreement between the Council and Bromley CCG should be signed off in a timely manner. **Priority 2**	To be signed off by Director of Adults and Chief Officer of CCG.	September 2019 Director of Adult Services

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DEPARTMENT

AUDIT REVIEW OF CREDITORS 2018/19

Issued to:	**Claudine Douglas-Brown, Assistant Director Exchequer Services** **Emma Richardson, Head of Financial Systems** **Lucinda Bowen, Head of Information Management**
cc	**Peter Turner, Director of Finance**
Prepared by:	**Senior Manager, (Audit contractor on behalf of London Borough of Bromley) and Senior Manager, (Audit contractor on behalf of London Borough of Bromley)**
Reviewed by:	**Principal Auditor and Head of Audit and Assurance**
Date of Issue:	**30 September 2019**
Report No.:	**CEX/08/2018/AU**

AUDIT REVIEW OF CREDITORS

INTRODUCTION

1. This report sets out the results of our audit of creditors. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Council's Exchequer contractor is contracted to provide the creditors service, which is delivered using the Oracle E Business Suite (EBS) (includes the iProcurement (or iProc) module and VersionOne). Information is also extracted from a number of Council maintained systems and MS Access databases to produce and validate payment requests for various services and petty cash reimbursements.
3. The Contract and Operations Team monitor the service provided by the Council's Exchequer contractor, as well as running various exception reports, such as the check for duplicate payments, and publishing the Council's expenditure for payments over £500 on the Council's website.
4. Support for the Oracle EBS, including user administration, is provided by the Financial Systems Team.
5. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference and the following were considered to be the key risks inherent to the creditors' process:
    - Payments may be made for goods and services which have not been received.
    - Regular duplicate payment monitoring may not be undertaken and the results may not be actioned.
    - The creation, amendment and deletion of creditors master-file data may not be properly controlled.
    - iProc authority levels for the payments of goods and services may not be set and in line with Financial Regulations.
    - The number of retrospective iProc orders raised may not be identified and addressed.

AUDIT REVIEW OF CREDITORS

- Set-up / amendment forms for the creditors' Masterfile may not be completed with a segregation of duties, or with an appropriate level of authority.
- The custody and handling of blank cheques may not be secure and properly controlled.
- The ledger control account may not be reconciled to the creditors' control account.
- Payments may not be accurate or goods may not be received which may lead to refunds.

AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Limited Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
1	5	2

SUMMARY OF FINDINGS

8. Controls noted to be in place and working well, based on the audit testing conducted, include:

- The Council's Financial Regulations and Procedures clearly detail the required procurement processes.
- The respective teams, namely the Contract and Operations Team, the Financial Systems Team and the Council's Exchequer contractor have procedural guidance and checklists in place.

AUDIT REVIEW OF CREDITORS

- A Service Level Agreement (SLA) is in place with the Council's Exchequer contractor for the service provided.
- All the suppliers sampled were set up on iProc / Oracle upon receipt of appropriately completed forms and the setup and amendment of these suppliers was subject to a double check process.
- Checks are in place to help prevent and detect duplicate payments.
- Appropriate batch controls, including a supervisory check, are in place for the processing of invoice payments.
- Payments over £500 are published on the Council's website as required.
- Invoices, or other appropriate supporting documents, are scanned and retained for all the transactions sampled to support the payments made.
- Regular reconciliations of the creditors' control account are being undertaken.
- Monthly performance reports are being received from the Council's Exchequer contractor, in line with the agreed SLA.
- Appropriate security over manual cheques is in place.

9. We would like to bring to management attention the following issues:

- The supplier set up forms do not include a privacy statement and appropriate bank mandate checks are not in place.
- Authorised signatory forms are not properly completed and staff no longer engaged by the Council have not been removed from the listing.
- Users to the iProc module / Oracle system are being set up without reference to the authorised signatory list.
- We found that some orders were being raised retrospective to the invoices being received for payment and, although recommended in the previous audit report, reports of retrospective orders are not being run regularly.
- Transactions paid by the AP1 process do not meet the criteria specified in paragraphs 6.7 (i), (ii) and (iii) of Financial Regulations. It could not be demonstrated that these were exceptions as agreed by the Director of Finance because a list of such agreed exceptions was not readily available to the Council's Exchequer contractor.

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- The remittance advice printed and posted to suppliers in respect of 'CareFirst' type payments detailed client names. As these are sent by post to suppliers there is the risk of a data breach.
- There is no evidence that vacation rules are being applied to enable staff who are out of the office for a period of time to have their Oracle notifications and financial approval responsibilities assigned to a colleague.
- The guidance available on One Bromley for the use of iProc could be improved and there are no scheduled courses to train staff on iProc. We were informed that these would be provided if requested.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

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AUDIT REVIEW OF CREDITORS

DETAILED FINDINGS AND ACTION PLAN

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	Supplier set up procedures Please see the detailed findings set out at Appendix C to this report.	The Council is exposed to a number of risks, including those of inappropriate suppliers being set up and of mandate fraud.	Management should : (i) critically review the supplier set up process and (ii) in the interim, and as a matter of urgency, put processes in place to conduct robust bank mandate checks. **Priority 1**	The supplier set up process has been reviewed and the recommended changes have been implemented.	Assistant Director Exchequer Services Completed
2	Retrospective Orders The 2015/16 and 2017/18 internal audit reports both identified an issue with orders being raised retrospectively and recommended that a retrospective Purchase Orders report should be run on a regular basis. We confirmed with the Assistant Director Exchequer Services that the required report had not yet been formulated and thus the recommendation was not yet	Where purchase orders are raised retrospectively to invoices, the authorisation requirements are being bypassed and there is a risk that inappropriate purchases are made.	A retrospective Purchase Orders report should be run on a regular 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. **Priority 2**	A retrospective Purchase Orders report will be run twice a year in October and March and the results will be provided to the Directors.	Contract and Operations Manager (Exchequer) 31 October 2019

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	actioned. Testing of a sample of payments identified for two of the six instances where iProc orders were raised, that these were retrospective (namely for order numbers 4208914 and 4209805)				
3	<u>Remittance advice</u> The Data Protection Act (DPA) 2018 requires that personal information is appropriately safeguarded and allows the Information Commissioner to levy significant fines for data breaches. We established that for all payments processed via CareFirst a remittance advice is printed and posted to the relevant care providers, which they are required to confirm and return. Subsequent payments to care providers will	There is a risk of a data breach and the Council consequently being fined under GDPR.	Management should ensure that : (i) The remittance advice for payments processed via CareFirst is amended to not detail personal information, (i.e. include a reference number instead of a client's name) and (ii) a more secure method of communicating the remittance advice between the Council and to the provider is put in place. **Priority 2**	A request has been made for the system provider OLM to amend the current remittance advice report to replace the full name with the client's initials. This is a standard report used by other OLM customers and we are waiting for a response from OLM regarding our options. In the meantime we will explore with IT Services whether the remittance advices can be processed between the Council and the providers by a more secure communication method	Assistant Director Exchequer Services and Head of information Management 31 October 2019

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	not be processed unless these remittances are returned. However, examination of a sample of remittance advices established that these detailed the client names.			i.e. secure email address. The specification for the replacement social care case management system will address the matter of GDPR compliance.	
4	Authorised Signatory List The Council's Financial Procedures paragraph 5.9 states that, '… The completed authorised signatory form should be forwarded to Accounts Payable (Resources Department) for them to hold in their records. Any changes should be notified immediately that they occur and not as a result of an update requested by Accounts Payable Department.' Examination of the completed	There is a risk that staff that have left the Council are still able to authorise transactions and that staff may be able to authorise transactions with a higher value than they should be able to.	Management should ensure that 'Corporate Authorised Signatories' forms should not be processed unless fully completed. **Priority 2**	The Council's Exchequer contractor has been reminded that any Authorised Signatories forms that have not been fully or accurately completed should be rejected. The Council's Exchequer contractor will now receive a monthly list of employees who have left the authority and will update the Authorised Signatory list.	Assistant Director Exchequer Services Completed

AUDIT REVIEW OF CREDITORS

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	'Corporate Authorised Signatories' forms for a sample of 5 staff added to the Council in 2019 found that 3 of these forms did not detail the financial limit delegated. It was explained that, unless the signatory form was for an Assistant Director or Director, that the maximum allowable delegated amount of £99,999 would be applied. Examination of the authorised signatory database for a sample of 27 staff that had transferred to Amey from the Council found that 17 of these staff were still on the Council's authorised signatory list - We are aware that this is also being addressed separately through recommendations about the process for the timely removal of leavers made in the audit of 'starters and leavers'.				

AUDIT REVIEW OF CREDITORS

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
5	Access to Oracle / iProc In order to obtain access to Oracle / iProc), staff are required to complete the 'New iProc User' form. We established that the staff who process the 'New iProc user' forms and set new users up on the system do not have access to or sight of the Council's authorised signatory list. For two of the sample of new users examined, the iProc limits assigned differed to the authorised signatory list delegated limit, (in both cases the iProc limit was far less). Furthermore, examination of the user accounts for a sample of five staff who had moved to Amey from the Council found that three of these users were still enabled, although assurances were provided that these users would not be able to access the system - We are	There is a risk that staff who are not on the Council's authorised signatory list obtain access to Oracle, staff remain set up on iProc after they have left the Council, or that the financial limits applied are not in accordance with those detailed in the authorised signatory list.	Management should ensure that: (i) new iProc users or changes to iProc user accounts should only be set up and processed if in accordance with the Council's authorised signatory list and (ii) the iProc accounts of staff who have left should be properly disabled. **Priority 2**	We will ensure that new iProc user accounts or changes to existing users' accounts are set up and processed in line with the Council's authorised signatory list. When a user's Oracle account is disabled, this action also disables the iProc access of their Oracle account, meaning that they no longer have ability to raise or approve orders. Their iProc set up however remains on the system until it is disabled separately. We will therefore identify all former employees who still have iProc set up on the system and disable it.	Head of Financial Systems 31 October 2019

AUDIT REVIEW OF CREDITORS

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	aware that this is being addressed separately through recommendations about the process for the timely removal of IT access for leavers made in the audit of 'starters and leavers'.				
6	Use of AP1 payment forms The Council's Financial Regulations and Procedures paragraph 6.4 details that, 'All orders should be raised on the iProc system. Where this is not possible, unique pre-numbered official hard copy orders should be raised, any exceptions should be agreed by the Director of Finance'; and paragraph 6.7 details that, 'An official order, or its equivalent, must be raised for all goods, works and services except where one or more of the following apply: (i) Where a specific formal	There is a risk that transactions are processed on AP1's rather than as required on iProc.	The use of AP1 payment forms to process transactions that do not meet the criteria specified in Paragraph 6.7 (1), (ii) and (iii) of the Financial Regulations and Procedures should be critically reviewed. A list of exceptions as agreed by the Director of Finance should be made available to the Council's Exchequer contractor staff to enable them to manage the use of AP1's. **Priority 2**	A list of exceptions as agreed by the Director of Finance will be made available to the Council's Exchequer contractor staff to enable them to manage the use of AP1's. Any that do not comply with Financial Regulations will be returned to the certifying officer.	Assistant Director Exchequer Services 31 October 2019

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	contract exists which does not incorporate any facility for the regular draw-down of services; (ii) Rents, business rates, council tax and utility services as supplies of a continuous and obligatory nature; (iii) Petty cash payments.' Examination of a sample of AP1 batches identified instances where payments were being made that did not meet the criteria specified in Paragraph 6.7 (i), (ii) and (iii) of the financial procedures. It could not be confirmed by the Council's Exchequer contractor staff whether these transactions were exceptions as agreed by the Director of Finance, as they did not have access to any listing of agreed exemptions.				

AUDIT REVIEW OF CREDITORS

DETAILED FINDINGS AND ACTION PLAN

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
7	<u>iProc guidance and training</u> We confirmed that general guidance on procurement is available in the Council's Financial Regulations and Procedures and that relevant forms are readily available on the One Bromley SharePoint site (i.e. AP1, AP2, authorised signatory and supplier set up forms). However, there is a lack of general guidance on the use of iProc or links to other relevant guidance, (for example HMRC self-employed and IR35 rules or the Council's tender and quote requirements, although we are aware that the Council's Financial Regulations and Procedures and Contract Procedure Rules are currently being reviewed). It was also confirmed that training on the use of the iProc system would be provided if	There is a risk that staff may not comply with the required iProc procedures.	Management should review the general guidance and training available to staff on the use of iProc, to help ensure that staff comply with expected controls and achieve desired objectives. **Priority 3**	We will liaise with the Assistant Director Governance & Contracts because the governance of iProc was the responsibility of the previous Head of Corporate Procurement. Appropriate guidance and training will then be put in place.	Head of Financial Systems 30 November 2019

AUDIT REVIEW OF CREDITORS

DETAILED FINDINGS AND ACTION PLAN

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No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	requested. There was, however, no scheduled training available.				
8	Vacation rules Oracle allows vacation rules to be set whilst staff are out of the office for a period of time, which allows them to delegate to another person to receive their Oracle notifications and approval responsibility. However, when delegated to more junior members of staff, this allows the authorised signatory delegated limits to be by-passed. Management were not able to confirm whether vacation rules were enabled or not.	There is a risk that authorised signatory delegated limits may be by-passed.	Management should confirm whether vacation rules are enabled or not and controls should be put in place to ensure that authorised signatory delegated limits are not by-passed. **Priority 3**	We will explore the option of putting in place vacation rules and examine what controls can be put in place to ensure that authorised signatory delegated limits are not by-passed.	Head of Financial Systems 30 November 2019

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Recommendation 1 – detailed findings

Supplier set up procedures

The Accounts Payable Service Level Requirements document, dated June 2016, between the Council and the Service Provider, i.e. The Council's Exchequer contractor paragraph 1.1.16 details that, 'The Service Provider will process requests to set up new suppliers and to amend existing suppliers' details…'.

In order for new suppliers to be set up or be amended, a 'Supplier Setup / Amendment Form' is required to be completed, section 1 by the relevant Council Service and sections 2, 3 and 4 by the supplier. As new suppliers may include individuals, who are providing personal data, the form should include a suitable 'privacy statement' to comply with the transparency requirements of the Data Protection Act 2018. It does not, however, include this.

Upon receipt of the completed form and after checking to confirm that the supplier does not already exist, the 'Supplier Management' Team within the Council's Exchequer contractor will set up the new supplier.

The 2017/18 internal audit report on creditors included a Priority 1 recommendation that 'before the supplier Setup / Amendment form is processed, it is checked and authorised by a budget holder or other designated manager'.

This check is not evidenced and, with a number of completed 'Supplier Setup / Amendment Forms' being e-mailed directly from suppliers to the 'Supplier Management' Team, the check does not occur in a number of cases.

Furthermore, with a lack of guidance to budget holders or designated managers, it is uncertain whether these officers are aware of the requirement to check completed 'Supplier Setup / Amendment Forms', or if they did so, what to check.

Where the supplier is VAT registered, this will be checked to the European Commission Taxation and Customs Union regulations and where the supplier is CIS (Construction Industry Scheme), the Unique Tax Reference and the Company Number will be checked by the 'Supplier Management' Team.

We found that no further checks, including those to verify the bank account details being provided, are conducted.

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FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

Issued to:	**Kim Carey, Director of Adult Services** **Laurence Downes, Assistant Director Governance and Contracts** **Tricia Wennell, Head of Service, Assessment and Care Management** **Wendy Norman, Head of Service Contract Compliance and Monitoring** **Ruth Wood, Head of Service, Placements and Brokerage** **Kelly Sylvester, Head of Service, Early Intervention, Prevention and Community Service Commissioning** **Naheed Chaudhry, Assistant Director Strategy, Performance and Corporate Transformation** **James Mullender, Head of Finance Adult Social Care, Health and Housing** **Claudine Douglas-Brown, Assistant Director, Exchequer Services**
Prepared by:	**Principal Auditor and Senior Manager (for LBB Internal Audit)**
Reviewed by:	**Principal Auditor and Head of Audit**
Date of Issue:	**23rd September 2019**
Report No.:	**ECHS/3/2018/AU**

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

INTRODUCTION

1. This report sets out the results of our audit of Adults Social Care (ASC) Domiciliary Care Contract Management. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. We would like to thank all staff contacted during this review for their help and co-operation.
3. Domiciliary care is provided to people who still live in their own homes, but who require additional support with household tasks, personal care or any other activity that allows them to maintain their independence and quality of life.
4. It was noted as part of audit scoping that the Council is currently considering whether its existing 'Framework' contract arrangement is working in practice, and whether it considers there to be a need to adopt a different model in future years. It was advised that capacity within the team is potentially an issue when the Council uses a higher number of domiciliary care providers. The ability to monitor, and improve, quality may therefore be better served if economies of scale could be obtained (potentially achieved through using a model with fewer providers). Such forward thinking is currently underway with a view to implementing a new approach by September 2021. The long-term vision is to refocus the provision of domiciliary care in line with the Care Act 2014, which requires developing a local approach to preventative support. Each local authority must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. Future changes may see a move towards a more 'incentive based' relationship with providers, with greater emphasis on the 'prevention' element (linked to the NHS Long Term Plan and Prevention Agenda), with use of tools such as 'telecare' (the use of technologies such as remote monitoring and emergency alarms to enable the unwell, disabled, or elderly to receive care at home so that they can live independently).
5. Whilst the above is forward looking, the focus of this audit fieldwork has been to review the system / processes that the Council currently has in place (the audit remains backwards looking per the standard Internal Audit methodology).

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 16 April 2019.

7. The audit objective was to review the key controls around the existing domiciliary care contract management, including the governance and management of the contracts, to provide assurance as to whether the controls are satisfactory to mitigate the risks in this area. We examined the controls in place to mitigate the impact of the key risk areas highlighted below. Controls relating to corporate and departmental risks were examined where applicable. Our audit included a review of relevant documentation, interviews with key officers and testing of related procedures and processes.

8. The following were considered to be the key risks inherent to the Domiciliary Care Contract Management process:

- Where a contract for the provision of domiciliary care is not in place and signed by all parties there is a risk that, if disputes arise, they cannot be easily resolved. Furthermore, it may mean that the contract cannot be easily monitored to ensure that an appropriate service is being delivered.
- Where a contract specification is not in place, there is an increased risk that planned domiciliary care work may not be carried out, or may not be completed to the required standard.
- Where variations to the contract are not signed-off by both parties, there is an increased risk that disputes could arise.
- Where ordering, payment and reconciliation for works is not carried out effectively, there is a risk to the Council that care work may not be carried out by the contractor but the Council is still paying for it.
- Where performance is not monitored (including through customer feedback), there is a risk that the contractor may not carry out their duties in line with the contract. In turn, this could lead to both reputational and financial loss.
- Where budgets are not monitored effectively, there is an increased risk that more money could be spent than is available. Where management are unaware of the performance of the contract, there is a risk that the contract may be underperforming without the ability to take effective and timely mitigating actions.

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

AUDIT OPINION

9. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Limited Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
1	2	2

SUMMARY OF FINDINGS

10. Controls noted to be in place and working well, based on the audit testing conducted, included:

- There are two types of domiciliary care service provider contracts in place; spot contracts and framework contracts. Providers on spot contracts are expected to be used on an ad-hoc basis when no framework providers are available. However, in practice, this is not the case and providers on spot contracts are used as much as framework providers to meet demand. There are currently 39 care providers in use by the Council, 22 on spot contracts and 17 on framework contracts. The majority of the initial contracts in place expired in August 2017, with extensions subsequently being agreed. We were provided with sight of the folder in which all extensions and contracts are held.

- The total plan of domiciliary care work is approved on a case by case basis for each service user. Care plans are approved on the case management system, which details the approved number of hours and the type of care the user is to receive. Assessments are conducted to identify the amount of hours and type of care that a service user requires. The assessed number of hours and type of care is then authorised by the Senior Care Manager/Team Leader. A random sample of 20 service users was selected for testing. It was confirmed, in all cases tested, that the expected care assessments, care plans and action plans were available on the case management system.
- A signed contract is in place with the Exchequer contractor, to provide an Accounts Payable (AP) function to the Council. We were provided with the signed contract and Service Level Agreement (SLA), which outlines the following responsibilities with regards to making payments for domiciliary care services:
  - Payment of agencies invoices in accordance with the deadline set out in Domiciliary Care statement timetable.
  - Upload of actual hours of service delivered and the variation of care hours received and/or charges made to clients records.
  - Respond to queries from the Authority's Exchequer Service, including requesting timesheets from Agencies.
  - Request invoices for recharges to the Primary Care Trust (now Clinical Commissioning Group).
- We were informed that the contract with the Exchequer contractor is currently being put out to tender. This was confirmed through sight of the draft contract and tender documents. Review of the existing SLA in place confirmed that the Exchequer contractor is to provide the Council with monthly reports detailing various Key Performance Indicators (KPIs) surrounding the provision of the AP service. We examined the past three monthly reports provided to the Council. The reports included a summary of the total invoices due, total processed and the total not yet paid.
- The Exchequer contractor is also responsible for matching invoices. A report, which details the budgeted hours of care to be provided to each service user, is compared to a spreadsheet provided from the service provider detailing the actual care provided. The acceptable variance rate is embedded in the system and is dependent on the number of hours in the care plan. The acceptable variances are as follows:
  - less than two hours plan - acceptable variance is two hours.
  - between two and 10 hours plan - the acceptable variance is three hours.
  - between 10 and 20 hours plan - the acceptable variance is five hours.

- above 20 hours plan - the acceptable variance is 15%.

- The system formula for the above variances was reviewed to provide confirmation that these are set, and applied, in the system.
- Any variances identified, which are above this threshold, require the officer managing the care plan to enquire with the provider as to the reason for the variance. A random sample of 20 invoices was selected from a report of all service users and examined to confirm if there were any variances, and whether such variances had been explained or were within the set tolerance. It was confirmed, for all cases tested, that the any variances identified were all within the stated tolerance levels.
- Once an invoice has been matched by the Exchequer contractor, they are batched for payment (it was noted that bulk invoices are usually received to cover all hours across all service users, relevant to a specific service provider). The batches are printed and signed by the Council's Accounts Payable Manager as authorisation for payment. A sample of 20 care plans, initiated since April 2018 to date, was selected. A random invoice for each plan was reviewed to confirm the invoice from the provider was on file and the relevant batch for the invoice had been signed for approval. In one of the cases examined, the invoice had not been scanned correctly by the Exchequer contractor. Consequently, we were unable to verify it. However, the Exchequer contractor have since been notified of this and have rescanned the invoice accordingly.
- Quality Assurance Framework (QAF) reports are produced on an annual basis for each domiciliary care provider (framework and spot) by the Contract Compliance Officers. A sample of five providers was selected and their relevant QAF reports were evidenced.
- Review of the QAFs showed that each contained an outline of the service provider, the number of hours which they provide and the number of complaints received (if any). Where required, the reports detail recommendations for the service provider to improve the quality of the care provided. Should any areas examined in a QAF visit be identified to be at an unacceptable standard (i.e. rated a D or below) a focus visit is conducted to follow up on any recommendations raised. Focus visits are conducted between three to six months following the initial QAF, depending on the area which was rated D. For the five QAF reports reviewed, three had some areas rated as D or below. It was confirmed for all three that a focus visit had then been conducted within a suitable timeframe. Review of the focus reports showed that they outline the recommendations of the QAF report and draw conclusions as to whether the recommendations have been implemented. Should the recommendations not be implemented, the Council will

suspend using the provider, and any suspended providers are outlined on the Care Quality Commission (CQC) monitoring spreadsheet (discussed below).

- A spreadsheet is maintained, and updated on a monthly basis, which provides links to the last CQC reports produced for each provider. We were provided with a copy of the CQC monitoring spreadsheet and our review confirmed that it provides a number of details on each provider, including the CQC rating, dates of Council Visits, the date of the last QAF report and an overall rating for each provider.
- The Head of Contract Compliance and Monitoring provides the Portfolio Holder with a domiciliary care update each month. This includes a copy of a spreadsheet detailing the CQC scores for each provider, as well as a briefing note. We were provided with the past three e-mails providing the updates to the Portfolio Holder, as confirmation of this control taking place.
- An annual report is produced which covers domiciliary care at the Council. It was confirmed that the previous annual report was issued on 21 November 2018, with the report providing an overview of the services provided, each service provider and a breakdown of overall CQC ratings. Minutes from the Adult Care and Health Policy Development and Scrutiny Committee meeting on the 21 November 2018 confirmed this group had formally reviewed the Domiciliary Care Services Annual Quality Monitoring Report.
- The budget for domiciliary care is included as a subjective code within client group budgets the largest being for Adults and Older People. We were provided with all supporting information for these budgets, and it was confirmed that the budgets in place identify any variances which may exist. We were informed by the Principal Finance Officer for Care Services that meetings are held with management (Directors) on a quarterly basis to discuss the current budget position. We were provided with example screenshots, calendars and agendas for these meetings, as confirmation that they take place.

11. We would like to bring to management attention the following issues:

- For the sample of contracts it was not possible to physically verify current contract documentation.
- From our sample testing, one case was identified which could not be evidenced as having been authorised by the Practice Review Group.

- Although a check is completed, as part of QAF reporting, which compares total hours and number of service users for each provider, the results of this check are not routinely documented.
- There were gaps in the version control and review / approval processes enacted on supporting policies and procedures, linked to Adults Social Care. Guidance was therefore potentially in need of updating, including clarifying guidance to cover expected domiciliary care contract management processes.
- There is currently no overarching management control / information in place which looks to track / monitor the percentage of jobs that meet the expected cost of the care plans, and how frequently there may be under / over charges.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

12. 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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

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REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	Contracts From the sample of current domiciliary care contracts, block and spot, it was found that:- • for one framework provider, the signed contract in place had expired in August 2017. As at May 2019 there were 19 active care plans assigned with a total weekly cost of £4,298 • for one spot contract provider the contract had expired in March 2015. As at May 2019 there were 15 active care plans assigned with a total weekly cost of £3,148 • for one provider the contract is due to expire in August 2019; there was no provision of an extension to sign at the time of the audit.	Where signed contracts are not in place, there is an increased risk that, if disputes arise, they cannot be easily resolved. Furthermore, it may mean that the relationship cannot be monitored to help ensure that an appropriate service is being delivered.	It should be ensured that the relevant contracts and extensions for all providers are agreed. The three contracts identified during audit testing should be reviewed and the outstanding contractual arrangements remedied. The Department need to utilise the contract database to ensure a timely alert to extend/renew contracts prior to expiry. The Department need to comply with the practice notes issued by the Assistant Director Governance and Contracts with regard to documentation held on the contract database. **Priority 1**	i) For the first provider it has been established that this is no longer a framework provider but has moved to a spot contract. Action is already in progress to update the relevant contract and finalise a signed copy. Once the action is completed, this will be confirmed. ii) For the second provider it has been confirmed that relevant extension letters had been sent to the provider but were not returned signed by the provider. Action is already in progress to reissue the extensions and finalise a signed copy. Once the action is completed this will be confirmed. iii) For the third provider action is already in progress to issue extension and obtain signed copy. Once the action is completed this will be confirmed.	i) Head of Service Community Living Team – by October 2019 ii) Head of Service Community Living Team – by October 2019 iii) Head of Service Community Living Team – by October 2019

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
				iv) A review of all Domiciliary Care framework and spot contracts is in progress to ensure all relevant contracts are accurately recorded on the Contracts Database and that all supporting contract documentation is present and uploaded to the Database. Once the review, and any actions arising, is completed, this will be confirmed.	iv) Head of Service Community Living Team – by November 2019

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	<u>Care Plans > £200 per week</u> Care plans, which have a total cost of more than £200 per week, require approval by the Practice Review Group (PRG), through the authorisation of a supporting form. All details regarding the approval should then be attached to the case management system. A sample of 20 care plans (weekly cost >f £200) was selected. For one case there was no evidence of PRG approval for the domiciliary care provided between 19/7/18 to 11/6/19 at a cost of £276.78 per week. It was noted that the hospital team have dispensation to authorise a care package >£200 per week outside of PRG but the authority for this process was not available.	Where the PRG are not aware of care plans in place which exceed £200, there is an increased risk that the Council may exceed its expected budget for domiciliary care services, potentially resulting in a lack of funding for potential users of the services provided. Ultimately, this could also result in reputational damage to the Council.	A periodic report should be generated from the case management system which details all active care plans in place with a value over £200. This should be reviewed by the PRG to confirm that they have authorised all expected plans. The Council should decide: - how often the report should be run and checked; - who should own the process; and - how breaches of the expected process should be escalated (to help reduce any future omissions). The case identified through audit testing should now be reviewed retrospectively to confirm ongoing appropriateness. The authority for the hospital team to award up to placement cost should be evidenced **Priority 2**	A periodic report is not considered necessary at this stage given the Operation Manager carries out spot checks on packages over £200 in her service area. The Brokers will not commission services without the service request or PRA being authorised. For the specific case identified during the audit there was an authorisation for the increase. This can be found in an observation held on the case management system dated 18th July 18. An email was sent to the appropriate officer for authorisation of an increase. This case was authorised in a Service Request form by on 18th July 18 as per agreed process. An email is used when there are urgent authorisations needed to help facilitate timely discharges. This should always be followed with a PRA added by the person requesting the authorisation and	The Operational Manager Ongoing

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
				authorised by the operational manager (or the TL/SCM with the authorising email copied in to the document). The PRA was not completed in this case. All staff will be reminded to follow procedures. The service will review the current process and put procedures, guidance including authority in the Hospital Team and AEIS in a written format	Head of Assessment and CM September 19. Head of Assessment and Care Management March 2020.

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	Verification of Hours Provided We were informed by the Contract Compliance Officer that checks are not conducted on every service user's hours specifically. This was deemed reasonable due to the high number of users. Instead, the overall numbers for total hours and number of service users for each provider is obtained from a report generated from the case management system, and recorded at the top of the QAF report. During the QAF visit the provider is requested to provide their figures. The report is compared to the service provider's data, to confirm that the correct number of hours is being provided. However, it was noted that this check is not routinely documented. It was advised that, should there be any discrepancy, these cases should be clearly documented.	Where such checking is not routinely documented, there is an increased risk that the providers are not providing the agreed levels of service, and that any exceptions may not be identified and escalated.	The reconciliation check which looks to verify the number of hours stated as being provided by the contractor, against the Council's record of expected time, should be clearly documented and made visible as part of the standard template for QAF reporting. Confirmation of a successful verification should be stated on the QAF report, as opposed to only reporting if there is an exception. **Priority 2**	The QAF documentation has been updated to accommodate the recommendations. The QAF documentation has been updated to clearly record the reconciliation check between Council data and provider data on hours provided, recording the outcome of the verification.	Head of Contract Compliance & Monitoring Completed September 2019

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
4	Policies and Procedures Review of the overarching policies in place, which cover Adult Social Care, found that there was no detailed procedural guidance for Domiciliary Care contract management processes.	Where policies and procedures are not in place updated accordingly, there is an increased risk that out of date or inappropriate working practices may be adopted, leading to potential for reputational damage or financial loss to the Council.	The current policies and procedures should be reviewed, updated and approved accordingly. Local procedures for Domiciliary Care contract management should be drafted and approved, to help provide comprehensive guidance surrounding the expected processes. Suggested content could include; the assignment of responsibilities to relevant officers, details on how contracts are expected to be monitored, the timeframe for completing QAF reports and focus visits. To avoid future slippages it its advised that: - ownership of the policies should be clearly assigned; and - future review dates should be monitored, potentially added a clear version history to all relevant documentation. **Priority 3**	A procedure/protocol document for contract monitoring and management is currently being drafted with the draft expected to be completed in October 2019. Consultation on the draft will then take place with relevant officers to finalise the document.	Head of Contract Compliance & Monitoring November 2019

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
5	Payment Tolerance Checks The Exchequer contractor is responsible for matching invoices. Before payment is processed, a report (which details the budgeted hours of care to be provided to each service user) is compared to a spreadsheet provided from the service provider (detailing the actual care provided). There is a built in a level of acceptable variance (as it is not realistic to expect an exact match due to the nature of work being delivered). There is currently no overarching management control / information in place which looks to track / monitor the percentage of jobs that meet the expected cost of the care plans and how frequently there may be under / over charges. However, it should be noted that the existing	If service providers realise that they will be paid, even if they charge slightly more than the expected activity, there is an increased risk that they may be indirectly incentivised to add on small additional values without any requirement to account for differences. Equally, the Council may not be able to routinely identify if a service user is regularly receiving less than the expected time input of care, which may suggest shortfalls in the quality of care being provided.	It may be advisable for the Council to consider introducing additional management information, which can be set up in such a way to identify the percentage of jobs that meet costs of the expected care plans. These statistics could also be used to help identify any potential trends / discrepancies to keep management informed of any areas that regularly go over budget (or are under budget) to be discussed at contract monitoring meetings with the provider. Care managers would use this information to when reassessing care plans for the service users. **Priority 3**	The Exchequer Service will liaise with the relevant budget holders to agree what additional management information they require in order to monitor the percentage of jobs that meet the expected cost of the care plans. The availability of reports will be limited by the constraints of the current case management system.	The Exchequer Contract and Operations Manager/Budget Holders for Assessment & Care Management, Learning Disabilities and Mental Health Services – November 2019

REVIEW OF ASC DOMICILIARY CARE CONTRACT MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	overarching budget monitoring controls do help to flag any significant variances.				

OPINION DEFINITIONS

APPENDIX B

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation Ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT FOR DISCUSSION

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

REVIEW OF EXTRA CARE HOUSING

Issued to: Kim Carey, Director of Adult Services
Tricia Wennell, Head of Service Assessment and Care Management
Laurence Downes, Assistant Director, Governance and Contracts
Colin Lusted, Head of Service Complex and Long Term Commissioning
Alex Pringle, Operational Manager Care Services
Naheed Chaudhry, Assistant Director Strategy, Performance and Corporate Transformation
James Mullender, Head of Finance Adult Social Care, Health and Housing

Prepared by: Principal Auditor and Senior Manager (For LBB Internal Audit)
Reviewed by: Principal Auditor and Head of Audit and Assurance
Date of Issue: 23rd September 2019
Report No.: ECHS/08/2018/AU

REVIEW OF EXTRA CARE HOUSING

INTRODUCTION

1. This report sets out the results of our audit of Extra Care Housing. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. We would like to thank all staff contacted during this review for their help and co-operation.
3. New forms of sheltered housing and retirement housing have been pioneered in recent years, to cater for older people who are becoming frailer and less able to do everything for themselves. Extra Care Housing is housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as sheltered housing or assisted living. It is a popular choice among older people because it can sometimes provide an alternative to a care home.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 08 April 2019. The audit looked to review the key controls around the management of Extra Care Housing, including the governance and management of the contracts in place, to verify whether controls are satisfactory and help to mitigate the risks for all schemes.
5. The following were considered to be the key risks inherent to the Extra Care Housing process:
    - If controls are not in place to monitor the quality of care received at Extra Care Housing sites, or if there are no processes in place to monitor key elements of contractual compliance, there is an increased risk that the Council may not achieve its strategic objectives for the provision of this care.
    - Variable arrangements between LBB and landlords in relation to 'nominations rights' to properties is a potential risk to the ability to place clients as required which could increase the likelihood of voids on the associated care support contracts and incur increased costs for the Council (if properties are left unoccupied).

- If invoices / payments to the contracted care providers for person specific care are not appropriately checked, processed and reconciled, there is an increased risk that the Council may pay for services not received (such as inappropriate variations outside of agreed tolerance levels that should otherwise prompt an independent review before payment). If similar checks are not conducted on standard / minimum contractual payments, the Council may find that it routinely pays the minimum payment when the care providers are not providing this level of time input.
- If roles are responsibilities are not made clear between duties expected of the care provider, and those officers charged with taking on a 'link-worker' post for the Council, there is an increased risk that the Council may find it difficult to hold providers to account for activity.
- If voids (and turnaround times), are not monitored, with timely management actions taken to limit the level of unoccupied properties (for example through the holding of regular meetings or ongoing review of an Action Plan), there is an increased risk that the Council may not effectively utilise its budget for the provision of Extra Care Housing in the Borough. This may also then hinder the level of service that can actually be provided to service users.

AUDIT OPINION

6. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**1**	**1**

SUMMARY OF FINDINGS

7. Controls noted to be in place and working well, based on the audit testing conducted, included:

- Quality Assurance Framework (QAF) reports are produced on an annual basis for each Extra Care Housing scheme property, by the Contract Compliance Officers. Each contains an outline of the property, the relevant landlord, the staffing structure, number of hours delivered and the number of residents. Each property's performance is assessed, covering criteria such as compliance with care plans, risk assessments, medication, care worker adequacy and safeguarding points. The reports also reference the last Care Quality Commission (CQC) publications on the property.

- Similar to the processes in place for Domiciliary Care provision, should any areas examined in a QAF visit be identified to be at an unacceptable standard (i.e. rated a D or below), a focus visit will be conducted to follow up on any recommendations raised. Focus visits are conducted three to six months following the initial QAF, depending on the specific area which was rated D. Our review of example focus reports showed that they outlined the recommendations of the QAF report and drew conclusions as to whether the recommendations had been implemented.
- The QAFs are monitored through a spreadsheet which outlines each housing unit's CQC rating and QAF score. The portfolio holder is provided with an update on Extra Care Housing each month. This includes a copy of a spreadsheet detailing the CQC scores for each provider and a briefing note. We were provided with sight of the past three updates to the portfolio holder as verification of the ongoing nature of this control.
- The Head of Service - Complex and Long Term Commissioning confirmed that, due to an evidenced decline in the quality of services provided by the Council's two care providers, both agreed to be put onto improvement plans. These improvement plans were provided and our review of the plans confirmed inclusion of various objectives for improvement, under 10 headings:
  - Management and Staff Resources
  - Staff Training
  - Effective Rota Management
  - Management of Staff
  - Client Activities
  - Safe Medication Management
  - Fire Safety
  - Quality Assurance Systems
  - Prevention and Effective Management of Complaints, Accidents, Incidents and Safeguarding Concerns
  - Any other Specific Quality issues arising from CQC and Council Inspections

- The above improvement plans have been agreed with the care providers and clearly outline the progress each care provider has made in achieving the specified objectives. It was confirmed that progress towards fulfilling the objectives outlined in the improvement plans has been monitored through regular meetings with both providers.
- A signed contract is in place with the Exchequer contractor who provide an accounts payable function to the Council. We were provided with the signed contract and Service Level Agreement (SLA) which outlines that it is the Exchequer contractor's responsibility to process payments for Extra Care Housing.
- Extra Care Housing users are set up on the case management system. The specific care plans to be provided are outlined on the system and these are subsequently authorised by a relevant manager. The case management system outlines the cost of each individual care plan. The authorisation by the manager consequently provides approval for payment of the plan. A sample of 20 care plans was selected for testing to confirm that the care plan had been appropriately authorised, which identified no issues.
- Weekly reports are received from each housing unit, which outline the number of hours of care received against the minimum number of hours to be billed, the associated costs and any variance between the two figures. The weekly reports are used by the Council to check that the monthly amounts invoiced from the care providers are accurate.
- It was confirmed, through discussions with the Contract and Operations Manager, that payment processing is outsourced to the Exchequer contractor, who is responsible for matching invoices. Once matched, relevant invoices are then uploaded onto the Authority's finance system along with the matching spreadsheet (used by the Exchequer contractor) and subsequently batched and authorised for payment.
- Key Performance Indicator (KPI) Reports are produced on a monthly basis by care providers and provided to the Council for review. We were provided with the past three KPI reports for each of the housing units. Review of the KPI reports show that they include staffing figures, compliance with mandatory requirements and details of any complaints.
- It was confirmed that, on a monthly basis, the Head of Service - Complex and Long Term Commissioning meets with both care providers to discuss the services provided, performance of the KPIs and the progress of any action points identified since the last meeting. We were provided with the minutes for the past three meetings held with both care providers.

- Monthly budget reports are produced which cover the Extra Care Housing function at the Council. The Senior Accountant for Care Services provided supporting evidence which demonstrated that the budgetary information produced detailed the income, expenditure and any variances identified for each of the properties used. It was also confirmed that the monthly budget reports produced contain a breakdown of the costs associated with any voids maintained at each of the units. Regular budget monitoring meetings are held with the Head of Assessment and Care Management to discuss the budgets produced.

8. We would like to bring to management attention the following issues:

- The Council utilises the services of three landlords, who hold all rental agreements with tenants. However, review of the Contracts Database in place found that signed contracts are not in place between the Council and some landlords. The respective roles and responsibilities of the landlords are in the process of being reviewed, in order to help gain a consistent approach across all landlords. Discussions on how the roles and responsibilities should be agreed going forward, and an initial terms of reference document for nominations disputes between the landlord and the Council (which outlines the roles and responsibilities of each party with regards to disputes on nominations) was provided. However, these have yet to be finalised and agreed. In addition, the signed contract between the Council and one care provider was found not to have been uploaded to the Contract Database.
- There is no formal policy or procedure which specifically covers the expected processes for how the Council should be monitoring its Extra Care Housing contracts.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF EXTRA CARE HOUSING

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	<u>Contracts with Landlords and Care Providers</u> The Council utilises the services of three landlords who hold all rental agreements with tenants. However, no signed contract was found on the Contracts Database. It was confirmed that for two, there were historical, informal agreements. For one provider it is a more recently negotiated agreement and was supported by a signed and dated (July 2012) contract. At the time of the audit this agreement had not been created on to Contract Database. For one care provider the signed contract had not been uploaded to the contract database at the time of the audit.	Where signed contracts are not held, there is an increased risk that, should any disputes arise, there may be no clear point of reference to resolve them. In the absence of clarity regarding the 'nomination rights' expected, there is an increased risk of disagreements which could increase the likelihood of voids and incur increased costs for the Council (if properties are left unoccupied). There is a risk that the landlord may refuse to accommodate Extra Care Housing applicants, putting pressure on the Council to source alternative accommodation.	The Department need to comply with the practice notes issued by the Assistant Director Governance and Contracts with regard to documentation held on the contract database. Management should continue to monitor the informal agreements to mitigate the risks around the nomination rights for ECH. **Priority 2**	The formal contract with the landlord will be added as an entry to the CDB and all relevant supporting documentation will be uploaded. The signed contract with the care provider will be uploaded to the CDB. All existing contracts relating to Extra Care Housing have been reviewed to ensure they are up to date on the CDB with all relevant supporting documentation uploaded. Informal nominations agreements will continue to be monitored to identify any issues arising, with action taken as required.	Head of Service Complex and Long Term Commissioning, by October 2019 Head of Service Complex and Long Term Commissioning, by October 2019 Head of Service Complex and Long Term Commissioning, by October 2019 Head of Service Complex and Long Term Commissioning, on ongoing basis

REVIEW OF EXTRA CARE HOUSING

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	Policies and Procedures / Roles and Responsibilities It was confirmed that an operational process overview is in place, which provides a process map summary from the initial application for Extra Care Housing to the end of placement. The CQC monitoring spreadsheet, utilised internally by the Council, also provides some guidance on the expected dates for Quality Assurance Framework (QAF) and focus visits. However, there is no formally documented overarching policy or procedure which specifically covers the expected monitoring processes in respect of Extra Care Housing contracts.	Where policies and procedures are not in place updated accordingly, there is an increased risk that out of date or inappropriate working practices may be adopted, leading to potential for reputational damage or financial loss to the Council.	An Extra Care Housing Contract Monitoring Policy / Procedure should be drafted, approved and made available to relevant members of staff. The guidance produced should outline key contract monitoring processes such as the frequency of QAF visits, the processes regarding the monitoring of the improvement plans and of any focus reports, and clearly define roles and responsibilities linked to contract monitoring tasks. **Priority 3**	An Extra Care Housing Contract Monitoring Policy / Procedure will be drafted, approved and made available to relevant members of staff.	Head of Contract Monitoring and Compliance with Head of Service Complex and Long Term Commissioning by November 2019

OPINION DEFINITIONS **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

CONFIDENTIAL

FINAL INTERNAL AUDIT REPORT

ENVIRONMENT & COMMUNITY SERVICES DEPARTMENT

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS) AUDIT

Issued to:	**Garry Warner, Assistant Director (Highways)** **Colin Brand, Director of Environment and Public Protection** **Sarah Foster, Head of Performance Management and Business Support**
Prepared by:	**Principal Auditor**
Reviewed by:	**Head of Audit & Assurance**
Date of Issue:	**04 October 2019**
Report No.:	**ECS/2/2018/AU**

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

INTRODUCTION

1. This report sets out the results of our audit of the Highways Maintenance (Major works). The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. In September 2016, the Executive approved capital funding of £11.8m for investment in planned highways maintenance. Members were informed that the carriageways and footways were identified for planned work using a prioritisation system based on highways condition, but also taking account of factors such as use, location on the network and frequency of reactive maintenance. Those roads with the highest overall priority were put forward for planned works programmes.
3. LBB's major highways contractor is responsible for delivering the planned highways maintenance programme. This contract started on 01/07/2018. There is no fixed fee for the major works contract and payments are made for agreed completed works.
4. Projects from the Members agreed planned works programmes are raised as jobs on the Confirm system by Highways Inspectors for action by the contractor. The contractor updates the Confirm system on completion. 100% of the major works completed are inspected before payment is made.
5. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 7 December 2018. The objective of the review was to ensure that a risk based approach was in place for the maintenance of the LBB's highways infrastructure including setting levels of service, inspections and their outcome, resilience, priorities and programmes. The contract arrangements and contract payments were also reviewed to ensure compliance with the Contract Procedure Rules and Financial Regulations. Controls to mitigate the following key risks were reviewed:

    - Failure to manage highways leading to deteriorating conditions
    - Increased repair costs, insurance claims (trips, falls and road traffic accidents) and reputational damage
    - Value for money may not be achieved within the procurement process

- Established procedures are not complied with

AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Limited Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
3	**2**	**0**

SUMMARY OF FINDINGS

Recommendation of schemes for the Highways Investment Project

8. The Highways Investment Project was originally approved by the Executive in September 2016.

Phase one of the project was considered by Environment Services PDS (ES PDS) on 24th January 2017, phase two on 12th July 2017, phase three on 5th October 2017, phase four on 30th January 2018, phase five on 15th March 2018 and the final phase six on 18th June 2019.

9. At each of these meetings Members were informed that carriageways and footways for the proposed phase have been identified for planned work using a prioritisation system.

10. Management advised that in respect of the selection of schemes for the Highway Investment Project, a series of assessments were undertaken before recommendations were made to the ES PDS. The network survey was completed by external consultants to identify the maintenance need of all sections of carriageway, each of which is up to 500m long. Reports from Highway Inspectors, Councillors or members of the public are considered to establish requirement for maintenance. Once the full list for maintenance has been compiled from the above information, further surveys are undertaken by Council officers to identify the need for maintenance in the short-term, the extent of the works and likely cost. This data is used to prepare each phase of the investment project which is circulated to all Ward Councillors for comment before being submitted to the ES PDS committee for scrutiny, and finally the Portfolio Holder for approval. Management stated that officers are not the decision makers for these projects.

11. A sample of 8 schemes from the Highways Investment Project was randomly selected by Internal Audit (4 footways and 4 carriageways) to review the process followed by management before recommending the schemes to ES PDS committee for decision making.

12. Four of four carriageways were found to be in ‘as new’ condition or ‘not requiring preventative maintenance for 5 years’ by the external consultants (survey undertaken October 2015 to February 2016). On enquiry management advised that while the overall condition of carriageway may have been recorded as ‘up to standard’ or ‘as new’, reports from Highway Inspectors, Councillors or members of the public have identified areas of carriageway that require maintenance. Management were asked to provide reports from Highway Inspectors, Councillors or members of the public as evidence and issues arising were as follows:

    - No documentary evidence was available to confirm the reasons for recommendation of 1 of 4 carriageways (Hayes Lane). The actual spend on resurfacing this carriageway was £160,079.

    - An email from the former Highways Inspector dated 04/03/2018 stating that he has used the data from the survey undertaken by the contractor and Inspectors’ data and Members comments to select the carriageways was provided as evidence for 3 of 4 carriageways. The information that the former Highways Inspector referred to in his email (survey data from contractor, inspector data and Members comments) and relied on to compile the

list of schemes was not available. The actual spend on resurfacing these carriageways was £64,644 (Heathfield Road), £57,589 (Cudham Lane North) and £23,610 (Darrick Wood Road)

13. Therefore, the rationale for recommendation of the 4/4 sampled carriageways for Highways Investment Project which cost £305,921 in total could not be satisfactorily evidenced.

Management of delivery of agreed Highways investment schemes

14. Schemes from the Members agreed Highways Investment Project are raised as jobs on the Confirm system by the Highways Contract Manager following the site visit by the Highways Inspector. It was noted that there are no written procedure notes for agreeing work to be undertaken, raising and varying orders, inspections and rectification of defects.

15. A sample of 4 footway and 4 carriageway schemes was selected from the report of paid invoices for the period June 2018 to April 2019 to establish the current working practices. The following were noted:

Carriageway schemes

- No formal process is in place to establish the work to be undertaken as part of agreed schemes. The order is not supported by a formal record of the site visit to establish measurement of site and description of work.
- Where the order amount differed from the invoiced amount, no records of agreed variation were found.
- Insufficient evidence is retained for the monitoring undertaken by the Highways Inspectors.
- 4/4 re-measurement sheets for carriageway inspections which support payment of works were not dated.
- The inspections are not diarised and are not supported by photographs.
- The Highways Inspectors do not maintain a written record of defects and their rectification.

Footway Schemes

- No formal process is in place to establish the work to be undertaken as part of agreed schemes. The order is not supported by any formal record of the site visit to establish measurement of site and description of work.
- Where the order amount differed from the invoiced amount, no records of agreement of variation were found.

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

Reconstruction of vehicle crossovers

16. Before commencement of a major footways scheme, residents are notified of the timetable of the proposed footways work and are offered the opportunity to have their vehicle crossover reconstructed and/or widened at a reduced rate. It was noted that there is no documented procedure to manage requests for reconstruction/ widening of crossovers. Internal Audit was informed that these requests are dealt with at short notice and in some instances the work is agreed verbally by the resident with the Highways Inspector.

17. For one of the footways scheme in the sample (Lake Avenue footways scheme):
    - Five requests for the vehicle crossings to be reconstructed and/or widened were received as per the ad hoc records kept by the Highways Inspector.
    - From the information obtained from the cashier, payments for only 3 crossover requests could be evidenced.
    - No documents were available to establish if the prices charged were correct.
    - No reconciliation is undertaken to ascertain the number of crossovers actually reconstructed or widened by the contractor and the income received.

Segregation of duties

18. For the payment process it was noted that the agreement of work to be undertaken, interim and final inspection of work completed and agreement of payment is undertaken by the same Highways Inspector. The inspections records are not maintained and before and after pictures are not taken in all instances. The Highways Contracts Manager advised that he periodically undertakes joint inspections with the Highways Inspector. However, this could not be confirmed as no records of these monitoring visits are retained by the Highways Contracts Manager.

Training

19. On enquiry the Assistant Director (Highways) advised that training is provided to staff involved in contract management to increase an understanding of the contract. Some team managers have attended contract management training; however other LBB staff working on the contract may need to be trained in contract management.

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

20. 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.

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REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	**Recommendation of schemes for the Highways Investment Project** The Highways Investment Project was originally approved by the Executive in September 2016. Phase one of the project was considered by Environment Services PDS (ES PDS) on 24th January 2017, phase two on 12th July 2017, phase three on 5th October 2017, phase four on 30th January 2018, phase five on 15th March 2018 and the final phase six on 18th June 2019. At each of these meetings Members were informed that carriageways and footways for the proposed phase have been identified for planned work using a prioritisation system. Management advised that in respect of the selection of schemes for the Highway Investment Project, a series of assessments are	Failure to adequately manage highways leading to deteriorating conditions Unnecessary expenditure on schemes that do not require it Members may not receive sufficient information for decision making	Management should ensure that: i) The process of recommendation of schemes for the Highways Investment Project to Environment Services PDS is evidenced as compliant to the prioritisation system agreed by the Executive. ii) The rationale for recommendation of the schemes for the Highways Investment Project should be documented and retained. iii) Summary of reasons for recommendation of schemes for Highways Investment Project should be included in the reports presented to Environment Services PDS for decision making. **Priority 1**	i) The procedure for selecting future planned highway maintenance schemes will continue to be compliant to the prioritisation system agreed by the Executive, but the process will be fully documented and records retained to provide transparency of decisions taken. ii) The results of all surveys and inspections will be retained centrally to show justification for recommendations to Councillors. iii) The reasons for recommendation of future planning Highways maintenance projects will be included in reports to ES PDS for decision making.	November 2019 - AD (Highways) Immediate - AD (Highways) Immediate - AD (Highways)

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	undertaken before recommendations were made to the ES PDS. The network survey was completed by external consultants to identify the maintenance need of all sections of carriageway, each of which is up to 500m long. Reports from Highway Inspectors, Councillors or members of the public are considered to establish requirement for maintenance. Once the full list for maintenance has been compiled from the above information, further surveys are undertaken by Council officers to identify the need for maintenance in the short-term, the extent of the works and likely cost. This data is used to prepare each phase of the investment project which is circulated to all Ward Councillors for comment before being submitted to the ES PDS committee for scrutiny, and finally the Portfolio Holder for approval. Management stated that officers				

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	are not the decision makers for these projects. A sample of 8 schemes from the Highways Investment Project was randomly selected by Internal Audit (4 footways and 4 carriageways) to review the process followed by management before recommending the schemes to ES PDS committee for decision making. The following were noted: 4 of 4 carriageways were found to be in 'as new' condition or 'not requiring preventative maintenance for 5 years' by the external consultants (survey undertaken October 2015 to February 2016). On enquiry management advised that while the overall condition of carriageway may have been recorded as 'up to standard' or 'as new', reports from Highway Inspectors, Councillors or members of the public have identified areas of carriageway that require maintenance. Management were				

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	asked to provide reports from Highway Inspectors, Councillors or members of the public as evidence and ○ No documentary evidence was available to confirm the reasons for recommendation of 1 of 4 carriageways (Hayes Lane). The actual spend on resurfacing this carriageway was £160,079. ○ An email from former Highways Inspector dated 04/03/2018 stating that he has used the data from the survey undertaken by the contractor and Inspectors data and members comments to select the carriageways was provided as evidence for 3 of 4 carriageways. The information that the former Highways Inspector referred to in his email (survey data				

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	from contractor, inspector data and members comments) and relied on to compile the list of schemes was not available. The actual spend on resurfacing these carriageways was £64,644 (Heathfield Road), £57,589 (Cudham Lane North) and £23,610 (Darrick Wood Road) Therefore, the rationale for recommendation of the 4/4 sampled carriageways for Highways Investment Project which costed £305,921 in total could not be satisfactorily evidenced.				
2	**Management of delivery of agreed Highways investment schemes** Schemes from the Members agreed Highways Investment Project are raised as jobs on the Confirm system by the Highways Contract Manager following the site	Loss to the Authority due to poor management of contracts	Management should ensure that for both carriageways and footways schemes: (i) Written procedure notes are produced for agreeing work to be undertaken, raising and varying orders, inspections and rectification of defects.	(i) Procedure notes to be prepared to record all decisions taken by Officers once schemes have been approved by	November 2019 - AD (Highways)

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	visit by the Highways Inspector. It was noted that there are no written procedure notes for agreeing work to be undertaken, raising and varying orders, inspections and rectification of defects. A sample of 4 footway and 4 carriageway schemes was selected from the report of paid invoices for the period June 2018 to April 2019 to establish the current working practices. The following were noted: Carriageway schemes • No formal process is in place to establish the work to be undertaken as part of agreed schemes. The order is not supported by a formal record of the site visit to establish measurement of site and description of work. • Where the order amount differed from the invoiced amount, no records of agreed variation were found.		(ii) Orders are supported by formal record of the site visit and agreement of work to be undertaken. (iii) Any changes to the order should be supported by records of agreed variation. (iv) Evidence should be retained for the inspection visits undertaken by the Highways Inspectors. The inspections should be diarised and supported by photographs. Re-measurement sheets for carriageway inspections should be dated and completed in full. (v) Defects identified should be noted and remedial action by the contractor should be verified before payment of invoice. Priority 1	Councillors. (ii) Formal site records to be retained centrally rather than Officers diaries to record site visits and instructions to contractor (iii) Changes to orders will continue to be recorded on re-measurement sheets, but supported by records as (ii) (iv) As (ii). Re-measurement sheets will continue to be signed and dated by the supervising officer and Contracts Manager, with name and signatures before payments are processed. (v) Defects identified during construction and agreed remedial actions will be recorded formally. Records of defects identified during the warranty inspection will be recorded centrally	Immediate - AD (Highways) Immediate - AD (Highways) Immediate - AD (Highways) Immediate - AD (Highways)

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	• Insufficient evidence is retained for the monitoring undertaken by the Highways Inspectors. • 4/4 re-measurement sheets for carriageway inspections which support payment of works were not dated. • The inspections are not diarised and are not supported by photographs. • The Highways Inspectors do not maintain a written record of defects and their rectification. Footway Schemes • No formal process is in place to establish the work to be undertaken as part of agreed schemes. The order is not supported by any formal record of the site visit to establish measurement of site and description of work. • Where the order amount			rather than Officers diaries, including null returns when no defects found.	

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	differed from the invoiced amount, no records of agreement of variation were found.				
3	**Reconstruction of vehicle crossovers** Before commencement of a major footways scheme, residents are notified of the timetable of the proposed footways work and are offered the opportunity to have their vehicle crossing reconstructed and/or widened at a reduced rate. It was noted that there is no documented procedure to manage requests for reconstruction/ widening of crossovers. Internal Audit was informed that these requests are dealt with at short notice and in some instances the work is agreed verbally by the resident with the Highways Inspector. For one of the footways scheme in the sample (Lake Avenue footways	Loss due to poor management of contracts. Potential for fraud to occur and remain undetected.	Management should ensure that: (i) Written procedure notes are produced to manage requests for reconstruction/ widening of crossovers as part of footways schemes. (ii) All vehicle crossovers reconstructed and/or widened should be supported by • Application/Request form • Site measurement by the Highways Inspector and the agreed price • Date of instructions to the contractor (This should postdate the receipt of payment) • Inspection record following completion. (iii) The number of crossovers	(i) Written procedure notes will be produced to manage requests for reconstruction/ widening of crossovers as part of footways schemes. (ii) Full records to be retained for all applications, including before and after photographs. Formal instructions to be issued to the contractor following receipt of payment, although works will be included in original orders and measured as part of project.	November 2019 - AD (Highways) Immediate - AD (Highways)

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	scheme): • Five requests for the vehicle crossings to be reconstructed and/or widened were received as per the ad hoc records kept by the Highways Inspector. • From the information obtained from the cashier, payments for only 3 crossover requests could be evidenced. • No documents were available to establish if the prices charged were correct. • No reconciliation is undertaken to ascertain the number of crossovers actually reconstructed or widened by the contractor and the income received.		actually reconstructed/widened and invoiced by the contractor as part of the individual footways schemes should be reconciled to the income received. Priority 1	(iii) Full details of crossovers reconstructed/widened as part of the individual footways schemes will continue to be reconciled with the income received and contractors invoice, although details to be recorded centrally.	Immediate - AD (Highways)
4	**Segregation of duties** For the payment process it was noted that the agreement of work to be undertaken, interim and final	Lack of segregation of duties may lead to fraud or error being undetected	Management should ensure that i) The agreement of work to be undertaken, interim and final inspection of work completed and	(i) where site inspections and valuations are agreed by a Contract Monitoring	Immediate - AD (Highways)

REVIEW OF HIGHWAYS MAINTENANCE (MAJOR WORKS)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	inspection of work completed and agreement of payment is undertaken by the same Highways Inspector. The inspections records are not maintained and before and after pictures are not taken in all instances. The Highways Contracts Manager advised that he periodically undertakes joint inspections with the Highways Inspector. However, this could not be confirmed as no records of these monitoring visits are retained by the Highways Contracts Manager.		agreement of payment for Highways projects should be undertaken by more than one officer. ii) All inspections and monitoring visits by Highways officers and their observations are recorded and retained. **Priority 2**	Officer, monthly audits will continue to be undertaken by the Contracts Manager or another responsible officer, but the results of the audit will be recorded centrally (ii) Formal site records to be retained centrally rather than Officers diaries to record site visits and instructions to contractor	Immediate - AD (Highways)
5	**Training** On enquiry the Assistant Director (Highways) advised that training is provided to staff involved in contract management to increase an understanding of the contract. Some team managers have attended contract management training; however other LBB staff working on the contract may need to be trained in contract management.	Loss due to poor management of contracts	Management should identify necessary training needs for contract management staff and ensure that these training needs are fulfilled. Records of training should be maintained. **Priority 2**	(i) the requirement for training in contract management and project management to be considered as part of personal development plans and discussed at regular appraisal meetings.	Immediate - AD (Highways)

OPINION DEFINITION **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

FINAL INTERNAL AUDIT REPORT

EDUCATION CARE AND HEALTH DEPARTMENT

REVIEW OF NO RECOURSE TO PUBLIC FUNDS AUDIT FOR 2018-19

Issued to: Lydia Bennett Head of Service, Referral and Assessment
Ifeoma Nwaosu , Group Manager (MASH)
Janet Bailey, Director of Children's Social Care
David Bradshaw, Head of Finance ECHS
Naheed Chaudhry, Assistant Director Strategy, Performance and Business Support

Cc Sara Bowrey, Director of Housing
Lynnette Chamielec, Head of Allocations and Accommodation
Dave Hogan, Head of Internal Audit

Prepared by: Principal Auditor

Date of Issue: 18th July 2019

Report No: ECHS/12/2018/AU

INTRODUCTION

1. This report sets out the results of our systems based audit of No Recourse to Public Funds 2018/19. The audit was carried out in quarter 4 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. Any Priority 1 recommendations or Limited Assurance opinions must be considered for inclusion in the Department's Risk Register.

3. The No Recourse to Public Funds (NRPF) function for families with children is part of the Referral and Assessment Team. Cases are referred through the MASH team and allocated to the designated Social worker and Social Worker Assistant for eligibility to access support from the Authority as NRPF clients. The initial assessment, collection of key documents, verification of a connection to Bromley, Home Office application status and evidence of destitution is recorded and held within the system used by the MASH team. Once the case is accepted as NRPF, the administrative team will create a record on the case management system and scan supporting documentation. The quality assurance of the social worker assessment and decisions recorded in the MASH IT system are not within the remit for Internal Audit. This audit review has considered the controls for the system to assess, procure accommodation and make subsistence payments to NRPF clients identified on the case management system. The processes in place to detect fraud and the arrangements to share data with neighbouring Authorities to mitigate fraud, was also considered.

4. The 2018/19 budget for NRPF was £300,570 for accommodation and £108,860 for subsistence payments; actual expenditure at year end was £166,373 for accommodation and £55,815 for subsistence. The number of cases presenting at Bromley is lower compared to neighbouring Boroughs and the number of active cases has decreased over the last three financial years. Monthly data reported to the Performance team show that there were 53 children supported at the start of 2016/17, 36 children in April 2018 and the team have just reported that there are 17 children currently supported as NRPF cases in April 2019. This is a snapshot of the service at the start of the year; it was noted that the number of new referrals was similar each year.

AUDIT SCOPE

5. The scope of the audit was outlined in the Terms of Reference issued on the 24/9/18. This audit considered the processes and controls for the NRPF cases managed by Children's Social Care. Adult Social Care currently supports 4 NRPF cases managed by the allocated social worker in the relevant service team; these cases were not reviewed this time.

AUDIT OPINION

6. 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 were in place and working well in the areas of utilisation of the Home Office online system to record cases, track progress and support counter fraud initiatives. Interrogation of the Home Office online system in the first instance allows timely confirmation that the client has a live application to the Home Office to support eligibility. Uploading all applications also allows connected Authorities to check for duplicate applications and enable counter fraud initiatives. All applicants sign a declaration to allow data sharing which allows the team to request a credit check undertaken by Greenwich Fraud Team (GFT). This credit check supports information declared by the applicant and has also highlighted withheld information that can be discussed with the applicant. There is a designated social worker (SW) and social worker assistant (SWA) for the NRFP cases that should allow a good working knowledge of this specialist area.

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

- .There is no formal contractual arrangement with the accommodation provider. The procurement process is weak and does not comply with Contract Procedure Rules. Comparison to rates paid by Housing for similar properties suggest the NRPF service are paying higher nightly rates and therefore not achieving value for money.
- There are no locally agreed procedures to support the work undertaken by the SWA.

- The Financial Assessment should support the payments to the client but this is an informal document that is not dated, owned or records standard information. There is no authorisation or sign off of the information reported.
- Scanned documents are not held in a standard referenced format in an agreed location.
- The subsistence payments did not agree to the published Home Office allowances. Discretionary payments and deviation to these allowances were not supported by an adequate audit trail.
- The information uploaded to Home Office online system for the sample of clients was incomplete. There are other users in the Council, Adult Social Care and Housing that would benefit from direct access to the Home Office via online system but this function is not available to them
- There is no classification for NRPF clients on the case management system.

SIGNIFICANT FINDINGS (PRIORITY 1)

9 There is one significant finding identified in this review relating to the procurement of accommodation for the NRPF clients.

10. The Social Worker assessment will consider eligibility and with regard to destitution will recommend the level of financial support for accommodation. The Social Worker Assistant (SWA) will procure accommodation for the NRPF families but this process does not meet the requirements of Contract Procedure Rules or Financial Regulations.

11. Accommodation is procured by the SWA via a telephone call; there is no contractual agreement with the providers or formal order. Recently Provider A has returned a booking confirmation to detail the rate and the property but this document was only retained for the last two placements. With no contract or purchase order there are no agreed terms and conditions that may impact on liability around health and safety, compliance to Housing Regulations and payments. The spend on accommodation has been committed by the SWA; the authorisation is on the funding decision form as the service agreement is uplifted to the case management system. The SWA had assumed that the contractual arrangement with the provider was actioned by the Central Placements Team when the service agreement is created on the case management system.

12. The actual spend for accommodation in 2018/19 was £166,373. The SWA indicated that advice had been sought from Housing in the past but there is no formal communication or contact established. Housing had suggested a provider, Provider B and one of the current cases is placed in their property. The SWA provided a summary of rates charged by the current provider but this was an informal document not originating from the provider and was not dated to put the charges to a time frame.

13. Concerned with the weakness in procurement for accommodation and the lack of competitive quotes, challenge or scrutiny for the rates accepted from in the majority of cases for the same provider, Internal Audit liaised with colleagues in Temporary Accommodation to quantify the cost of nightly rates paid by the NRPF team.

14. The nightly rate paid for the sample of 10 NRPF cases (6 current and 4 former) selected for audit testing was compared to the pan London maximum rate. The weekly rate, including utilities was used as a comparison to the actual cost paid by the NRPF team. The post code of the accommodation was checked to identify the Borough, inner or outer and then the type of unit provided. The main issues arising were that:-

- The accommodation charge paid by NRPF to the provider was higher in 8 cases. The difference in cost for the period of placement during 2018/19 totalled £24,617.
- The placement through Provider B, suggested by Housing, has the same weekly rate.
- For one property the tenant was in situa when presenting as NRPF and received a weekly allowance to cover rent, utilities and subsistence; this case was not compared.

15. In summary, if Housing had placed these clients according to the Pan London guidelines, £24,617 could have been saved for the 8 cases sampled. If this value is indicative and applied to previous years, savings would have been significant. The actual cost of accommodation for NRPF 2018/19 is £166,373; the potential saving represents 15% of this value.

16. During the course of the audit it was noted that the SWA had also procured accommodation from the Provider A on behalf of other CSC teams. The findings identified for NRPF will therefore be replicated for the accommodation procured for the families in these other teams.

17. As part of the Transformation agenda the Authority will be reviewing Housing services. There will be scope to refer the accommodation element of the NRPF to Housing if sufficient resources are available. There is also the provision of Temporary Accommodation at Belle Grove and Manorfields that needs to be fully occupied to minimise the cost of voids. Given the audit testing highlighted that the NRPF SWA places families on behalf of other CSC teams, using Provider A for these placements will also need to be identified and reviewed. There is a need for all processes relating to accommodation and Housing to be standardised.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

18. 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

19. 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	**Accommodation** The Social Worker assessment will consider eligibility and with regard to destitution will recommend the level of financial support for accommodation. The Social Worker Assistant (SWA) will procure accommodation for the NRPF families but this process does not meet the requirements of Contract Procedure Rules or Financial Regulations. Accommodation is procured by the SWA via a telephone call; there is no contractual agreement with the providers or formal order. Recently Provider A has returned a booking confirmation to detail the rate and the property but this document was only retained for the last two placements. With no contract or purchase order there are no agreed terms and conditions that may impact on liability around health and safety, compliance to Housing Regulations and payments. The actual spend for accommodation in 2018/19 was £166,373. The SWA indicated that advice had been sought from Housing in the past but there is no formal communication or contact established. Housing had suggested Provider B as a	The Authority has placed clients with a provider without any contractual arrangement and may therefore be unable to enforce terms and conditions regarding standards or payments. The Authority may be at risk for placing clients with a provider without ensuring adequate insurance, health and safety and compliance to Housing legislation is in place.	**The Department must review the process to procure accommodation for NRPF to ensure compliance to contract procedure rules and financial regulations.** **The arrangements to procure accommodation must be formalised, transparent and ensure an adequate audit trail is evident of any communication or decision.** **The contractual arrangements with the provider must be formalised to ensure that**

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
	provider and one of the current cases is placed in their property. The spend on accommodation has been committed by the SWA; the authorisation is on the funding decision form as the service agreement is uplifted to the case management system. The SWA had assumed that the contractual arrangement with the provider was actioned by the Central Placements Team when the service agreement is created on the case management system. The SWA provided a summary of rates charged by Provider A but this was an informal document not originating from the provider and was not dated to put the charges to a time frame. Concerned with the weakness in procurement for accommodation and the lack of competitive quotes, challenge or scrutiny for the rates accepted from in the majority of cases the same provider, Internal Audit liaised with colleagues in Temporary Accommodation to quantify the cost of nightly rates paid by the NRPF team. The nightly rate paid for the sample of 10 NRPF cases (6	The Authority may not be achieving value for money and incurring additional expenditure.	**the provider has adequate insurance arrangements (public liability cover), compliance to health and safety and Housing regulations. Contract management should then include placement reviews and formal meetings with the provider.** **All documentation including e-mails must be retained on the client file in the case management system.**

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
	current and 4 former) selected for audit testing was compared to the pan London maximum rate. The post code of the accommodation was checked to identify the Borough, inner or outer and then the type of unit provided. The main issues arising were that:- • The accommodation charge paid by NRPF to the provider was higher in 8 cases. The difference in cost for the period of placement during 2018/19 totalled £24,617. • The placement through Provider B, which was suggested by Housing, has the same weekly rate. • For one property the tenant was in situa when presenting as NRPF and received a weekly allowance to cover rent, utilities and subsistence; this case was not compared. In summary if Housing had placed these clients according to the Pan London guidelines, £24,617 could have been saved for the 8 cases sampled. If this value is indicative and applied to previous years, savings would have been significant. The actual cost of accommodation for NRPF 2018/19 is £166,373; the potential saving represents 15% of this value.		**The Department will need to identify placements for families in other CSC teams, arranged by the NRPF SWA and confirm the procurement and contractual arrangements.** **All current placements should be reviewed and the Team liaise with Housing colleagues to identify opportunities to reduce costs and ensure compliance.** **[Priority 1]**

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
	During the course of the audit it was noted that the SWA had also procured accommodation from Provider A on behalf of other CSC teams. The findings identified for NRPF will therefore be replicated for the accommodation procured for the families in these other teams. As part of the Transformation agenda the Authority will be reviewing Housing services. There will be scope to refer the accommodation element of the NRPF to Housing if sufficient resources are available. There is also the provision of Temporary Accommodation at Belle Grove and Manorfields that needs to be fully occupied to minimise the cost of voids	The Authority may not be maximising the opportunities in terms of skills or costs by not utilising Housing specialists to procure accommodation.	

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
2	**Procedures** NRPF is a section included in the Children's Social Care Procedure Manual. There are no additional procedure notes held in the Bromley Resources section which would be specific to the working practices of the Bromley Team. Given the SW and SWA are exclusively assigned to the NRPF cases it would be imperative that the locally agreed procedures and working practices be documented. There had previously been a flow chart to support the referral, assessment and ongoing support for cases but these have lapsed and were not available. The SWA relies on external agencies such as Greenwich Fraud Team and the Home Office to process the NRPF and there was no formal record of the relevant contacts, templates and working practices to allow another officer to cover the role during absence. The SWA evidenced a "Client Documentation Request" checklist that had been developed to ensure collection of key documentation but this record had not been formalised.	Business continuity may not be effective. The NRPF is reliant on one officer, in her absent the delivery of the service may be compromised.	**The development of locally agreed procedures and working practices will allow business continuity, cover should the designated officer be absent and allow management to exercise challenge and scrutiny of working practices.** **The flowcharts should be reviewed, revised and stored in a shared area available to all appropriate officers.** **The Client Document Request should be used**

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
	Completed and attached to the client record this would be an acceptable record to support the application. The Central Placements Team (CPT) will set up the service agreement for accommodation on the case management system on receipt of the authorised funding request form. Approval to extend the service agreements is evidenced by an e-mail exchange between the CPT Administrative Officer and the SWA. It is unclear if the extension is appropriately authorised and what oversight management have of NRPF caseload.		**for all new cases to ensure the eligibility is complete and be a guide to all information collected.** **Procedure notes should be dated "owned" and a revision note embedded in the footer of the document.** **[Priority 2]**

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	**Financial Assessments** To be eligible for financial support the applicant is financially assessed to determine destitution. Based on this assessment the client will receive support for accommodation, subsistence or both. The SWA will complete a financial assessment that is used by the SW to extract information to include in the Initial Assessment. The Financial Assessment is a key document to support the payments made to NRPF clients. The main issues with the current practice are as follows:- • The Financial Assessment is currently a word document with no standard text • The document is not dated or owned • The document is not authorised • The SWA confirmed that there had been a Financial Assessment template developed for the planned new case management system that was abandoned • The financial assessment should be reviewed and updated annually • Long term clients were not supported by a financial assessment as the informal document was introduced	Payments made to NRPF may not be supported by key documentation.	**The Financial Assessment should be developed as a standard template document to capture all relevant information.** **The document can be used to record referral and responses from the Greenwich Fraud Team.** **The Financial Assessment should be signed, dated and authorised.** **Financial Assessments should be reviewed regularly, at a minimum annually.**

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
	during 2018/19 and not backdated for existing clients. • Financial Assessments and GFT credit checks should be available for all clients currently receiving support.		**A financial assessment should be available for all clients currently supported by the Authority** **Priority 2**
4	**Scanned Documents and Retention of Evidence** Since 2016 the SWA has referred all new cases to GFT for a credit check. At the initial assessment clients are asked to sign a declaration that the information supplied is correct (financial interests), submit copies of bank statements and are advised that a credit check will be undertaken. GFT is e-mailed the client details and will return the credit check as an attachment. Currently the SWA retains these e-mails in her Outlook folders but as part of the assessment process these responses should be stored in a secured location on the shared drive or secured folder on the case management system.	Information may not be available to appropriate officers to support payments. Business continuity may not be effective	**All documentation supporting the payments made to a client should be available for inspection and therefore stored in a shared area appropriately secured.**

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
	A check with the Information Governance Officer agreed that the bank statements could be retained in a secured format as they support the financial assessment and the expenditure. As detailed in the online procedures there are four elements to eligibility. These should be available in a standard format and stored in a standard location on the case management system. Initial checks on the sample identified that the reference to scanned documents did not always agree to the content and more than one category of documents were batched together.		**Scanned documents should be batched and referenced to allow identification and retrieval.** **Priority 2**
5	**Subsistence Payments** The subsistence should be a standard weekly fee per child as set out on the Home Office web site. The SWA confirmed that at Bromley the financial assessment may be taken into account to calculate the subsistence. There was no formal trail to document any deviation from the standard allowance, however both the petty cash vouchers and funding request forms are authorised by the Team Leader. For clients with a bank account the subsistence is paid direct, supported by an authorised funding decision sheet and a service agreement on CareFirst. For clients without a bank account, weekly cash payments are sourced from the imprest	The Authority may make payments above the Home Office published allowances	**The agreed weekly subsistence allowance should be in line with the published Home Office rates. Deviation to these rates should be supported by the authorised financial assessment and manager's approval.** **For cases that span financial years the Team should ensure that**

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
	account. The signed petty cash voucher should be scanned and held on the case management system but was not available in all cases. The main issues arising from the audit testing was that:- • Inconsistency of information recorded on the case management system; in some instances the weekly amount was divided equally between all siblings in another the full amount was shown against one child. • For the three vouchers sampled £136 (sample 7), £151 (sample 8) and £163.50 (sample 1) was paid but this did not equate to the weekly rate of £37 per child. • Inadequate documentation to support deviation from the published allowances.	The information on Case management system may not reflect the actual service activity	**allowances are updated in line with published allowances.** **The Team should ensure that the subsistence allowance is divided equally between siblings on the case management system or agree the standard representation.** **Priority 2**

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	**Home Office Online System** Access to the Home Office online system has improved the process to verify eligibility and track the progress of each case. In the first instance the team can check on Home Office online system to verify that the applicant is known to the Home Office including checking the photograph that has been uploaded to each record. The immigration status and history allows the team to identify if the applicant is known to another Authority. On line access to the Home Office via the message function expedites enquiries. Access to the Home Office online system and the information uploaded by Bromley is a useful tool to mitigate the risk of fraud. The sample of NDPF cases selected for audit examination was checked to the online system and agreed. The summary reports, generated from Home Office online system, were also checked for the sample cases, the following issues arising:- • Incomplete data as not all fields had been completed for each case • The case management system unique P number was not recorded for all cases	Inaccurate or incomplete information may negate the effectiveness of counter fraud initiatives	**Ensure that the information uploaded to the Home Office online system is accurate and complete. All relevant fields should be completed and the information reconciled to the details held in the case management system.** **Consideration should be given to allowing access to colleagues in ASC and Housing or liaising with colleagues to facilitate improved communication with the Home Office.** **Priority 2**

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
	• 5/10 cases in the sample were not found but this may be due to the lead name on Home Office online system being different to the children. • Values declared as payments did not agree to the service agreements on the case management system. Access to the Home Office online system is a key resource for the CSC NRPF team but during the course of the audit it was evident that other teams in the Council would also benefit from access, namely ASC (currently supporting 4 NRPF cases) and Housing (required verification of the legal status of a Temporary Accommodation client)	Protracted communication with the Home Office may incur unnecessary costs	
7	**Classification on the Case Management System** At the start of the audit the Children's Performance Team was requested to generate a report showing all NRPF cases. However there is no specific classification in the case management system to identify these cases and the report had to be filtered on case load allocation to the designated SW and SWA. This is limited given some NRPF cases will start in other teams, for example Children with Disabilities and both officers may have non NRPF cases assigned to them.	NRPF clients may not be identified on the case management system	**NRPF cases should be assigned a unique classification on the case management system.** **Priority 3**

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 NO RECOURSE TO PUBLIC FUNDS AUDIT 2018-19

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
1	**Accommodation** The Department must review the process to procure accommodation for NRPF to ensure compliance to contract procedure rules and financial regulations. The arrangements to procure accommodation must be formalised, transparent and ensure an adequate audit trail is evident of any communication or decision. The contractual arrangements with the provider must be formalised to ensure that the provider has adequate insurance arrangements (public liability cover), compliance to health and safety and Housing regulations. Contract management should then include placement reviews and formal meetings with the provider.	1	Please note that the current arrangement for procuring NRPF accommodations were in place before the current post holders joined Bromley. Action will be taken to review the current procurement of provision.	Head of Service, Referral and Assessment/ Group Manager (MASH)	May 2019

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
	All documentation including e-mails must be retained on the client file in the case management system. The Department will need to identify placements for families in other CSC teams, arranged by the NRPF SWA and confirm the procurement and contractual arrangements. All current placements should be reviewed and the Team liaise with Housing colleagues to identify opportunities to reduce costs and ensure compliance.		Social Worker and NRPF will ensure that all correspondence are placed on the relevant sections of the child's case file A meeting with Housing colleagues will be arranged to consider contractual arrangements and suitable housing providers	Head of Service, Referral and Assessment/ Group Manager (MASH) Head of Service, Referral and Assessment	July 2019 July 2019

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
2	**Procedures** The development of locally agreed procedures and working practices will allow business continuity, cover should the designated officer be absent and allow management to exercise challenge and scrutiny of working practices. The flowcharts should be reviewed, revised and stored in a shared area available to all appropriate officers. The Client Document Request should be used for all new cases to ensure the eligibility is complete and be a guide to all information collected. Procedure notes should be dated "owned" and a revision note embedded in the footer of the document.	2	This is under review.	Head of Service, Referral and Assessment/ Group Manager (MASH)	June 2019

REVIEW OF NO RECOURSE TO PUBLIC FUNDS AUDIT 2018-19

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
3	**Financial Assessments** The Financial Assessment should be developed as a standard template document to capture all relevant information. The document can be used to record referral and responses from the Greenwich Fraud Team. The Financial Assessment should be signed, dated and authorised. Financial Assessments should be reviewed regularly, at a minimum annually. A financial assessment should be available for all clients currently supported by the Authority.	2	The Group Manager is currently reviewing the financial document from another Local Authority which will be adapted for Bromley once agreed by Senior Management.	Group Manager (MASH)	June 2019

REVIEW OF NO RECOURSE TO PUBLIC FUNDS AUDIT 2018-19

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
4	**Scanned Documents and Retention of Evidence** All documentation supporting the payments made to a client should be available for inspection and therefore stored in a shared area appropriately secured. Scanned documents should be batched and referenced to allow identification and retrieval.	2	This is being reviewed and will agree if Business Support or the Social Worker/NRPF worker) should be uploading scanned documents and evidence to the system.	Group Manager (MASH)	Immediate.

REVIEW OF NO RECOURSE TO PUBLIC FUNDS AUDIT 2018-19

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
5	**Subsistence Payments** The agreed weekly subsistence allowance should be in line with the published Home Office rates. Deviation to these rates should be supported by the authorised financial assessment and manager's approval. For cases that span financial years the Team should ensure that allowances are updated in line with published allowances. The Team should ensure that the subsistence allowance is divided equally between siblings on the case management system or agree the standard representation.	2	This was addressed when the issue came to our attention. The NRPF officer has amended previous existing payments to be in line with the Home Office rates and this has been authorised on the Child's file on the database.	Group Manager (MASH)	In place.

REVIEW OF NO RECOURSE TO PUBLIC FUNDS AUDIT 2018-19

APPENDIX B

MANAGEMENT ACTION PLAN

Finding No.	Recommendation	Priority *Raised in Previous Audit	Management Comment	Responsibility	Agreed Timescale
6	**Home Office Online System** Ensure that the information uploaded to the Home Office online system is accurate and complete. All relevant fields should be completed and the information reconciled to the details held in the case management system. Consideration should be given to allowing access to colleagues in ASC and Housing or liaising with colleagues to facilitate improved communication with the Home Office.	2	To be reviewed and improved upon. The knowledge here has not been passed on to other workers who should be using the system. Management will identify an appropriate worker that can support training officers to be able to use Home Office online system without the reliance on one worker.	Head of Service, Referral and Assessment/ Group Manager (MASH)	August 2019.
7	**Classification on Case management system** NRPF cases should be assigned a unique classification on CareFirst.	3	To be discussed with HOS and Change Management control	Head of Service, Referral and Assessment	July 2019

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.

CONFIDENTIAL

FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE AND HEALTH DEPARTMENT

REVIEW OF RIVERSIDE SCHOOL

Issued to: Steve Solomons, Headteacher
Sue Crane, School Business Manager
George Christian, Chair of Governors (final only)
Jared Nehra, Director of Education (final only)
Schools Finance Team (final only)

Prepared by: Principal Auditor
Trainee Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 24th September 2019
Report No.: ECHS/09/2019/AU

REVIEW OF RIVERSIDE SCHOOL

INTRODUCTION

1. This report sets out the results of our audit of Riverside School. The audit was carried out as part of the work specified in the 2019-20 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The audit reviewed the system of controls surrounding the financial administration of the school, as required by the 1998 School Standards and Framework Act Section 48, paragraph 2(d) and the Authority's Scheme for Financing Schools.
3. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 28th June 2019.
5. The key risk areas were identified as:-
   - **Financial management information** including budget monitoring, financial reports and returns to London Borough of Bromley
   - **Primary accounting documentation** including payments, income, contracts, voluntary funds, bank reconciliations and payroll.
   - **Asset control**
   - **Governance arrangements** including financial delegation, governor minutes, budget approval and business interests
6. Audit testing was selected from financial transactions for the period June 2018 to June 2019 and the minutes for the previous three Governor meetings for Resources Committee and Full Governing Body were reviewed. Findings were discussed with the School Business Manager during the course of the site visits on the 9th and 11th July and reported to the Headteacher at the end of audit meeting on the 16th July.

REVIEW OF RIVERSIDE SCHOOL

AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**5**	**1**

SUMMARY OF FINDINGS

8. Overall the controls were in place and working well for financial management and governance. However the following issues arising need to be considered:-

- The school evidenced a satisfactory expenditure process, achieving separation of duties however with only three officers designated to authorise the orders, invoices or cheques there is a concern that the procedures may not offer adequate resilience. The scheme of delegation requires governor sign off for payments over £10K however there was no specimen signature. Similarly a specimen signature should be held for the budget holders as they may sign for the receipt of goods or services. Purchase orders were available for all payments selected for audit testing but in 6/22 cases the order was raised after the invoice. Sample testing identified that the audit trail to evidence decisions should be improved with regard to the date and specification of quotes and the authorisation of additional work. For 1/22 payments the invoice did not specify the VAT registration number although the sales order had.

- The check on payments to individuals identified three cases that should have been supported by the online HMRC questionnaire to support the self employed status.
- The contract register was a comprehensive document but was not dated to evidence the latest revision. The document needed updating as contracts detailed had expired. It is acknowledged that the register is not reported to Governors at their request; minutes of the Resources Committee 16/6/16 show that Governors agreed to receive "reports will only contain £10K or more" although it was unclear if that was an annual value or life of the contract.
- The sample testing on the petty cash identified that not all transactions were supported by the signature of the claimant to evidence receipt of the cash.
- There are no current lettings however testing on two hiring's for the hydro pool identified that the agreement had not been signed by the school, the insurance section had not been completed and the VAT had been incorrectly calculated which resulted in a loss to the school.
- The asset register was generated from the system but was not dated and signed by the SBM; the Headteacher should certify the asset register annually to certify the accuracy of the record. The expenditure testing identified 10 I-Pads and 10 I-Pods that had been added to the asset register and assigned an asset number but the unique serial number had not been detailed on the stock book.

9. It is acknowledged that that the school had experienced issues with a member of the Finance Team during the previous 12 months which has impacted on performance. This has now been resolved but would account for the errors identified with the lettings sample and some of the expenditure findings.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

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REVIEW OF RIVERSIDE SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale/ responsible manager
1	**Expenditure Process** The authorisation process for expenditure identified 3 officers; this may impact on the resilience to achieve separation of duties. Governors are required to authorise expenditure >£10K but there was no specimen signature. A sample of 22 payments selected from the bank history identified that the audit trail to evidence decisions with regard to quotes and additional work should be improved. In 6/22 cases the purchase order had been raised after the invoice and for 1/22 payments had been made against an invoice that did not detail the VAT number. Detailed findings set out in Appendix C on page 10	Unauthorised expenditure may be processed through the school accounts. Payments may not be made in compliance with Financial Regulations and the School's own procedures	The school should:- (i) review and increase the number of officers nominated to authorise the expenditure process (ii) specimen signatures should be available for Governors and budget holders required to sign off documents (iii) purchase orders should be raised when the expenditure is committed iv) additional work or goods should be supported by an authorisation on the purchase order v) for complex projects a summary of tenders would support the decision to award and clarify the comparison of quotes vi) quotes should be collected in the same timeframe and all relate to the procured goods vi) invoices should detail the VAT number. **Priority 2**	(i) Finance officer will be added as authorised signatory. (ii) Staff involved in the processing of orders recognise the signatures so this did not create any risk exposure, however an extended list will be kept for any new staff/auditors. (iii) PO's are raised as soon as practicable and additional efforts will be made to communicate decisions in good time and ensure online/account purchases are processed at the earliest opportunity. (iv) Additional works will be referenced and authorised on the purchase order (v) There were no complex tenders reviewed and the project examined had been fully reported to, and considered by Governors. Comments noted for future projects. (vi) Noted and actioned. Where quotes not possible reasons will be recorded and authorised. (vii) Noted. VAT number was in evidence on other associated paperwork.	September 2019/ SBM September 2019/ SBM Ongoing Ongoing As appropriate Ongoing Ongoing

REVIEW OF RIVERSIDE SCHOOL

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale/ responsible manager
2	**IR35 – HMRC** The bank history for the sample period was used to identify all payments to named individuals. For 2 payments the HMRC online questionnaire should have been completed to support the self employed status of the engagement. A third case was identified during the check on cancelled payments and the cheque reissued to the named individual.	Non-compliance with HMRC regulations resulting in a financial penalty.	The online assessment should be completed in all instances where a payment to an individual is planned. This assessment should be printed out, dated, signed by the authorising officer and retained as supporting documentation with the order and invoice. **Priority 2**	Previously unaware of this requirement unless relating to regular suppliers such as peripatetic music teachers. Requirement now noted and actioned	September 2019/ SBM/Finance Officer

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REVIEW OF RIVERSIDE SCHOOL

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale/ responsible manager
3	**Petty Cash** The main petty cash float is held at the St Pauls Cray site with a sub float of £50 at the Beckenham site. The imprest claim for April to June 2019 was checked and identified that the claimant had not signed for the receipt of the cash.	Petty cash transactions may not be completed in accordance with Financial Regulations or the schools own financial procedures	The petty cash claim form is to be completed in full including the signature of the receiving officer to evidence that the transaction is accurate and complete. **Priority 2**	Reminder issued to obtain signature of receiving officer. Re-imbursement not to be released without signature.	September 2019/SBM/Finance Officer
4	**Lettings** There are no current lettings however testing on two previous hiring's of the hydro pool identified that for one the application form had not been authorised by the school and for the other the insurance section had not been completed. The calculation of the charges and VAT for the invoice to the regular hirer was incorrect and led to a loss of income to the school.	Unauthorised use of school premises Loss of income to the school	The letting of any school facility for one off or regular hiring, should be supported by an authorised application form that considers the hirers arrangement for insurance and clearly sets out the agreed charge. The invoice raised to collect the income should be generated by Finance and if necessary double checked by a more senior officer to ensure accuracy. **Priority 2**	New Finance Officer employed and Letting Policy in place. System will be re-examined if any Lettings are approved. No current lettings in operation. Finance Officer qualified to produce invoices but checks can be completed if necessary.	As appropriate.

REVIEW OF RIVERSIDE SCHOOL

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale/ responsible manager
5	**Asset Register** The asset register evidenced during the audit site visit had been signed by the School Business Manager rather than the Headteacher and was not dated. A delivery of 10 I-pads and 10 I-pods was identified during the expenditure testing and although added to the asset register and allocated asset number, the unique serial number had not been recorded.	The Financial Regulations requirement for the Headteacher to certify the asset register annually may not be achieved Assets lost or stolen may not be easily identified.	The asset register should be printed off annually, pages numbered and dated to allow the Head teacher to sign off the document and certify that the asset register is complete and accurate. All assets received on site should be added the stock register, detailing the unique serial number to allow that item to be identified. **Priority 2**	Asset register will be added to the annual year end closedown paperwork for signature by the HT. System in place for identifying assets that should be recorded. Reminder issued to include all unique details to allow identification.	March 2020. HT/SBM October 2019/SBM/Technician

REVIEW OF RIVERSIDE SCHOOL

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale/ responsible manager
6	**Contract Register** The contract register was a comprehensive document however it should be dated and at the time of the audit required update as some of the contracts had expired. It is acknowledged that the contract register is not reported in full, to Governors annually, at the request of the Resources Committee in June 2016, however it is good practice for the Governors to have an overview of all contracts, the use of rollover contracts and consider changing market forces and opportunities.	Contracts may be let without following proper procedures and/or rolled over without proper approval	The contract register should be updated to show current contracts. The register should be owned and dated. Consideration should be given to report the complete register to Governors annually to allow scrutiny and challenge. **Priority 3**	Will be reviewed as part of discussion with the Resources Committee and an annual summary produced in addition to reviews of specific contracts.	October 2019/SBM

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Recommendation 1 – detailed findings

A sample of 22 payments was selected from the bank history for the period June 2018 to June 2019. The main issues arising were as follows:-

- All 22 payments were supported by an authorised purchase order but for 6/22 the purchase order was raised after the invoice date.

- At the meeting of the Resources Committee in February 2018, Governors agreed to waive competitive quotes and procure through one supplier given the specialist nature of the purchase (Sample 1 - £33,968). The Headteacher should also approve the decision to waive obtaining quotes and although part of Resources Committee it would offer greater independence if the Headteacher's authorisation was seen as separate and additional to the committee minutes.

- The expenditure testing identified issues with the collection, recording and use of quotes, specifically:-

    - Sample 3 and 11 – £22,426 and £8,225. One invoice was not authorised. Quotes were available for this project from these two companies and a third supplier, however it was difficult to compare like for like. There was a project summary to support tender evaluation but to an independent assessor this was not transparent. The decision to award work to these two providers was confirmed by Resources Committee in June 2018.

    - Sample 7 – £9,830. 3 quotes were evidenced to support the procurement of IT equipment but two of the quotes were online and had not been dated to allow verification that the quotes were obtained at the same time

    - Sample 9 – £9,195. The invoice was based on quotations 316 and 317 dated 15/1/19; whereas the invoice was received on the 3/5/19. The purchase order dated 7/5/19 refers to quotations 329 and 330 which were not provided with the evidence. The Resources Committee minutes refer to online and verbal phone quotes but these were not evidenced. One quotation did not have a price.

    - Sample 10 – £8,511.33. The value of the quote evidenced in March 2018 was not reflected in an increased price charged on the invoice in November 2018. There was no evidence that updated quotes had been sourced.

- Sample 13 – £6,140. Only 2 quotes were evidenced; the quote from this provider was for one make of laptop but the order placed was for an alternative. There was no evidence to support the decision to purchase a different product or obtain additional quotes.

- For two of the payments examined additional work was evidenced on the invoices. The variation should have been authorised on the purchase order. Sample 5 - £10,134 had additional work of £460 and for sample 7 - £9,830 additional equipment agreed in an e-mail trail but not approved by an authorising officer.
- For sample 14 - £7,246.12, the invoice did not detail the VAT registration although the reference had been detailed on the sales order.

INTERNAL AUDIT FINAL REPORT

CHILDREN'S SOCIAL CARE

INTERNAL AUDIT REVIEW OF THE TROUBLED FAMILIES CLAIM FOR THE PERIOD 1 APRIL 2019 TO 30 SEPTEMBER 2019

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

Cc Janet Bailey, Director of Children's Services
David Dare, Assistant Director, Children's Social Care
David Bradshaw, Head of Finance, ECHS

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 30 September 2019

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 2019 and 30 September 2019.

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 progress 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 ending 30 September 2019. This was to ensure continuity of testing from the previous claim period.

METHODOLOGY

4. There were 403 individual claims closed between 1 April 2019 and 30 September 2019 and our sample for checking consisted of 40 claims. Two of the claims examined were where a client had gained employment, enabling a claim to be made. The other 38 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 each one in our sample for testing met the relevant criteria for a claim to be made. We also confirmed that these families had not been claimed for previously.

6. We verified that the total amount claimed for payment by results for the 403 individual claims submitted between the period 1 April 2019 and 30 September 2019 was £322,400. As a result of our testing there are no findings and there are no recommendations arising from this review.

7. Finally, we would like to thank everyone contacted during this review for their help and co-operation.

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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF CONTRACT MANAGEMENT OF THE COUNCIL'S IT CONTRACTOR

Issued to:	**Mark Bowen, Director of Corporate Services** **Vinit Shukle, Head of IT and SIRO** **Dee Jackson, IT Contract and Operations Manager**
Prepared by:	**Assistant Manager and Senior Manager (Audit contractor on behalf of London Borough of Bromley)**
Reviewed by:	**Head of Audit**
Date of Issue:	**30 July 2019**
Report No.:	**CEX/02/2018/AU**

REVIEW OF CONTRACT MANAGEMENT OF THE COUNCIL'S IT CONTRACTOR

INTRODUCTION

1. This report sets out the results of our audit of contract management of the Council's IT contractor. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. We would like to thank all staff contacted during this review for their help and co-operation.
3. IT Contracts and Operations are responsible for the client management of the IT contracts placed with the Council's IT contractor. These contracts were originally tendered under a joint procurement on behalf of both Lewisham and Bromley Councils in 2010, and as a result awarded to 'Contractor A', with the contract commencing 1 April 2011 for an original five year term and an option to extend for two further periods of two years each. That contractor was subsequently bought out by 'Contractor B' and has performed the contract for both authorities. New contracts were placed with the Council's current IT contractor under a Framework Agreement held by Westminster City Council. The contracts commenced 1 April 2016 and cover Distributed Computing and the Data Centre.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 21 March 2019.
5. The following were considered to be the key risks inherent to the contract management process for the Council's IT contractor:
    - Where a contract is not in place and signed by all parties there is a risk that, if disputes arise, they cannot be easily resolved. Furthermore, it may mean that the contract cannot be easily monitored to ensure that an appropriate service is being delivered.
    - Where a contract specification is not in place, there is an increased risk that planned work may not be carried out, or may not be completed to the required standard.
    - Where ordering, payment and reconciliation for works is not carried out effectively, there is a risk to the Council that work may not be carried out by the contractor but the Council is still paying for it.

- Where performance is not monitored, there is a risk that the contractor may not carry out their duties in line with the contract. In turn this could lead to both reputational and financial loss.
- Where budgets are not monitored effectively, there is an increased risk that more money could be spent than is available. Where management are unaware of the performance of the contract there is a risk that the contract may be underperforming without the ability to take effective and timely mitigating actions.

AUDIT OPINION

6. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Substantial Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**0**	**3**

SUMMARY OF FINDINGS

7. Controls noted to be in place and working well, based on the audit testing conducted, included:

- The Council has entered into call-off contracts under Westminster City Council Framework Agreements related to IT services. The framework agreements are dated 19 December 2013 and are for Distributed Computing (Lot 1) and Data Centre Legacy Systems (Lot 3). The Framework Agreements commenced 1 January 2014 and are for a four year term.

The call-off contracts were formed by completion of the Framework Agreement Schedule 7 Order Forms for each of the two lots on 16 December 2015. The order forms identify both Lots as being effective from 16 December 2015 and services commencing 1 April 2016 (Lot 1 to expire on 20 December 2020 and Lot 3 to expire on 15 November 2020). Both order forms, for the call-off contracts under the Westminster City Council Framework, were signed for the Council by the Director of Corporate Services on 17 December 2015. The call-off contracts were executed under seal as required and the original documents retained by Legal Services.

- Both of the above call-off contracts have since been extended to 15 December 2023, which were completed by Change Control Notice, executed under seal and signed by the Director of Corporate Services. A report was prepared seeking approval for the transfer of the remaining IT services to the Council's current IT contractor as from November 2017 and for a minimum of six years, by way of a variation to the existing call-off contracts. This report was approved by the Executive on 9 August 2017 in accordance with the requirements of Contract Procedure Rules. It is noted that an e-mail conversation between the Director of Corporate Service and Legal Services commented that, while framework agreements are for a fixed term of up to four years, and cannot be extended beyond the end date, it is possible to call-off contracts under the framework agreement which do last beyond the framework.
- There is, for each Lot, a Framework Agreement (Schedule 5) which specifies the terms and conditions for the call-off contracts.
- A report was prepared for the Executive on 17 September 2015 by the Head of ISD. This report reviewed the history of the IT contracts and included consideration of five options for the future, which covered the option of the framework agreements for the Council's current IT contractor. It also included a financial comparison of using the frameworks over continuation of the contracts operated by the Council's IT contractor at that time, which identified a saving of £400k per annum (pa). The report recommended approval in principle to employ the frameworks, which was approved by the Executive. A further report was prepared for the Executive on 14 October 2015, providing an update and calculated the savings over the contracts operated by the Council's IT contractor at that time as being £476k pa. It recommended the use of the framework agreements with effect from 1 April 2016 and this was approved by the Executive.
- The desired outcomes for each call-off contract are stated in the Framework Agreement Schedule 15.2. There are 12 and 11 such service areas for each of Lots 1 and Lot 3 respectively. Each of these service areas includes a description of what the service is, desired outcomes and service provider requirements.
- The Contract Call-Off Order Forms include Appendix 1, which lists each Service Entity Description Name, the Service Entity Code, volumes at the contract effective date, anticipated volumes across the following 12 months, price based on current framework volumes, notice period for volume changes and minimum call-off period. The Contract Call-Off Order

Forms specify the individual fee payable for each service entity to be provided under the contract and, using the volumes stated at the start date of the contract, an estimated cost for the contracts. These are as follows:

- Call-Off Contract Lot 1 estimated cost over five years for Distributed Computing £3.185M, Service Desk £1.538M; and Network Monitoring & Management £1.422M; and
- Call-Off Contract Lot 3 Data Centre estimated cost over five year £3.836M.

- Purchase Order (PO) 19040 was raised by the Council on 10 May 2018 for £2.385M, against which, all invoices raised in 2018/19 by the Council's IT contractor for Lots 1 and 3 are paid. PO 19625 was raised on 2 May 2019 for £2.414M against which all the Council's IT contractor invoices raised in 2019/20 for Lots 1 and 3 are paid. The POs are orders against which invoices are paid, as and when amounts are confirmed as received. It was confirmed the amount invoiced for May 2019 was in accordance with that agreed as received.
- The Council's IT contractor submits, in arrears, a monthly summary invoice which states the amount payable for the month. In addition, they submit a spreadsheet which encloses the volume data for each service and with the appropriate fee for each service. These figures are reviewed and verified by the Council against the raw data supplied e.g. Daily Volume and Back-ups, and the volume and performance reported monthly by the Council's IT contractor. Where agreed, the value of the invoice is goods receipted against the annual PO.
- Framework Agreement Schedule 2 sets out the reporting requirements for the service provider, which states that Service Reports shall be provided at least monthly, unless otherwise agreed. It was confirmed that the Council's IT contractor has produced and submitted to the Council presentations on performance for January, February, March and April 2019. Examination of these performance presentations confirm they review Key Performance Indicators (KPIs) for Lots 1, 3 and bespoke services, service volumes, risks and issues and service improvements. It is noted that, over the period selected, there is only one KPI where performance is poor. This is for Lot 3 with regard to P3 Incident Management, and it is only off target in January and April 2019, with an explanation noted.
- There is a Contract Monitoring and Performance Board (CMP) which is required to meet at least once a month. Minutes of these meetings were provided which had file names of 17 January 2019, 14 February 2019 and 23 April 2019. Examination of these minutes identified:
  - they consist of a series of actions, stating whether they are ongoing or closed, and record an update from each meeting; and
  - meetings are attended by both the Head of ISD and IT Contract & Operations Manager.

- A 2019/20 original budget of £3.711M for the costs of the IT contracts has been allocated within the financial system on cost centre 400031 and against the following subjective codes:
  - 3005 (Contract Payments) Original Budget £1.594M (Revised Budget £1.679M).
  - 3664 (Core IT Contract) Original Budget £1.844M.
  - 3665 Main IT Contractor Original Budget £0.272M (Revised Budget £0.221M).
- The IT Contracts and Operations Manager has access to the financial system through which transactions and actual spend against budget can be viewed as and when required. Examination of the most recent financial statement identified the forecast year end outturn is in line with the revised budget.

8. We would like to bring to management attention the following issues:
   - CMP meetings are required to be held between the Council and the service provider on a monthly basis, but it was noted there was no meeting in March 2019.
   - Minutes are taken for each CMP meeting recording actions agreed, though it was identified there were none for the meeting of 14 February 2019. The meeting minutes for 24 April and 30 May 2019 do record updates to actions for 14 February 2019.
   - CMP minutes were provided which were titled 14 February 2019, but which were those for 30 May 2019. CMP minutes were also provided which were titled 14 February 2019 but were in fact the minutes for 23 April 2019.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

CONFIDENTIAL

REVIEW OF CONTRACT MANAGEMENT OF THE COUNCIL'S IT CONTRACTOR

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	Contract Meetings Contract Monitoring and Performance Board (CMP) meetings are required to be held between the Council and the service provider on a monthly basis, but it was noted there was no meeting in March 2019.	There is a risk that where issues arise, there are delays in taking remedial action.	In the event that regular physical meetings cannot be held (for CMP), arrangements should be put in place to allow for an alternative date, or a review by conference call, with an email confirmation of any actions agreed issued. **Priority 3**	There was one instance this year whereby it proved impossible to co-ordinate diaries for one month CMP Board – the invoice for that month was not paid until the CMP Board for that month was held with the following month's CMP Board.	IT Contract and Operations Manager Implemented
2	Meeting Minutes Minutes are taken for each CMP meeting recording actions agreed, though it was identified there were none for the meeting of 14 February 2019. The meeting minutes for 24 April and 30 May 2019 do record updates to actions for 14 February 2019.	There is a risk that actual minutes of meetings may be misplaced and / or lost.	Minutes should be taken of each CMP meeting and circulated to all relevant officers. **Priority 3**	Every meeting is minuted with key discussion points and actions and then circulated. Recommendation noted and addressed with the attendees from both LB of Bromley & the Council's IT contractor.	IT Contract and Operations Manager Implemented

REVIEW OF CONTRACT MANAGEMENT OF THE COUNCIL'S IT CONTRACTOR

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	Accuracy of Minutes CMP minutes were provided, which were titled 14 February 2019, but which were those for 30 May 2019. CMP minutes were also provided, which were titled 14 February 2019 but were in fact the minutes for 23 April 2019.	There is a risk that disputes may arise over agreed actions, and delays in their implementation.	CMP minutes should be checked to confirm accuracy, including the dates of such meetings. Where errors are identified, these errors should be noted and corrected. Such checking should be a standard agenda item at the beginning of each meeting. **Priority 3**	Recommendation noted and addressed with all attendees of C&P board from both LB of Bromley & the Council's IT contractor.	IT Contract and Operations Manager Implemented

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE & HEALTH SERVICES

REVIEW OF DIRECT PAYMENTS (CHILDREN)

Issued to: Mark Smith, Group Manager,
Vicky West, Head of Fostering, Adoption & Resources,
Viktoria Flagg, Contract Compliance Officer,
Debi Christie, Head of SEN Service,
David Dare, Assistant Director Children's Social Care,
Janet Bailey, Director, Children's Services,
David Bradshaw, Head of, Finance, Education, Care and Health Services (ECHS)
Claudine Douglas-Brown, Assistant Director, Exchequer Services,
Naheed Choudhry, Assistant Director, Strategy, Performance and Corporate Transformation,

Prepared by: Principal Auditor,

Reviewed by: Head of Service, Audit & Assurance.

Date of Issue: September 30th 2019

Report No.: ECHS/13/2019/AU

REVIEW OF DIRECT PAYMENTS (CHILDREN)

INTRODUCTION

1. This report sets out the results of our audit of Direct Payments (Children). The audit was carried out as part of the work specified in the 2019-20 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.

2. A Direct Payment is money that is given to a child aged 16 years or over who has a disability and to parents or carers, aged 16 or over of young people, by the authority to enable them to buy in support that is assessed as being needed, instead of the authority providing that support through their own services. Direct Payments can be made for special educational provision, health care and social care provision.

3. The relevant legislation can be found within :-

   - The Care Act 2014
   - Care and Support (Direct Payments) Regulations 2014

4. The total net budget for Safeguarding and Care Planning West, Preventative and Support Services for 2019-20 is £2,550,410. Included within this amount is the Disabled Children Direct Payments budget of £597,180. As at May 2019, the forecast spend at the end of the financial year is £1,015,772, which would result in a forecast overspend of £418,592. There are currently 206 service users. The current forecast spend for Direct Payments in 2019-20, after accounting for these payments, is £792,570 against a budget of £597,180. This gives a current forecast overspend of £195,390.
   It should be noted that this review did not include a review of pre-paid cards.

5. Contractor A provides information advice and support to service users, as well as the payroll service, which are all designed to empower people to have more choice and control over how their care and support needs are met.

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

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference issued on 19/6/19.

REVIEW OF DIRECT PAYMENTS (CHILDREN)

8. The key risks reviewed as part of this audit included:-

- Assessments are not undertaken within agreed timescales.
- Service agreements are not appropriately authorised.
- Direct payments may be paid to ineligible clients for the incorrect duration and the incorrect amount.
- Split funding is not recovered from other departments.

AUDIT OPINION

9. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**5**	**0**

SUMMARY OF FINDINGS

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

10. Redacted.

REVIEW OF DIRECT PAYMENTS (CHILDREN)

11. DP1 & 7 Forms (Referral or change of Service Form)

It was found that there were delays in completing the DP1 form for Sample 10 and 18.

For Sample 10 the service agreement commenced on 24/9/18 and the DP1 was dated 25/10/18. Management confirmed that the payment was backdated hence the delay in dates.

For Sample 18 the service agreement commenced on 27/3/17 to 16/9/18 and the DP1 was dated 21/9/18. An email from the contractor confirms the delay was down to the Contractor A.

12. Reviews

From sample testing of 20 cases it was found that issues arose in three cases at the time of testing. In some cases the reviews could not be located or they had been delayed. It should be noted that management are setting up a new online review assessment, but this is still in progress at the time of the audit.

13. Service Agreements

All service agreements sampled for review on Carefirst had been authorised. However, sample testing showed that there had been delays in authorising service agreements in a timely manner in 16 cases. The delays ranged from a matter of weeks to four months in one case.

14. DP Calculation

Through sample testing, it was found that for Sample 11, the calculation detailed within the DP1 dated 24/4/19 was not clear. The calculation is based on 50 weeks which has been queried as well as the payment should be made monthly.

15. Direct Payment Rate for Children

It was confirmed by management that the direct payment rate of £10.73 for children had not been reviewed in line with the adult rate.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF DIRECT PAYMENTS (CHILDREN)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	DP1/7 Forms It was found that there were delays in completing the DP1 form for Sample 10 and 18. For Sample 10 the service agreement commenced on 24/9/18 and the DP1 was dated 25/10/18. Management confirmed that the payment was backdated hence the delay in dates. For Sample 18 the service agreement commenced on 27/3/17 to 16/9/18 and the DP1 was dated 21/9/18. An email from the contractor confirms the delay was down to the contractor.	Assessments are not undertaken in a timely manner and payment delays may occur.	**Management should ensure that the contractor undertakes the completion of the DP1/7 forms in a timely manner to ensure that payments are not delayed to service users.** **Priority 2**	The reason for delays are often due to the family not having a worker or family delay in setting up the meeting with Contractor A, as opposed to a delay in administration with the service. Consideration to be given to setting up a tracking system for direct payment referrals to Contractor A.	Group Manager End of October 2019.
2	Reviews From sample testing of 20 cases it was found that issues arose in three cases at the time of testing in relation to the annual reviews.				

REVIEW OF DIRECT PAYMENTS (CHILDREN)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	Sample 4 a review could not be found at the time of testing. Sample 13 the review is due and has yet to be undertaken as confirmed by the Group Manager as at 30/07/19. Services commenced for this service user on 1/10/18. Sample 20 this was confirmed by the Group Manger that this review is outstanding as at 30/7/19. Management confirmed that a review date has now been arranged with the social worker. The last Disabled Children's review was dated 24/11/15-12/2/16. It should be noted that management are setting up a new online review assessment, but this is still in progress at the time of the audit.	Direct payments may not be utilised in accordance with the terms and conditions.	**Reviews should be undertaken in a timely manner to ensure that the service user is managing with the direct payment**. **Priority 2**	IT development required of review on line assessment system to support annual monitoring of low level direct payments	Group Manger End of November 2019 to set up review on line assessments Sample 4 – Child has been discussed at placement panel today. There are regular CIN meetings. Sample 13 and 20 to be allocated and review assessment to be completed in 45 days. Option of on-line review assessment to be offered.

REVIEW OF DIRECT PAYMENTS (CHILDREN)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	Service agreements All service agreements sampled for review on Carefirst had been authorised. However, sample testing showed that there had been delays in authorising service agreements in a timely manner in 16 cases. Samples 1, 3, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. These delays range from one or two weeks and for one case four months.	Delays in authorising service agreements will result in delayed payments to service users.	**Management should ensure that service agreements are authorised in a timely manner.** **Priority 2**	Managers will continue to sign off service agreements when alerted. The aim is to sign this off with 24 hours.	Group Manager and Team Managers Ongoing
4	DP Calculation Through sample testing, it was found that for Sample 11, the calculation detailed within the DP1 dated 24/4/19 was not clear. The calculation is based on 50 weeks which has been queried as well as the payment should be made monthly. '1 x ABA Tutor @ £25 per hour for 14 hours direct work x 50 weeks = £17,500 + £1,800 for				

REVIEW OF DIRECT PAYMENTS (CHILDREN)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	2 x hours indirect work @ £18 per hour. Total = £19,300 50 weeks x ABA consultant 5 hours per month @£85 per hour & 2 hours £45 per hour for remote work per month = £7115.60 (these totals also include any travel costs)'. Total for ABA programme: £26,415.60 (divided by 52 week to be paid monthly) £507.99 per week 50 week rate: £528.31 per week. This service agreement continues to be paid weekly at the rate of £507.99.	Payments are made for the wrong amount and frequency.	**This case should be reviewed with SEN to ensure that the direct payment is being paid at the correct amount and frequency.** **Priority 2**	This was a one off calculation made by colleagues in SEN.	Business Support Officer to liaise with Senior Tribunals and Mediation Manager – 1 week.

REVIEW OF DIRECT PAYMENTS (CHILDREN)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
5	Direct Payment Rate for Children It was confirmed by management that the direct payment rate of £10.73 (unit of support) for children had not been reviewed in line with the adult rate. (as detailed within the Children With Disabilities Report 2017/18).	The current direct rate may not be sufficient to enable the direct payment to work for families.	**The direct payment rate should be reviewed.** **Priority 2 ***	The business case has not been finalised and it is hoped will be dealt with as part of the Medium Term Financial Strategy. The service will need to evidence the rationale for the increase which as a growth item will need to be agreed by the Executive.	In time for the 2020/21 Budget. Head of Finance, ECHS/ Group Manager.

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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CONFIDENTIAL

FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE AND HEALTH SERVICES DEPARTMENT

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

Issued to: Rob Bollen, Head of Strategic Place Planning
Jared Nehra, Director of Education

Cc (Final Only) Naheed Chaudhry, Assistant Director, Strategy, Performance and Corporate Transformation
David Bradshaw, Head of Finance, Education and Children's Services
Pete Turner, Director of Finance
Tracey Pearson, Chief Accountant
Shupriya Iqbal, Head of Legal Services

Prepared by: Principal Auditor

Reviewed by: Head of Audit & Assurance

Date of Issue: 16th August 2019

Report No.: ECHS/2/2018/AU

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

INTRODUCTION

1. This report sets out the results of our audit of the Schools' Capital Programme element of the Education, Care and Health Services Capital Schemes. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Local Authority has a statutory duty under Section 14 of the Education Act 1996 to ensure that there are sufficient primary and secondary school places available to meet the needs of pupils in the area. This duty is not restricted to those schools under the 'control' of the Local Authority but includes, for example, Academy Schools.
3. The School Place Planning Strategy provides analysis of the requirement for school places by local area together with details of what has been delivered through expansion of existing schools, either permanent or 'bulge' classes, and the opening of Free Schools over the past year, together with the schemes currently under construction and details of the Council's future proposals. The Council also has obligations to ensure that Maintained School premises are maintained to an appropriate standard.
4. The Schools' Capital Programme (Basic Need Programme) is a set of capital projects which the Council plans to undertake within a given timetable and is funded primarily through the Basic Need Capital Grant. £77.8m has, thus far, been allocated for 2011-2020. In addition, the Programme receives smaller capital contributions from schemes such as the Capital Maintenance Grant, Section 106 contributions and SEND (Special Educational Needs and/or Disabilities) Provision Capital Funding. The total Basic Need Capital Programme, as approved by Council in October 2018, is £85.1m
5. Between 2009/10 and 2018/19, the Basic Need Capital Programme has added 1,635 temporary and 2,987 permanent school places in mainstream and specialist settings.
6. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference and covered the effectiveness of the Schools' Capital Programme controls. The key risks reviewed within this audit were:-

- Lack of clear process for making capital bids to identify schemes and prioritise use of capital resources
- Proposals are not supported by appropriate documentation to allow for an effective assessment of feasibility, options and funding assessment
- Schemes are not subject to appropriate authorisation
- Contract awards are not made in compliance with contract procedure rules, signed contracts are not held and contracts are not recorded on the contracts register
- Regular progress meetings to monitor Capital Projects and spending against budget are not held
- Post completion reports are not produced

AUDIT OPINION

8. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**4**	**0**

SUMMARY OF FINDINGS

9. Our testing identified four issues which we would like to bring to management's attention.

Contracts
At the time of the audit, signed contracts could not be located for two schemes, the construction of a primary school hygiene room and a primary school expansion, the latter being of a value whereby execution under seal through the Legal department was required. For a further scheme, whilst a copy of the contract was located and had been signed on behalf of the contractor, the same Director's signature was in both the 'Director' and 'Company Secretary/Director' boxes and the contract had not been executed on behalf of the Local Authority.

It is acknowledged that these issues pre date the current Director of Education who has confirmed that the department was aware of the weaknesses in the system prior to the audit and had put in place a process, in conjunction with the Legal department, to ensure that all current and future contracts over £200k are scanned. The Education Capital department will ensure that all contracts under £200k are copied and retained. The robustness of this process will be tested as part of the Follow Up process.

During the fieldwork stage of the audit, the contract for the hygiene room was returned signed by the contractor. At the draft audit report stage, the school expansion contract remained unaccounted for and was evaluated as a 'Priority One' issue, resulting in an overall 'Limited' assurance audit opinion. Following subsequent extensive efforts by officers, the executed contract was located leading to the recommendation relating to contracts being revised to a 'Priority Two' and the overall level of assurance being increased to 'Reasonable'.

Policy, Procedures and Resilience
There is no definitive process map or a formal end to end written procedure for the delivery of projects within the School Capital Programme.

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

File Management

Historically, the primary repository for financial and programme records for the Education Capital Schemes was spreadsheet data held on the Senior Project Manager for Strategic Education Capital and Client Services' 'personal' drive within the IT systems. Subsequent to the post holder's departure, this was transferred to the 'shared' drive to enable ongoing access. Whilst this required IT support and occurred at a time when space on the 'shared' drive was critical, and meant that some of the links to underlying data proved inaccessible, it is understood that there was no interruption to real time information.

The historic financial records database has been reconstructed and a system is in place to monitor current and future expenditure. Work to rebuild the programme records element is being undertaken, in addition to existing duties, to ensure that all scheme programme documentation follows the same file structure and that all records are correctly filed in, for example, the Contracts database or within a shared area as opposed to ad hoc records on personal drives or in E mails.

Whilst the significant progress made with standardising the file management system above is acknowledged, a complete audit trail/suite of programme documents for the audit sample could not be established/identified.

Post Completion Reports

Committee reports FSD 18027 dated 27th March 2018 and FSD 18058 dated 18th July 2018 identified two post completion reports as being due before the end of the 2018/19 monitoring cycle. As at the time of concluding the audit, neither had been presented to the Education, Children and Families Budget Sub Committee or its successor, the Children, Education and Families PDS Committee.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	**Contracts** Of the five Capital Schemes sampled:- At the time of the audit, signed contracts could not be located for two of the schemes; a primary school expansion and a primary school hygiene room, with the former being of a value whereby, in line with Contract Procedure Rules section 17.3, execution under seal through the Legal department was required. During the course of the audit, the hygiene room contract was returned signed by the contractor and at the draft report stage, following extensive efforts by officers, the executed school expansion contract was located. For one scheme, a copy contract was located which, whilst it had been signed on behalf of the contractor, had been signed by the same Director in both the 'Director' and 'Company Secretary/Director' boxes and had not been executed on behalf of the Local Authority. The final two schemes had yet to reach the stage where signed contracts for delivery of the project should be in place.	Where correctly executed contracts are not in place, the Local Authority's position may be weakened in the event of instigating legal action or making a claim under the terms of the contract.	Contracts should be correctly executed on behalf of both the Contractor and the Local Authority prior to any works commencing and securely retained. **Priority 2**	All contracts over £200k executed under seal are retained by Legal and Democratic Services. Historically scans of contracts have not been provided to the Education Capital Team. All current and future contracts over £200k are to be scanned by Legal Services with a copy provided to Education Capital. Education Capital will ensure that all contracts under £200k are copied and retained.	Already implemented for all new projects (Head of Strategic Place Planning and Head of Legal Services)

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	**Policy, Procedures and Resilience** Whilst the underlying governance process for the School Capital Programme is Contract Procedure Rules and there are comprehensive Corporate Capital Programme procedures in place, there is no definitive process map or a formal end to end written procedure for the delivery of projects within the School Capital Programme. The lack of a process map/written procedure could lead to processes not being carried out consistently and business continuity/resilience issues in the event of staff absence/turnover. It was noted during the audit that the April 2019 structure charts indicated that all three posts directly reporting to the Head of Strategic Place Planning are currently vacant:- • Senior Project Manager • Education Capital Project Manager • Education Project Officer/Co-ordinator; the high level of vacant posts in this area could also weaken resilience. At the draft report stage, an appointment had been made to the Senior Project Manager post.	The lack of documented procedures may lead to:- i) the process not being carried out consistently ii) business continuity issues within the service in the event of staff absence/turnover.	The School Capital Scheme procedures should be documented and accessible. Parameters should be established to ensure that all officers involved in the process are clear as to their area(s) of responsibility. **Priority 2**	The procedure along with a process map will be put in place and reviewed when the new Senior Project Manager is in post. The Service's business continuity plan is currently being developed with the authority's emergency planning lead and a business continuity plan introduced.	October 2019 (Head of Strategic Place Planning) December 2019 (Head of Strategic Place Planning)

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	**File Management** Historically, the primary repository for financial and programme records for the Education Capital Schemes was spreadsheet data held on the Senior Project Manager for Strategic Education Capital and Client Services' 'personal' drive within the IT systems. Subsequent to the post holder's departure, this was transferred to the 'shared' drive to enable ongoing access. Whilst this required IT support, occurred at a time when space on the 'shared' drive was critical and meant that some of the links to underlying data proved inaccessible, it is understood that there was no interruption to real time information. The historic financial records database has been reconstructed and a system is in place to monitor current and future expenditure. Work to rebuild the programme records element is being undertaken, in addition to existing duties, to ensure that all scheme programme documentation follows the same file structure and that all records are correctly filed in, for example, the Contracts database or within a shared area as opposed to ad hoc records on personal drives or in E mails. Whilst the significant progress made with standardising the file management system above is acknowledged, a complete audit trail/suite of programme documents for the audit sample could not be established/identified.	Lack of an effective File Management system may lead to documentation not being accessible and a full audit trail not being available.	i) All documentation should be filed according to a defined structure and held within a shared area in order that it can be accessed by all relevant officers involved in the process when required. ii) Consideration should be given to a shared system/process which supports collaborative working by allowing the relevant external contractors controlled access. This will enhance document control by ensuring that all staff work from the same version of documents and reduce the need for sending (electronically or paper based) commercially sensitive information between organisations. **Priority 2**	Current information has been filed within the new file structure since summer 2018. This will be audited during Summer 2019. Historic data will continue to be moved across to the new database. Consideration of the greater use of electronic is reliant of corporate Sharepoint project.	September 2019 (Head of Strategic Place Planning) Summer 2020 (Head of Strategic Place Planning)

REVIEW OF EDUCATION, CARE AND HEALTH SERVICES CAPITAL SCHEMES

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
4	**Post Completion Reports** Committee Reports FSD 18027 dated 27th March 2018 and FSD 18058 dated 18th July 2018 identified two post completion reports as being due by the end of the 2018/19 monitoring cycle. As at the time of concluding the audit, neither had been presented to the Education, Children and Families Budget Sub Committee or its successor, the Children, Education, and Families PDS Committee.	Where Post Completion Reports are not competed in a timely manner, performance cannot be evaluated and any lessons learnt used to drive through improvements in future Capital Projects.	In line with Capital Programme Procedures, Post Completion Reports should be submitted for all completed Capital Projects to the relevant Committee within one year of scheme completion. **Priority 2**	The 2 Post Completion Reports will be considered during the 2019/20 cycle and a programme of post completion reports created. These will follow on from Lessons Learnt meetings held with the school, consultant and contractor for all projects valued in excess of £1m.	March 2020 (Head of Strategic Place Planning)

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

CONFIDENTIAL

FINAL INTERNAL AUDIT REPORT

EDUCATION, CARE & HEALTH DEPARTMENT

REVIEW OF FOSTERING

Issued to: Vicky West, Head of Fostering, Adoption & Resources,
Janet Bailey, Interim Director, Children's Social Care,
Ruth Wood, Head of Placements & Brokerage,
David Bradshaw, Head of Finance, ECHS,
Claudine Douglas-Brown, Assistant Director, Exchequer Services,

Prepared by: Principal Auditor,
Reviewed by: Head of Audit,

Date of Issue: June 19th 2019

Report No.: ECHS/11/2018/AU

REVIEW OF FOSTERING 2018-19

INTRODUCTION

1. This report sets out the results of our audit of Fostering. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. There are a number of different types of fostering within the Bromley Fostering Service. These include: emergency, respite, short term, long term amongst others. This is delivered by our in house fostering service and independent fostering arrangements.
3. Applicable legislation includes The Fostering Services (England) Regulations 2011, Fostering National Minimum Standards and the Children's Act 1989.
4. The total net budget for the family placement service for 2018/19 was £6,595,450. Fostering is subsumed within this budget area and the end of year actual is £7,916,654.
5. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 27th March 2019. The scope of this audit covered assessments, reviews and payment procedures for both in house and independent fostering arrangements. Respite payments were touched on additionally.
7. Payments made to foster carers for professional fees and maintenance were reviewed along with any relevant interim payments or payments made outside of Carefirst. This was included to confirm that the payment procedures in place had been complied with. The Payments Policy has been updated and there have been changes to the allowances paid to foster carers. This is effective from 1/5/19.
8. This audit also reviewed the Form F Assessments for foster carers and the Standard of Care Assessments to ensure the relevant assessments had taken place as expected.

REVIEW OF FOSTERING 2018-19

AUDIT OPINION

9. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Substantial Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**3**	**0**

SUMMARY OF FINDINGS

10. Our testing identified the following issues which we would like to draw to management's attention:-
Queries arose with one of the Independent Fostering Arrangement (IFA) placement relating to an incorrect date for the start date of the placement and the date of birth of the child was recorded incorrectly within the contract.

11. Service agreements were found to have not been closed down as a matter of process by Fostering or Commissioning. There is confusion as to which team should close the service agreements as and when relevant. Carefirst therefore does not show the current position and can be misleading.

12. Supporting documentation had not been uploaded onto Carestore for review in respect of an interim payment. This was subsequently uploaded.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

13. 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, together with management's responses and timescales for implementation are also raised at Appendix A. Appendix B details the definition of the assurance ratings and priority ratings.

CONFIDENTIAL

REVIEW OF FOSTERING 2018-19

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	<u>IFA Placements</u> For Sample 7 (child), the placement contract states that the start date of the placement is 05/01/2015 however, the start date on Carefirst commences on 27/3/13 and the child's date of birth is recorded incorrectly.	Contracts do not contain the correct information.	**The case identified should be reviewed and contracts amended accordingly.** **Priority 2**	This young person was originally placed with these carers in 2011. In 2013 he was permanently matched to carers and in 2015 there was a change to the funding agreement as carers were being paid additional sums for transporting long distances to contact. Each of these changes is likely to cause either a new service line to be added to Carefirst or the issue of a new contract. Staff have been advised to use the Observations area of Carefirst to record amendments and to add notes to Service Agreements (SA) or new contracts as they are created.	**Head of Placements & Brokerage** **June 30th 2019**

REVIEW OF FOSTERING 2018-19

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	<u>Service Agreements</u> The service agreement commencing on 21/5/18 had not been authorised for Sample 13 (child). It was found that an Independent Fostering Arrangement (IFA) placement was open at the same time as an in house fostering placement in respect of Sample 15 (child). Having discussed the responsibility for the closure of service agreements with the fostering team, there does not seem to be a set process in place, between fostering team and commissioning.	Open service agreements are held on the system without proper authorisation. Service agreements that are not closed do not reflect the current service provision in place. Carefirst does not reflect the correct information. Ineligible payments could be made.	**Management should ensure that :-** **(i) Service agreements should be closed if the service is no longer being provided.** **(ii) Clarification is made as to which team should be closing off service agreements for particular services provided and the respective procedures updated accordingly.** **Priority 2**	Sample 13 : A number of these open service agreements (SA) are for respite. So whilst a child is placed long term with a main carer there remains time when young people will have planned respite with a carer or two. We do not open and close the SAs at the beginning and end of each respite session, we just open and close the allowances. In respect of the placement service agreements the Fostering service added a new service line for a long stay placement but not closed the short stay agreement. Fostering team will be reminded to do this if they are amending SAs. Children's Placement Team (CPT) have now closed and suggested that these changes can be undertaken by CPT if notified when permanency is agreed. Sample 15 : In this case the in house fostering placement was not closed when child moved to an IFA by CPT. Staff have been advised to close a SA as soon as a placement change occurs to prevent over payments.	**Head of Placements & Brokerage** **June 30th 2019**

REVIEW OF FOSTERING 2018-19

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	Supporting Documentation An Interim Payment was made to a Foster Carer for the period 25/9/18-20/10/18 for £2,767.96. Supporting documentation could not be located for this payment on Carestore. This was subsequently loaded onto Carestore on 15/5/19 when queried by the Auditor. (Sample 14 Foster Carer).	Duplicate payments may arise if evidence of the interim payments made to date are not readily available or accessible.	**Supporting documentation in relation to Interim Payments should be uploaded to Carestore without delay or entered within observations.** **Priority 2**	The interim payments that are made cannot be duplicated because Carefirst is updated straightaway, but not approved in time for regular payment. Contractor A holds credit in Oracle to avoid overpayments. The Finance Officer will create an observation so there is a note on system, as not everyone always has access to Carestore to check payments.	**Head of Fostering, Adoption & Resources** **July 31st 2019**

OPINION DEFINITIONS **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

FINAL INTERNAL AUDIT REPORT

ENVIRONMENT & COMMUNITY SERVICES DEPARTMENT

REVIEW OF LICENSING

Issued to:	**Steve Phillips, Team Leader,** **Dr Hedley Pugh, Head of Food Safety & Licensing,** **Sarah Foster, Head of Performance Management & Business Support,** **Joanne Stowell, Assistant Director of Public Protection,** **John Nightingale, Head of Revenues & Benefits,**
Cc :	**Claire Martin, Head of Finance, Corporate & ECS,** **Claudine Douglas-Brown, Assistant Director, Exchequer Services.**
Prepared by:	**Principal Auditor**
Reviewed by:	**Head of Audit**
Date of Issue:	**July 16th 2019**
Report No.:	**ECS/03/2019/AU**

INTRODUCTION

1. This report sets out the results of our audit of Licensing. The audit was carried out as part of the work specified in the 2019-20 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. Bromley Council is the Licensing Authority under the Licensing Act 2003 and is responsible for the administration and enforcement of a range of permissions such as the sale and /or supply of alcohol through annual licences. There have also been changes in legislation relating to animal boarding businesses, dog breeders, pet shops and riding establishments that will be covered under the new legislation, the Animal Welfare (Licensing of Activities Involving Animals) Regulations 2018 that came into force on 1st October 2018.
3. There are different teams under the remit of the Head of Food Safety & Licensing including, Licensing. The majority of this audit related to the Licensing team remit, but also in part the Private Rented Sector Enforcement Team.
4. There have been changes in legislation in respect of houses in multiple occupation (HMO's).Given the changes occurring in the area this was also briefly examined. Currently, mandatory Licensing applies to HMO's of at least three storeys and five occupants comprising of two or more family units. The new changes will remove the three story rule and is covered by the Licensing of Houses in Multiple Occupation Order 2018 that came into force on 1st October 2018. The licence period for HMO's is for 5 years.
5. A committee report to the Public Protection & Enforcement Portfolio Holder on 3rd July 2018 detailed the proposed increase in HMO licence fees.
6. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference issued on 24/04/2019 and included assessing the controls in place and compliance with legal and regularity requirements.

8. The key risks reviewed as part of this audit were :-

    - Operational procedures may not be in place and available to all staff
    - Licences are not issued in accordance to legal and regularity requirements
    - Licensing fees and charges may not be collected as expected.

9. There is a medium risk relating to the lack of processes to reconcile actual licence fee income against expected income held on service specific IT systems.

10. A random sample of licences were selected from the various licence types detailed on the website. This audit review included special treatment licences, premises licences and licences for houses in multiple occupation (HMO's).

11. The budget for Licensing is subsumed within the budget for public protection, which also includes Public Health, Nuisance Team, Trading Standards, Housing Enforcement and Environment Protection. The total net budget for public protection for 2019/20 is £1,671,450 which includes these areas.

12. The total income from licence fees in 2018/19 was £413,086.32 and for 2019/20 from April 1st to 4/7/19 is £95,535. The total income for HMO income for 2018/19 was £21,764.40 and for 2019/20 from April 1st to 4/7/19 is £96,869.

AUDIT OPINION

13. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	5	0

SUMMARY OF FINDINGS

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

14. Procedures provided at the start of the audit, of which there were many, had various dates although the Auditor was advised that this was not correct. The Team Leader advised that the procedures were in the process of being updated in respect of the changes in legislation in regard to the animal licenses. The updated procedures could not be tested as they were not provided to audit at the time of the review.

15. It was confirmed that the HMO team do not notify council tax of HMO properties within the borough. With the change in legislation regarding the mandatory Licensing classification of premises that came into force on 1st October 2018, it is likely that the number of HMO properties will increase.

16. At the time of the audit it was noted that the Public Protection, Trading Standards & Community Safety Fees and Charges document does not currently include the fees and charges in relation to HMO's.

17. Supporting documentation could not found on Uniform in respect of some of the samples selected for review; applications, licences and details of payment method.

18. The Licensing team officers explained to the Auditor that problems were experienced by them in trying to determine whether individual licence fees had been received. Enquiries have been made to ensure that a report is made available to the team as well as access to the Discoverer reporting tool to enable the team to check on income received as and when required.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

19. 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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

CONFIDENTIAL

REVIEW OF LICENSING 2019-20

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	Procedures Current procedures were provided to the Auditor in respect of the various license types available and these are held on the N drive. The procedures are dated 11/9/17 and there is no review date recorded. The current procedures in respect of animal licenses are in need of review due to a change in the legislation that came into effect in October 2018. The whole set of procedures for Licensing are currently with the Performance Management and Business Support team who are updating the procedures and these will be moved from the shared area to the Sharepoint site. These will be reviewed by the Licensing team prior to these being circulated. It has not been possible to test the revised Licensing procedures as they were in the process of being updated during the audit.	Staff may operate to different working practices. Staff are not able to access procedural guidance. Procedures may not reflect current legislation.	Procedures should be updated to reflect the changes in legislation, regularly reviewed and updated. Procedure notes should be readily available and accessible to all relevant staff. **Priority 2**	The Performance Management Team are currently working on these procedures.	Head of Performance Management & Business Support October 31st 2019

REVIEW OF LICENSING 2019-20

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2.	<u>Notification of Houses In Multiple Occupation (HMO's) properties to Council Tax</u> On 1st October 2018, a change in legislation came into force and mandatory Licensing will no longer be limited to certain HMO's that are three or more storey high, but will also include one or two storey, by means of the Licensing of Houses in Multiple Occupation Order 2018. As detailed within the committee report to the Public Protection & Enforcement Portfolio on July 3rd 2018, it was detailed that there were 82 HMO's registered under the current mandatory scheme and 16 were due for renewal. In June 2019, it was confirmed that there are currently 120 HMO's registered under the current mandatory scheme and 2 due for renewal The HMO team confirmed that they do not notify the Council Tax Department as a matter of course of the licenced HMO properties within the borough.	Additional council tax liabilities may not be identified resulting in loss of income.	A process should be put in place to ensure that the HMO Licensing team regularly notify Council Tax of all HMO licences granted in order that all council tax liabilities are identified. Procedures should be updated additionally. **Priority 2**	A draft procedure has been sent to Council Tax Department for their consideration. When a response is received amendments will be incorporated into the process and the procedure implemented. The Assistant Director of Public Protection requests that the Council Tax Department notifies the HMO team of all HMO's regularly.	Head of Food Safety & Licensing October 31st 2019

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REVIEW OF LICENSING 2019-20

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3.	Fees & Charges It was found during the audit that the current fees and charges for Public Protection, Trading Standards & Community Safety document do not include the fees and charges relating to houses in multiple occupation. It was confirmed by the Head of Performance Management and Business Support that the HMO fees and charges would now be included.	Incorrect fees and charges may be raised.	The Public Protection, Trading Standards & Community Safety fees and charges for 2019/20 should be updated to include the houses in multiple occupation fees and charges. **Priority 2**	The Performance Management & Business Support team to update Fees and Charges List.	Head of Performance Management & Business Support September 30th 2019

REVIEW OF LICENSING 2019-20

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
4.	<u>Supporting Documentation held on Uniform</u> A review of the sample documentation held on the Uniform system, for applications and licences, was undertaken at the time of the audit testing. It was found that for Samples 5 (special treatment) and 12 (special treatment) copies of the licence application forms could not be located on Uniform at the time of testing. For Samples 5 (special treatment), 16 (premises), 17 (premises) and 18 (special treatment), copies of the licences could not be located on Uniform at the time of testing. For Sample 17 (premises) a query arose regarding the payment method as the Uniform system detailed paid by invoice but instead an internal transfer was made. Uniform had not been updated with the correct details of the payment method.	Documents may have been misfiled. Income is not easily identifiable.	All supporting documents should be readily available and uploaded to Uniform. Uniform should be kept up to date. **Priority 2**	The application forms were available on the premises soft files and have now been added to IDOX The Licences were available in the premises soft file and have now been copied to IDOX. This fee was paid by internal departmental transfer. Confirmation was stored in the “receipt” tab of uniform and has been supplied to Audit details updated on uniform	Team Leader Completed Completed Completed

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REVIEW OF LICENSING 2019-20

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
5.	Licence Fee Income Report/Access to Discoverer The Licensing Team officers explained to the Auditor that problems were experienced by them trying to determine whether individual licence fee income has been paid. There is a process in place in that licences should be revoked if licence fees continue to be unpaid. Enquiries were made to ensure that a report could be made available to the Licensing Team in order for them to identify individual licence fee income easily.	Licence fee income is not reconciled. Unpaid debts are not identified and followed up.	A report should be made available to the Licensing team to ensure that that Licensing income can be easily identified and reconciled. **Priority 2**	Updated permissions to allow Team Lead Licensing to access "Discoverer" to run unpaid fees report for monitoring purposes. Chase up and response should be generated through income team in the normal way unpaid accounts would be pursued.	Team Leader August 31st 2019

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT
HOUSING, PLANNING AND REGENERATION DEPARTMENT

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

Issued to:	**Tim Woolgar, Principal Client, Libraries** **Lydia Lee, Assistant Director, Regeneration**
Cc **(Final only)**	**Sara Bowrey, Director of Housing, Planning and Regeneration** **Vicki Boyes – Senior Accountant for ECS Finance**
Prepared by:	**Principal Auditor**
Reviewed by:	**Head of Audit & Assurance**
Date of Issue:	**19th September 2019**
Report No:	ECS/08/2019/AU

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

INTRODUCTION

1. This report sets out the results of our post implementation review of the Libraries Contract. The audit was carried out as part of the work specified in the 2019-20 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Public Libraries and Museums Act 1964 governs public library services in England. It requires local authorities 'to provide a comprehensive and efficient public library service for all persons desiring to make use thereof' (Section 7 (1)).
3. The contract for the provision of Library Services across the borough was awarded to Contractor A ('the Contractor') and commenced on 1st November 2017. The total contract value is £41m for a term of ten years plus an option to extend for five years by mutual agreement in writing.
4. Services to be delivered under the contract include:-
    - Front line library services
    - Local studies and archives
    - Management of historic collections
5. The transfer involved the decommissioning and commissioning of major IT systems and hardware, changes to operational management of multiple satellite sites and the TUPE transfer of over 130 staff ranging from Assistant Operations Manager to Customer Services Assistants.
6. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference, the objective of which was to review the governance and management of the contract to ensure controls are satisfactory and mitigate risk.

8. The key risks reviewed within this audit were:-

- Management information is not obtained from the contractor on a timely basis and checked for accuracy
- Contractor performance is not measured or monitored against performance standards and milestones as set out in the contract
- Contractor delivery failures and/or declining contractor performance is not identified at an early stage and dealt with in line with contractual requirements
- The financial position is not monitored throughout the term of the contract.

AUDIT OPINION

9. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Substantial Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	0	3

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

SUMMARY OF FINDINGS

10. Our testing identified the following areas where the efficiency or effectiveness of the control environment could be improved.

10.1 **Contract Monitoring Meetings**

A well embedded contract review process is in place with monthly meetings taking place between the Client Team and the Contractor.

To provide further clarity to the recording process, it is recommended that the Client Team:-

i) ensure that all action plans state to which meeting they refer, as opposed to 'actions from last meeting'

ii) clarify in meeting minutes that a timescale of 'ASAP' is quantified as, for example, 'before the next monthly meeting'.

10.2 **Payment of Invoices**

The contract price is paid by the Council to the Contractor in 12 equal monthly instalments, one month in arrears. Payment is not authorised by the Client Team until after the monthly contract monitoring meeting has taken place.

It is recommended that the Client Team agrees with the Contractor a standing monthly date for submission of the invoice, to maximise the time available for processing payment.

10.3 **Raising of Orders**

Five of the eight Orders for items outside of the monthly contract fee (e.g. pension costs), had been raised on the same, or subsequent, date to the invoice. If orders are not raised in a timely manner, commitments will not be accurately reflected in the budget monitoring.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	**Contract Monitoring Meetings** A well embedded process is in place for reviewing delivery of the contract. Monthly monitoring meetings take place between the Client Team and the Contractor, which are supported by detailed minutes and action plans. In 13/18 sets of contract monitoring meeting minutes it was noted that the summary of key action points referred to the 'actions from last meeting' and did not record the date of the meeting to which they referred. The timeframe stated within the summary of key action points of 'ASAP' was not defined.	The Client Team and Contractor may lack a common understanding as to timescales for the implementation of actions.	To provide further clarity to the recording process, it is recommended that the Client Team:- i) ensures that when recording progress against the previous meeting's action plan, the date of the meeting to which it refers is stated, as opposed to 'actions from last meeting' ii) quantifies the timeframe currently defined as 'ASAP' within the summary of key action points as, for example 'prior to [state month and date if the latter is known] meeting'. **Priority 3**	Following discussions during the audit process this has already been addressed as follows i) The format of the minutes has been revised to ensure that the date of the previous meeting is stated clearly, replacing the term actions from the last meeting. This was used in the minutes from the August 20th Contractor/Client Meeting. ii) A new action record sheet was implemented this month and used at the August monitoring meeting. This clarifies the date by which the action must be completed. This new system has been explained to the Contractor. The term ASAP will no longer be used in the minutes.	Implemented August 2019 Principal Client

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	**Payment of Invoices** The contract price is paid by the Council to the Contractor in 12 equal monthly instalments, one month in arrears. As payment is not authorised by the Client Team until after the monthly contract monitoring meeting has taken place and it is satisfied that there are no penalty points to be applied, presentation of the invoice at the beginning of the month in which payment is due can lead to the Authority not adhering to the contract which specifies payment terms within 21 days (9/16 invoices) or, the public sector requirement that the payment period must not exceed 30 days following receipt of the invoice (6/16 invoices).	Increase of financial risk to the authority should the Contractor invoke the right to a late payment fee.	It is recommended that the Client Team agrees with the Contractor a standing monthly date, taking into account the fact that the monthly meetings, thus far, have taken place on, or after, the 13th of the month, for submission of the invoice, to maximise the time available for processing payment. **Priority 3**	The Client Team will propose to the Contractor that from September onwards they submit their monthly invoice no earlier than the first day of the following month and within 10 working days, in line with the rest of the KPI paperwork. This will maximise the time available for processing payment and ensure that contract terms are adhered to.	September 2019 Principal Client

POST IMPLEMENTATION REVIEW OF LIBRARIES CONTRACT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	**Raising of Orders** From the eight payments made to the Contractor for items outside of the monthly contract fee (e.g. pension costs), on five occasions it was noted that the Order had been raised on the same, or subsequent, date to the invoice. Whilst, on all occasions, it was evidenced that the Client Team was aware of the liability, an official Order should be raised in a timely manner for all goods, works and services to ensure that financial commitments are accurately reflected in the budget monitoring.	If orders are not raised in a timely manner, commitments will not be reflected in the budget monitoring.	It is recommended that the Client Team agree with the Contractor a process to ensure that the Client Team are in a position to place an official Order prior to presentation of the invoice. **Priority 3**	The Client will agree with the Contractor that where possible prior warning must be given of invoices that will be raised. This will ensure that Official Orders can be placed by the Client Team prior to receipt of the invoice in order to assist with the accuracy of budget monitoring.	September 2019 Principal Client

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF STARTERS AND LEAVERS

Issued to: Charles Obazuaye, Director of HR and Customer Services
Emma Downie, Head of HRIS and Reward
Vinit Shukle, Head of ISD
Lucinda Bowen, Head of Information Management

Prepared by: Corporate Assistant, (Audit contractor on behalf of London Borough of Bromley) and Senior Manager, (Audit contractor on behalf of London Borough of Bromley)

Reviewed by: Principal Auditor and Head of Audit and Assurance

Date of Issue: 30 September 2019

Report No.: CEX/13/2018/AU

REVIEW OF STARTERS AND LEAVERS

INTRODUCTION

1. This report sets out the results of our audit of starters and leavers. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. We would like to thank all staff contacted during this review for their help and co-operation.
3. The Human Resources (HR) Department is responsible for processing the Council's starters and leavers. Before a new employee commences work, HR complete a series of pre-employment checks to help provide assurance over the suitability of the prospective employee to the respective role. These checks are summarised within an HR appointment checklist, which is then held on the new employee's file. Similarly, when an employee leaves the Council's employment, HR completes a leaver checklist that summarises all procedures that should take place in relation to a leaver. In conjunction with the role of HR in the leavers' process, The Council's IT contractor is responsible for terminating IT systems access on the employment termination date. The Council's IT contractor should be notified of employment termination via an eForm that is submitted through the intranet by the leaver's line manager. Additional staff are involved in the expected processes for controlling security pass card and purchase card access i.e. the Facilities and Support Client Services Manager and the Contract and Operations Manager respectively. Therefore, it should be noted that maintaining compliance with core processes linked to starters and leavers requires engagement across a number of teams within the Council.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 21 March 2019. The audit looked to review systems and procedures for (i) engaging new employees and (ii) employees leaving the Council, to provide assurance as to whether the controls are operating effectively. Controls relating to both corporate and departmental risks were examined, where applicable. The audit specifically covered activity within the 2018/19 Financial Year period. During the period April 2018 to March 2019, the Council processed a total of 267 starters and 242 leavers.

5. It should be noted that this audit did not include examination of controls over agency staff, as these were assessed in a separate audit carried out in 2017/18. Audit testing on starters focussed on reviewing the controls in place over the taking up of references and satisfactory completion of health checks / Disclosure and Barring Service (DBS) checks prior to starting employment at the Council. The timely completion of corporate induction training was also reviewed. The scope did not, however, check the controls in place for recording new employees onto the HR system (ResourceLink) or the payroll system, including the calculation and recording of correct pay rates and deductions. Testing of these aspects was carried out as part of the Payroll Expenses audit which was completed recently.

6. Audit testing on leavers reviewed the controls in place for removing employees from the HR system (ResourceLink) and the payroll system, removal of IT access and return of any Council equipment, purchase cards and ID security passes.

7. The following were considered to be the key risks inherent to the starters and leavers' process:

   - Managers may not be aware of their roles, responsibilities and action to be taken when employees join or leave the Council, leading to an increased risk that such actions are not carried out, or are undertaken incorrectly.
   - References, health checks and DBS checks may not be carried out prior to starting employment, leading to an increased risk that employees are engaged who do not meet the Council's standards and values.
   - Induction training is not carried out promptly, leading to a lack of knowledge about the Council and the employee's responsibilities.
   - Assets such as IT equipment, mobile phones, purchase cards and ID security passes may not be returned when employees leave the Council, resulting in an increased risk of loss of assets, fraudulent activity and unauthorised access to Council premises.
   - Employees who leave the Council may not have their IT system access removed promptly, leading to a risk of fraudulent activity and theft of data.
   - Employees' payroll details may not be removed timely when they leave the Council, resulting in the risk of overpayments being made to individuals.

AUDIT OPINION

8. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Limited Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
1	4	1

SUMMARY OF FINDINGS

9. Controls noted to be in place and working well, based on the audit testing conducted, included:

- An HR appointment checklist is completed as a record of when the various processes required to on-board a new employee have taken place. Examination of those new starters in our sample who were deemed to have a relevant safeguarding role, identified all as having a DBS witness sheet retained on their file and the HR appointment checklist being fully completed.

- Our examination of the new starters in our sample identified all as having evidence of the on-line health questionnaire being completed and retained on file and all had suitable references covering the two year period prior to employment.

- The Council's intranet 'onebromley' contains a page dedicated to the Council's standards and values which is available for all employees to view.

- The Contract and Operations Manager runs a leavers' report from HR once a month to monitor against a register of purchase card holders.

10. We would like to bring to management attention the following issues:

- Workforce eForms, which are required to be completed for staff who are leaving the Council, are not always being submitted by management. Our examination of a sample of leavers identified five instances where an eForm had not been submitted. In those cases, IT, Facilities and Support Client Services and the purchase cards team remained unaware of the staff member leaving the Council and so were unable to take action to mitigate the risks associated when somebody departs from their employment.
- A report is run, on a monthly basis, by the Council's IT contractor, to indicate successful logins of users against their individual laptops. However, instances where a laptop has not been logged onto for a considerable period of time are not being escalated until a period of six months inactivity has passed. Managers / services / individuals are not therefore being challenged in a timely manner when a laptop has not been used for a significant period of time (which could indicate that the member of staff has left). Due to existing staff levels / capacity, management were not agreeable to reducing this to a monthly timescale, however it was agreed that the existing process is not ideal and does increase the risk of not identifying and recovering assets.
- In connection with the above point we were informed by HR, whilst concluding this audit, that they had identified an instance where an employee had left the Council in September 2018 but was continuing to be paid. There was no evidence that the HR team had received the employee's resignation and the employee's manager had since left the Council and so could not be questioned about the matter. The Head of HRIS and Reward is dealing with this matter separately. The above check to identify users who have not accessed their IT user account for a given period of time could assist in identifying any further instances of this in future.
- A security pass monitoring document is maintained by the Facilities and Support Client Services Manager. However, this is only monitored on the assumption that the expected Workforce eForms have been submitted (which has been

identified as ineffective in practice, as explained above). Consequently, there is a lack of the necessary reconciliation controls in place to ensure that security passes can be effectively controlled.

- When a new employee joins the Council, an induction checklist is sent, by HR to the employee's respective team manager. However, our testing evidenced that these checklists are not being signed, submitted and verified, and therefore there is no regular assurance to confirm that the expected induction checks have been completed. There are mandatory on-line training courses to be completed by a new employee but these are not specified on the induction checklist. The checklist is dated June 2011 and in need of review and with ownership assigned.
- The existing Leavers' Procedure Notes are outdated and not reflective of the current processes that take place. This guidance is currently being reviewed by the Head of HRIS & Reward.
- Our testing identified that the leavers' checklist was not completed and retained on file for two instances in our sample.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	<u>Leavers' process workflow and risk assessment of new IT processes</u> Our testing identified that managers are not always sending the eForm required to the relevant departments for action to be taken when a member of their team is leaving. Therefore, although HR may be notified of a staff leaver, the IT, Facilities Management and Purchase Card teams etc. were omitted from the notification process. Our sample testing of 20 randomly selected cases identified five exceptions (721572, 670836, 607007, 383251, 661069) where notification was not received by IT in relation to these employees leaving. The Council is currently planning to cross over to a new Windows 10 and SharePoint system. Along with this SharePoint and server based system roll out,	Where there is no system workflow in place, there is an increased risk that core elements of the leavers' process may be omitted. This could result in a lack of control over access to information and/or financial loss and the safeguarding of assets. Where adequate controls are not in place for the retention of IT equipment when an individual leaves the Council, there is a risk that an increased number of equipment assets could be misplaced or stolen. There is also a significant risk that the Council has no way of identifying, challenging and	Management should combine the processes involved when an employee leaves the Council's employment, taking into consideration the roles of HR, IT, Facilities Management and the Purchase Card Team to ensure the timely, complete and secure management of leavers. Due to the known shortfalls in the existing retention process for IT equipment, and acknowledging that the Council has already suggested that these concerns may in part be addressed by the planned IT process redevelopment, management should also undertake a formalised internal risk assessment of this process before any movement to the new proposed way of working is implemented. The risk assessment should look to identify whether the overhaul will adequately ensure that there are no remaining gaps in the established controls framework. Any perceived gaps should be	With the new version of Sharepoint that will be rolled out in 2020, IT will look to introduce a leaver form that can notify all relevant parties of an intended leaver. A meeting with the IT contractor who will write the IT solution for this to happen is taking place in the next few weeks. This will allow a 'one stop shop' approach for managers. In the interim, there are automatic notifications from the HR/Payroll system to IT when a termination date is input. However, this only covers LBB employees and not agency workers. Therefore, from now on, when HR are notified of any employee, including an agency worker, leaving the Council, we will put processes in place to ensure that IT and Facilities Management are informed	Head of ISD and Head of Information Management 31 March 2020 Head of HRIS and Reward 31 October 2019

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	there are plans to combine the currently separated HR notification into one eForm. This is expected to have the value of notifying all relevant teams. The new workflow will consider HR, IT, Facilities and Purchase Cards. Discussion with the Head of ISD established that the Council's IT contractor runs a monthly report on user login times, which can then be used to identify any user who has not logged onto the system for an extended period of time. However, any such cases where the user has not logged into the system for a considerable period of time are not escalated until six months have passed. Due to existing staff levels / capacity, management were not agreeable to reducing this to monthly, however it was agreed that the existing process is not ideal and increases the risk of not	escalating instances where IT assets are not returned. Users may continue to have access to the Council's information after they have left.	escalated onto a risk register / action plan, which is then subject to ongoing monitoring by management. This plan should be kept under review until the point that full implementation can be verified. It may be advisable to consider setting Key Performance Indicators (KPIs) and / or introduce standing reports to specific groups, to help fully embed the required changes. **Priority 1**	timely of the employee's name, job title, leaving date. We will also include the relevant manager's name so that the manager can be contacted to discuss any specific IT matters eg transfer of emails and any folders before the employee leaves. We will also inform Finance Directorate for the removal of the leaver from the authorised signatory list, Oracle, FBM/EBM and the procurement card register (as appropriate). HR will risk asses the above processes, once implemented, to ensure that there are no gaps in the notification process. HR write out to leavers and their managers already, reminding them about returning IT equipment, purchase cards and ID cards before their last day of service. Therefore, we will issue a reminder to Managers Briefing re Leaver Process and importance of notifying HR.	

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	identifying and recovering assets. No specific exceptions regarding non-return of assets were identified from the audit sample testing conducted during this review, but interviews with staff during the fieldwork suggested there had been known previous instances where temporary staff had left the Council with iPads etc., resulting in the need to remove access and recover these. The capital investment for IT equipment is decentralised to individual team managers. IT is currently in the process of centralising this so that it has increased ownership. This will likely be implemented in conjunction with the switch to Windows 10, where all office desktop computers will be replaced with laptops. These laptops will be allocated to an individual.			We will also remind Directors / Heads of Service of the need to reconcile EBM information regularly to confirm that all their staff members are current employees and to identify any anomalies in staff names, numbers and positions.	

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	<u>Removal of IT systems user access</u> As described above, the Council's IT contractor runs a monthly report which can be used to identify any user who has not logged onto the system for an extended period of time. During the audit, we were informed by HR that they had identified that an employee had left the Council in September 2018 but was continuing to be paid. There was no evidence that HR had received the employee's resignation. The employee's manager had since left and so could not be questioned about the matter. During our fieldwork, staff also highlighted that there were issues with removing system access rights after staff had left and inconsistencies over the management/removal of staff files eg.from users' M drives.	There is a risk that users may continue to have access to the Council's information after they have left, resulting in the possible theft of sensitive and/or commercial information. IT storage space may not be used efficiently to store documents for historic staff and useful records may be lost if they are deleted from an individual leaver's folder rather than being transferred to a group folder for other team members to access.	ISD management should: (i) use the reports run by the Council's IT contractor on a monthly basis to identify users who have not accessed the Council's IT systems over a given period e.g. two months and establish from the user's manager if the user has left the Council, (ii) notify HR of any employees who have had their IT user access removed following confirmation from the manager that the employee has left the Council, and (iii) remind all managers of the action to be taken over the management/removal of staff files (e.g. those on 'M' drives) when staff leave the Council. **Priority 2** (This recommendation should be read, and implemented, in conjunction with recommendation 1 above)	We will put procedures in place, using management information reports, to identify users who have not accessed the Council's IT systems over a given period and liaise with HR to find out who the user's manager is. We can then establish the user's status eg left the Council, on long term sick leave etc. We will discuss with the user's manager about the action to be taken on the management of emails and folders. This will require the introduction of an Acceptable Use Policy, which we are currently preparing for issue. In any instances where we find that the user has left the Council, we will notify HR for them to take appropriate action.	Head of ISD and Head of Information Management. 31 October 2019

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
3	<u>Security pass termination procedure</u> The security pass termination procedure should monitor leavers against their security pass access. This cross check is intended to ensure that site access is not permitted to staff who have left the Council. Discussion with the Facilities & Support Client Services Manager identified that this procedure relies on the Workforce eForm (for staff leaving) being received by her as a basis for subsequent monitoring. Our testing established that the expected eForms are not being submitted in all cases (recommendation 1 refers) and therefore insufficient reconciliation controls are in place to ensure that security passes are effectively terminated for those staff who leave the Council.	Where security card access is not monitored and reconciled on a regular basis, there is an increased risk that leavers may still have access to the Council's sites post-employment. This could result in unauthorised access to the Council's property and potential theft of assets.	Management should ensure that:- (i) ID Card access is routinely monitored. It is recommended that a monthly report be generated by HR and made available to the relevant teams / staff with the ability to disable IT led functions (including staff ID access cards). (ii) Clear responsibility should then be set to confirm who will then systematically reconcile stated leavers to make sure that all those listed effectively have their access privileges removed. Management should seek assurance that this control continues to occur, to a timely frequency. Any exceptions should be escalated. **Priority 2** (This recommendation should be read, and implemented, in conjunction with recommendation 1 above)	We will provide a monthly report of leavers to Amey. Adecco already produce a report of monthly leavers to HR which can also be provided to aid in reconciliation.	Head of HRIS and Reward 31 October 2019

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REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager

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DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
4	<u>Verification of induction procedure</u> The HR induction checklist has a number of induction tasks that should be undertaken by the starter and manager (i.e. communication of fire safety procedure etc.). There is however no subsequent monitoring by HR to confirm that this has been done. A corporate induction course is run by HR. We noted that the email inviting the new employee states which on-line training courses are mandatory and must be completed before attending the course (customer service standards and values, information governance and cyber security). These are not specified or shown as mandatory on the induction checklist. The checklist is dated June 2011 and in need of review and with ownership assigned.	Where mandatory training is not undertaken and/or the completion of induction tasks by starters is not verified, there is a risk that a lack of awareness could expose the employee and others to preventable hazards and incidents.	Management should:- (i) review and update the starter checklist to ensure that it clearly sets out which mandatory on-line training courses must be completed as soon as possible, and any other areas which should usefully be included e.g. gifts and hospitality and raising concerns. (ii) put monitoring arrangements in place to confirm that the mandatory on-line training courses and induction tasks have been completed, escalating any non-compliance with managers accordingly. This could include running reports to confirm the completion of on-line training courses and asking managers to return the completed and signed checklist to HR with the completed 3 month appraisal form. (iii) decide who will be responsible for ensuring that the above monitoring has been carried out and how and to whom any issues of non-compliance which are identified will be escalated. **Priority 2**	We have already started reviewing the starter checklist as recommended, ensuring that it clearly sets out the mandatory on-line training courses which need to be completed and including any other areas which are required. Monitoring arrangements and escalation processes will be put in place to ensure that mandatory training is complied with and 3 month appraisal forms for all new starters have been completed satisfactorily by managers.	Head of HRIS and Reward 31 October 2019

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
5	HR leavers' procedure notes Through walkthrough testing with the Head of HRIS & Reward, it was established that the leavers' procedure notes made available to staff are not reflective of the existing expected processes. We were informed that all procedures are being reviewed by the Head of HRIS & Reward over the coming months.	Leavers may not be processed correctly, resulting in them not being terminated and remaining on the payroll. This could have the impact of leavers being paid after their employment has been terminated.	Management should:- (i) Review the existing procedures in place and establish a procedure document(s) that fully encompass both the starter and leaver processes. (ii) Publish the procedure document(s) on the intranet making them easily accessible to staff. (iii) Review the document(s) at the end of an agreed timeframe (e.g. every two years), or when changes to any core process have been made. As part of this, management should decide what oversight will be required to review and approve the procedures. **Priority 2**	We have already started reviewing the existing procedures as suggested in the recommendation, including reviewing and deciding what oversight will be put in place.	Head of HRIS and Reward 31 October 2019

REVIEW OF STARTERS AND LEAVERS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
6	Electronic document management system From our sample testing of 16 cases, 14 were identified as having the leavers' checklist completed and retained on their physical file. One case (201748) did not have a corresponding leavers' checklist and another (383251) was not completed fully (the termination date was not completed on the Resourcelink database). Discussion with the Head of HRIS & Reward established that talks are being held for the team to switch over to an electronic document management system that will replace the current hard copy versions of the starters' and leavers' checklists. This will reduce the likelihood of errors and inconsistencies in completion.	There is a risk that the Council is not able to identify if procedures have been consistently followed, or if errors have been made. Consequently, management decisions may be made based on incorrect information.	Management should :- (i) put monitoring arrangements in place to ensure that leavers' checklists are fully completed. Where gaps in completion are identified, checks should be carried out to ensure that the action required in each case has been taken, and (ii) introduce a time bound plan to switch over to an electronic document management system. **Priority 3**	We have already started work on this and will put monitoring arrangements in place for the satisfactory completion of leavers' checklists and introduce a timescale for switching over to an electronic document management system.	Head of HRIS and Reward 31 October 2019

OPINION DEFINITIONS **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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FINAL INTERNAL AUDIT REPORT

HUMAN RESOURCES DIRECTORATE

REVIEW OF WORKFORCE PLANNING AUDIT

Issued to: Charles Obazuaye, Director of Human Resources and Customer Services
Antoinette Thorne, Head of Learning and Development, HR Directorate
Shakeela Shourie, Workforce Development Projects Lead, HR Directorate

Prepared by: Principal Auditor
Reviewed by: Head of Audit and Assurance

Date of Issue: 9 September 2019

Report No.: CEX/14/2018/AU

REVIEW OF WORKFORCE PLANNING AUDIT

INTRODUCTION

1. This report sets out the results of our audit of workforce planning. The audit was carried out as part of the work specified in the 2018-19 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. Workforce planning is an area which has not been audited previously. The purpose of the audit was to review the extent to which the Council has assessed its current and future skills gap and addressed risks caused by the demographic make-up of its workforce.
3. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference. It included the following key risks:

- The Council has not identified its future staffing and training requirements as part of its strategic planning process and the need to meet future operational demands,
- Analysis of the Council's current workforce profile and future workforce needs, including skills gaps, has not been carried out. In particular, demographic, technological, economic and staffing issues have not been considered,
- Strategies to address future gaps by recruiting, developing and retaining key staff have not been put in place. These could include HR initiatives, policies, procedures, recruitment, selection and staff development strategies and succession planning,
- There are no action plans in place to implement workforce planning strategies,
- There are no monitoring arrangements in place for reviewing action plans periodically and responding to any unanticipated events and changes required.

REVIEW OF WORKFORCE PLANNING AUDIT

AUDIT OPINION

5. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Limited Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	3	0

SUMMARY OF FINDINGS

6. The Council has a number of HR initiatives and strategies in place to support workforce planning. They are aligned to 'Building a Better Bromley' and the Council's REAL leadership values. These include an Apprenticeship Scheme, a Graduate Intern Scheme and an Organisational Development Pathway. A Management Training Programme for all managers was launched in 2018. A dedicated Recruitment and Retention Board has been put in place for Adult Social Care and Children Social Care staff, together with a plethora of training courses and initiatives for staff in those areas. The Bromley Learning Hub has a range of learning and development activities for all staff.

7. One of the documents provided to us as evidence for our audit testing was a report in the form of a position statement, written by the Head of Learning and Development in 2018. It reviewed current and past talent management and succession planning programmes in the Council and included an action plan with nine recommendations to address various elements of workforce planning. We have included the recommendations from that action plan as Appendix C to this report and the Head of Learning and Development has provided an update on each of the recommendations.

REVIEW OF WORKFORCE PLANNING AUDIT

8. Controls over succession planning are not widely in place except for hard to fill posts mainly in Adult Social Care and Children Social Care, although we acknowledge that a 'Critical Post Identification Tool for Succession Planning' has been created and is in draft form. An Organisational Development Pathway diagram confirms how talent management and succession planning will be part of the workforce planning arrangements of the Council. A culture of talent management with criteria and measures to evaluate its success and review and analyse progress has not been established however. These findings are being addressed via the HR action plan recommendations (Appendix C).

9. A Recruitment and Retention Board has been set up to identify and implement initiatives to recruit to 'hard to fill' positions in Adult Social Care and Children Social Care. The skills and training required to retain staff in these key posts have also been identified and appropriate action taken. There is, however, nothing similar in place for other areas of the Council where 'hard to fill' vacancies in key positions exist.

10. The Council's HR strategy includes areas relevant to workforce planning such as recruitment and retention, skills development, performance management and organisational development. Within these areas there is a statement of how success will be measured, however these will not always determine how effective the measurement will be. Furthermore, there is no evidence that management information has been obtained and used to review and evaluate the delivery and level of effectiveness of workforce planning action plans.

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, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings and Appendix C shows the action taken by HR in response to the recommendations made in their own 2018 report on talent management and succession planning.

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REVIEW OF WORKFORCE PLANNING AUDIT

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
1	Identifying 'hard to fill' positions across the Council A Recruitment and Retention Board has been set up to identify and implement initiatives to recruit to 'hard to fill' positions in Adult Social Care and Children Social Care. The skills and training required to retain staff in these key posts have also been identified and appropriate action taken. There is nothing similar in place for other areas of the Council where 'hard to fill' vacancies in key positions exist.	There is a risk that the Council is not using more widely the initiatives which were successfully employed when seeking to recruit and retain staff for roles in Adult Social Care and Children Social Care which were proving difficult to recruit to.	The scope and remit of the existing Recruitment and Retention Board should be expanded to include other business areas of the Council which have vacant positions for which it is difficult to recruit and retain staff. **Priority 2**	We keep an eye on hard to fill posts. If and when there is any indication that this is the case, they are invited to be present at the board. The board helps them to develop a recruitment and retention strategy to find and attract the right people, help them action the strategy and monitor it for a period of time until the service becomes stable. There is a capacity issue hence the focus in the main is on the most critical areas namely Adult Social Care and Children Social Care qualified staff. Housing has recently joined the Board. HR colleagues are also working with Finance, Planning, etc. to address staff recruitment challenges. Managers are also being encouraged to recruit from within in an attempt to grow tomorrow's managers/leaders.	Ongoing – Head of Learning and Development

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REVIEW OF WORKFORCE PLANNING AUDIT

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

APPENDIX A

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
2	Management information We were unable to evidence that management information has been obtained and used to review and evaluate the delivery and level of effectiveness of workforce planning action plans.	Without the use of management information supported by comprehensive, accurate and timely data, workforce planning initiatives and procedures may not be effective or meet their objectives.	Management should identify what information it requires and how it will be used and reported to demonstrate that workforce planning action plans are being delivered and are operating effectively. **Priority 2**	The Change Consultant will liaise with key HR leads to ascertain the staffing numbers, profile and skills and knowledge sets in order to ensure action plans are delivered and are operating effectively. A suite of key HR indicators are now part of the corporate KPIs managed by the Performance Management Service under the Assistant Director, Strategy, Performance and Corporate Transformation.	Ongoing – HR Employment Lawyer
3	HR strategy – workforce planning measures of success The Council's HR strategy includes areas pertinent to workforce planning such as recruitment and retention, skills development, performance management and organisational development. Within these areas there is a statement of how success will	Performance in workforce planning may not be either measurable or measured effectively.	The measures of success for workforce planning as set out in the HR Strategy are reviewed and amended as necessary to ensure they determine how effective the measurement will be. **Priority 2**	We will review the measures for success outlined in both pages 6 and 8 of the HR strategy document and amend them as necessary by 31 October 2019. Once the strategy is finalised, an owner, published date and future review date will be included on the cover.	31 October 2019 - Workforce Development Projects Lead

REVIEW OF WORKFORCE PLANNING AUDIT

APPENDIX A

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

No	Finding	Risk	Recommendation and Priority *Raised in previous Audit	Management Response	Agreed timescale and responsible manager
	be measured, however these will not always determine how effective the measurement will be eg for ensuring a workforce with a good mix of skills, knowledge and experience, the measurement is 'The number of apprentices and graduate interns.'				

APPENDIX B

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

APPENDIX C

RECOMMENDATIONS MADE IN THE HR ACTION PLAN ON TALENT MANAGEMENT AND SUCCESSION PLANNING, WRITTEN BY THE HEAD OF LEARNING AND DEVELOPMENT IN 2018

RECOMMENDATION	ACTION TAKEN
Create a position to lead on Talent Management across the Council	Completed
Develop a talent management and succession planning strategy (including talent acquisition)	In development
Identify critical posts at all levels in the organisation and continuously monitor this information (held in Resourcelink)	In process – tool is being trialled
Use a gap analysis tool to highlight developmental needs of all staff in line with critical posts in the team (utilising the DISCUSS process)	In development – will be trialled after critical post tool is rolled out
Identify potential candidates to fill the critical posts from the talent pool and talent acquisition methods	Framework for talent pool is being developed – indicative roll out date April 2020
Implement development plans for the identified candidates and ensure they have access to development opportunities and learning tools (including mentoring)	Mentoring scheme has been identified – list of mentors currently being compiled
Establish a fully integrated and resourced development programme that would identify and develop rising stars at any level within the organisation, with access to a range of bespoke internal development programmes as well as technical 'on the job' training to support them to achieve the required skills and knowledge for the next steps on their management and potential leadership journey	Completed – pathway developed and ongoing commissioning taking place

APPENDIX C

RECOMMENDATIONS MADE IN THE HR ACTION PLAN ON TALENT MANAGEMENT AND SUCCESSION PLANNING, WRITTEN BY THE HEAD OF LEARNING AND DEVELOPMENT IN 2018

RECOMMENDATION	ACTION TAKEN
Ensure that the recruitment strategy is aligned with the talent management and succession planning strategy to ensure that when recruiting to management positions, the default position is to refer to the talent pool	Will action once talent development strategy is developed. Default position of referring to talent pool will be reviewed in the recruitment strategy.
Realign graduate interns salaries in line with national trends or reinstate the National Graduate Development Programme	No action to date – this recommendation will have to be agreed at Chief Officer and Member level given considerable impact on salary budgets

Statement

Although recommendations were made re. talent management initiatives by the Head of Workforce Development in 2018, all actions taken in regards to Talent Development must now be in line with the Council's new roadmap (Transforming Bromley)