PART 1

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DATE: 22 February 2022

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Wednesday 2 March 2022

1 **REVIEW OF COVID 19 RISK ASSESSMENTS** (Pages 3 - 14)

2 **REVIEW OF DOWNE PRIMARY SCHOOL** (Pages 15 - 30)

3 **FINANCIAL ASSESSMENTS--2021-2022** (Pages 31 - 44)

4 **REVIEW OF HOUSING NEEDS , EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)** (Pages 45 - 58)

5 **REVIEW OF THE IT ASSET REGISTER** (Pages 59 - 70)

6 **REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME** (Pages 71 - 94)

7 **REVIEW OF SUPPORTED LIVING PLACEMENTS** (Pages 95 - 108)

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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INTERNAL AUDIT FINAL REPORT

CHIEF EXECUTIVE'S DEPARTMENT

REVIEW OF COVID 19 RISK ASSESSMENTS

Issued to: Health & Safety Officer
Director of HR & Customer Services
Assistant Director, Property
Head of Planning & Development Support
Assistant Director, Customer Services
Assistant Director, Operations
Head of Early Interventions,

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: January 31st 2022

Report No.: CEX/07/2021

REVIEW OF COVID 19 RISK ASSESSMENTS

INTRODUCTION

1. This report sets out the results of our audit of Covid 19 Risk Assessments. The audit was carried out as part of the work specified in the 2021-22 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. Risk assessments can be categorised into 3 main types:-

   a) Corporate Risk Assessment.
   b) Service Risk Assessment.
   c) Individual Risk Assessment.

3. For the purposes of this review, the audit concentrated on the service risk assessment that should include Covid 19 risk assessment (or a stand alone risk assessment). The risk assessments are covered by the Health & Safety at Work Act 1974 as well as the Management of Health & Safety Regulations 1999.

4. The National Association of Local Councils advise that 'A Covid 19 risk assessment is a logical step by step process looking at each individual place, service or activity and identifying who uses them and the risks to these people when they do'. The risk assessment process adopted by Councils is no different but instead concentrates more on the 'specific risks arising from the coronavirus pandemic'.

5. There should be a consistent approach to these risk assessments and service risk assessments should clearly identify which teams are covered by the Covid 19 risk assessment and also detail the number of staff / sites that it encompasses. There should be linkage also to the completion of individual staff risk assessments.

6. Guidance on completion of the Covid 19 risk assessment was provided via the Corporate Leadership Team (CLT) to senior management. This is also available on the Intranet and training has also been made available to managers. The Staff Handbook- Return to The Workplace supports this and is readily available to all staff on the Covid 19 portal.

7. Regular monitoring and review of the risk assessments is essential to ensure that arrangements remain effective and adhered to.

REVIEW OF COVID 19 RISK ASSESSMENTS

8. A sample of 5 services were selected for review, 4 services that had submitted a risk assessment to Corporate Health & Safety and 1 where no risk assessment had been submitted for their service.

9. The service selected for testing were :-

   Planning

   Registrars

   Citizenship

   Contact Centres

   Children's Centres

   Assessment & Care Management

   Property

10. We would like to thank everyone contacted during this review for their help and co-operation.

AUDIT SCOPE

11. The original scope of the audit was outlined in the Terms of Reference issued on 22/6/21.

12. We identified the following key risks:

    - Risk Assessments and Procedures are not readily available and may not have been updated to reflect changes in processes, within individual service areas.
    - All areas have not been identified and therefore may not have submitted a covid-19 risk assessment.
    - Assessments may not be in compliance with Health & Safety or Covid regulations.

REVIEW OF COVID 19 RISK ASSESSMENTS

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

14. We would like to bring the following to management's attention :-

- At the time of testing, it was found that there were 4 areas who had not completed and submitted a service risk assessment. Additionally, one other area was relying instead on the Corporate Risk Assessment.
- Two areas had not completed a risk scoring matrix unlike other services and detailed within the issued guidance.
- The review of the service risk assessments was not always detailed.
- It was not clear how staff were updated with any changes to the service risk assessment for one area.
- Service risk assessments did not detail the number of staff covered by the service risk assessments.

REVIEW OF COVID 19 RISK ASSESSMENTS

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

15. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, 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 COVID 19 RISK ASSESSMENTS

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Submission of Covid 19 Risk Assessment by all services.	
Finding It was confirmed by the Health & Safety Officer on 18/11/21 that the following areas had not submitted a risk assessment. - **Communications and Public Affairs** - **Mental Health Services** - **Property** - **Office – Leader of the Council** Property was included within the testing. It was found that Property had not undertaken a specific risk assessment because they were relying on having been included within Corporate Risk Assessment. This corporate risk assessment document was dated June 2021 and states that the service specific risks are to be further updated. There is no specific coverage for this service area for a Covid 19 risk assessment. Corporate Health and Safety advised that they had been emailing all four of the remaining services about the need to carry out a service risk assessment. Internal Audit were advised that the Communication & Public Affairs team have since submitted their service risk assessment dated 18/1/22 to the Corporate Health and Safety Officer. **Risk** Non- compliance of the legal duty to assess the risks to the health and safety of all employees (and others) to which they are exposed while they are at work.	
Recommendation All services should comply with the legal duty to assess risks to the health and safety of staff and others and include the risk of Covid 19. The identified areas should submit a completed risk assessment as soon as possible.	**Rating** **Priority 2**

REVIEW OF COVID 19 RISK ASSESSMENTS

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager *Corporate Response : Meetings will be arranged with the leads for each of these areas by the Corporate Health and Safety Officer. These meetings will take place by the end of February 2022. In these meetings, Corporate Health and Safety will clearly outline what is required and agree urgent deadlines for completion of the risk assessments. In addition to this, an email will be sent out to CLT colleagues, with all directors copied in, to remind services that they have a legal duty to assess risks (including COVID-19) to the health and safety of staff and others. The recently revised risk assessment guidance will be provided with this email, which will be sent out by the 7th February 2022.* Departmental Responses Agreed, Assistant Director, Property. The Covid Risk Assessment for Assessment and Care Management will be reviewed and shared with staff, Audit and the Health & Safety Lead. Assistant Director, Operations.	**Agreed timescale** *February 7th 2022.* January 31st 2022 February 28th 2022

2. Risk Assessment Scoring	
Finding Children Centres & Contact Centres It was found that for these services, although the risk assessments were detailed, there were no risk assessment scoring included as per guidance, unlike other areas reviewed. **Risk** Identified hazards are not rated and risks may not be adequately determined.	
Recommendation A risk assessment scoring should be undertaken to accompany the main body of the risk assessments for each area. This will also ensure that there is a consistent approach across the Authority.	**Rating** Priority 2
Management Response and Accountable Manager The form used has been updated to reflect the advice and recommendations made in this Audit Report. It is worth noting that the form used was originally provided to the Service to use but has since been updated. As an action from this Audit, all our COVID Risk Assessments were immediately reviewed, updated and were passed from Head of Service to the Assistant Director, to Director of Children's Services and finally up to the Director for HR in his capacity as the Chair of the Corporate H&S Board, for approval and authorisation. Approval was granted by Director for HR on 12 January 2022. The Service is waiting for the signed copies to be returned by have an email from the Director of H.R. dated 12 January 2022 confirming his approval. As soon as the signed copies are returned to the Service, they will be forwarded to Internal Audit to complete this record. The Service were grateful for the clarification provided by colleagues in Internal Audit and the opportunity to discuss this element of the audit process. Agreed, Head of Early Interventions.	**Agreed timescale** January 31st 2022.

REVIEW OF COVID 19 RISK ASSESSMENTS

DETAILED FINDINGS AND ACTION PLAN

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3. Planned Review of Risk Assessments	
Finding It was found that there was no evidence of review in relation to the risk assessment for:- • Assessment & Care Management The risk assessment for this Assessment & Care Management service is dated 1/7/20 and was completed at the time by a previous post holder. There is no evidence of review since that date and whether this is a draft or final document. **Risk** Risks detailed within the assessment may have changed and further control measures may be required.	
Recommendation The agreed final service risk assessment should be regularly reviewed and updated.	**Rating** **Priority 2**
Management Response and Accountable Manager It is noted that the Covid risk assessment for this Assessment & Care Management service is dated 1/7/20. Since that time the author has retired. The role was covered by an Interim Head of Service for Assessment and Case Management until the Assistant Director took up the role in August 2021. This audit has been shared with Head of Service Operation Management on 7th Jan. A formal review of the services risk assessment will take place in February 2022.	**Agreed timescale** February 28th 2022.

REVIEW OF COVID 19 RISK ASSESSMENTS

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

4. Risk Assessment – Communication to Staff	
Finding It was not clear how updates and reviews of the risk assessments were being clearly communicated to staff. This was found to be the cases in respect of Assessment & Care Management. It should be noted that there has been changes in staffing within this post since last year. **Risk** Staff may be operating to different working practices and affecting management of risks/ hazards.	
Recommendation Updates and reviews of the service risk assessments should be clearly and comprehensively communicated to staff. Staff should be made aware of all changes to risk assessments within their service area.	**Rating** **Priority 2**
Management Response and Accountable Manager Agreed. Assistant Director, Operations.	**Agreed timescale** February 28th 2022.

5. Risk Assessment Coverage	
Finding Through testing it was found that it was not clear for all areas reviewed, the number of staff that were covered by the individual service risk assessment. **Risk** It is possible that not all staff are identified within the risk assessment, which may also affect completion of individual risk assessments for staff.	
Recommendation The service risk assessments should clearly state that how many staff are covered by the individual service risk assessment.	**Rating** Priority 2
Management Response and Accountable Manager *Corporate Response:* In the email to CLT, regarding service risk assessments, which will be sent out by the 7th February, colleagues will be advised that service risk assessments must state how many staff members are covered by the assessment. The Corporate Health and Safety Officer will also be emailing all colleagues who completed service risk assessments to advise that their service risk assessments must clearly state how many staff are covered by the assessment. This will also be completed by 7th February 2022. Furthermore, in the section about risk assessments on the H&S intranet site, there will be a line added to clarify this. Departmental Response:- Agreed, Assistant Director, Property Agreed, Assistant Director, Customer Services. The number and names of staff covered by each risk assessment will be added to all of the Covid 19 risk assessments. Agreed, Assistant Director, Operations. Agreed, all staff and service users will be captured within the risk assessments, Head of Early Interventions.	**Agreed timescale** February 7th 2022. January 31st 2022 January 21st 2022 February 28th 2022 January 31st 2022

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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.

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FINAL INTERNAL AUDIT REPORT

EDUCATION DEPARTMENT

REVIEW OF DOWNE PRIMARY SCHOOL

Issued to: Headteacher
Senior Administrative Officer
Chair of Governors (Final report only)
Director of Education (Final report only)

Prepared by: Trainee Auditor

Reviewed by: Principal Auditor, Head of Audit and Assurance

Date of Issue: 25 January 2022

Report No.: PEO/08/2021

REVIEW OF DOWNE PRIMARY SCHOOL

INTRODUCTION

1. This report sets out the results of our audit of Downe Primary School. The audit was carried out as part of the work specified in the 2021-22 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 review was completed remotely to comply with Government Covid 19 restriction guidelines to work from home where possible. The information required for audit examination was scanned and e-mailed by the School Administrative Officer (SAO). The standard Internal Audit Questionnaire has been revised for 2021/22 to include the impact and response to COVID-19. The questionnaire forms part of the audit review as a self-assessment. As such the questionnaire, completed by the SAO, was certified by the Headteacher and the Chair of Governors to give an adequate assurance that the return was representative of current working arrangements; the certification was independent of the Finance function.
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.

5. The key risks in the areas set below were examined during the audit review: -
   - **Financial Management Information** including budget monitoring, financial reports and returns to London Borough of Bromley
   - **Primary accounting documentation** including payments, income, contracts, voluntary funds and bank reconciliations
   - **Asset control**
   - **Governance arrangements** including financial delegation, governor minutes, budget approval and business interests

REVIEW OF DOWNE PRIMARY SCHOOL

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	3	4

SUMMARY OF FINDINGS

7. The audit review has found evidence to conclude that the controls are in place and working well for budget monitoring, utilisation of reports from the FMS (financial system) to support the financial management of school, asset management and governance arrangements such as financial delegation, budget approval and business interests. However, the school should consider the findings summarised as follows:

- Audit testing of 10 payments from the bank history identified one sample had a purchase order raised retrospectively and two purchase orders were not authorised.
- Audit testing of 23 payments made to six individuals identified that online HMRC assessments had not been completed for the engagement of these six individuals. Three of these payments were made directly to the individual but the company's name was detailed on the invoice and should have been used. Purchase orders had not been raised for payments to these six individuals, one invoice was not authorised and one invoice was price checked and authorised by the same officer.

- The interim arrangements for ordering goods and services during Covid-19 were agreed verbally between the SAO and the Headteacher and were not recorded and authorised formally.
- Audit testing showed that seven laptops were purchased using a member of staff's personal bank card. The school does not hold a purchasing card. We have advised the school to contact LBB's Head of Finance, Children, Education and Families to arrange a Purchasing card for an appropriate officer nominated by the school. This will allow school to purchase items that are required urgently and reduce the number of reimbursements claims where staff members had to use their personal bank cards.
- We examined three contracts; the school did not hold a signed copy of one of these on site. Further, the Contract Register does not detail the whole life value of the contract and only shows the annual value.
- Monthly VAT returns to the Council's Principal Accountant were not submitted in a timely manner. Section 9 of Financial Regulations for Schools sets out the timetable for the monthly return.
- Although there is currently no external hiring, the Lettings Policy, last updated in September 2017 and the Lettings Form need to be updated as the Council is no longer the school's insurer.
- The Aged Debtors Report identified one debt that has been outstanding since 14 July 2020 and where further action is required.

8. We requested a copy of the Risk Register; however, this is currently a work in progress which the SAO and the Head teacher are preparing.
9. The responses to the Internal Audit Questionnaire state that the school's IT provider is responsible for back up and protection of systems. This is done remotely and error emails are sent through to notify the school of any problem with the backup. Although the responsibility has been passed to the IT provider, the risk remains with the school and given recent ransomware attacks on education establishments the threat is topical and should be reviewed as a priority. We have issued a cyber security awareness self-assessment for the school to complete. The questionnaire should prompt discussion with staff and governors to assign roles and responsibilities and ensure that there is adequate protection should the school be subject to a cyber-attack. This should include any specific insurance cover, including cyber security.
10. The school does not have a formal asset disposal process or policy in place. The school has confirmed that they have not disposed of any IT assets to date but envisage disposing of IT assets in the future. We advised the school to have a policy in place for disposing of old assets and to ensure that they are aware of their responsibilities related to information security and GDPR when disposing of the assets.
11. The school currently has three authorised signatories for the payment process. Although this fulfils the Financial Regulations requirement to have at least three officers evidenced in the expenditure process, it is advisable to have four authorised signatories to cover for any absence

or long-term illnesses. We noted that on occasions initials were used to authorise the invoices rather than the full signature as evidenced on the Authorised Signatories List. We suggest that a new column is added to the Authorised Signatories List to record the initials/ short signatures for verification purposes.

12. Responses to the Internal Audit Questionnaire set out the arrangements to account for COVID expenditure and funding. Although this was not reviewed during this audit, we noted that the school had put in interim arrangements for paper handling such as email and telephone or quarantining the paper documents for 72 hours, and since the start of the Autumn Term 2021 the school had resumed normal activity.
13. We would like to thank all staff at the school for their help and cooperation during the audit.
14. The Management Action Plan is set out in Appendix A and Appendix B defines the audit opinion and recommendation rating.

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REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Expenditure process	
Finding We reviewed a sample of ten payments made between October 2020 and October 2021. There were revised arrangements for ordering goods and services until Autumn term 2021 due to Covid 19 and responsible officers stated in the Internal Audit Questionnaire that it was not always possible to raise purchase orders due to remote working during that period. Our testing identified the following issues: • For 1/10 payments, the purchase order was raised retrospectively. • 2/10 payments did not have an authorised purchase order. The interim arrangements for ordering goods and services during Covid-19 were agreed verbally between the SAO and the Headteacher and were not recorded and authorised formally. On occasions initials were used to authorise the invoices, which did not match the sample signatures recorded on the Authorised Signatories List. **Risk** Unauthorised expenditure may be incurred by the school.	
Recommendation Purchase orders should be raised as the expenditure is committed and should be authorised timely. Any alternative arrangements and deviation from the agreed process should be formally recorded and authorised by an appropriate officer or Governor. A new column on the Authorised Signatories List should be added to record the initials/ short signatures for verification purposes.	**Rating** **Priority 2**

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
We will continue to try as much as possible to raise orders on FMS prior to purchases being made and any alternative arrangements will be formally recorded and authorised. Please note, if payments are by direct debit, orders cannot be raised within FMS. Manual journals are done within FMS at the time of the direct debit transaction. A new column has been added to the signatories list to record any shorter signatures and a fourth member of staff has been added to the signatories list.	In place

2. Payment to individuals & HMRC regulations (IR35)
Finding Between October 2020 and October 2021, 79 payments were made to individuals. The SAO confirmed that 56 of these payments were for expense claims by staff and therefore excluded from this audit review. For the remaining 23 payments related to 6 supply teachers, we found that: • online HMRC assessments had not been completed for any of the 6 individuals who had been paid directly for services delivered. • 3 of these payments were made directly to the individual but the company's name was detailed on the invoice • purchase orders were not raised for the 6 individuals engaged.

- for 1/23 payments, the invoice had not been authorised.
- for 1/23 payments, the price check and invoice authorisation were done by the same officer and given there was no purchase order, separation of duties was not achieved.

Risk

Financial penalty for non-compliance with HMRC Regulations (IR35), non-compliance with Financial Regulations.

Recommendation	**Rating**
The procedure to engage off payroll staff must be implemented to ensure compliance with IR35 regulations for all current and future procurement and payments. For any payments to named individuals the school should complete the online questionnaire on the HMRC website to establish payroll /self-employment status. New regulations effective from April 2021 state that this assessment must be given to the individual to be engaged. For school purposes the assessment should be retained, dated, and certified to support payment to a named individual. A purchase order should be raised for payments made to named individuals to evidence committed expenditure and it also forms a contractual agreement to confirm terms and conditions including hourly rates. Separation of duties should be evidenced for the expenditure process including checking and authorising the invoices.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
We are in the process of carrying out the online HMRC questionnaires and therefore payment is pending to these individuals. - Head teacher An order will be raised in advance of invoice received for these individuals evidencing committed expenditure.	By 31st January 2022 In place

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

3. Purchase made by a staff member using personal bank card	
Finding Audit testing showed that seven laptops with a total value £3492.97 were purchased for the school using a member of staff's personal bank card. The expense was eventually claimed by the member of staff by filling the personal expense claim form. The school does not hold a purchasing card. **Risk** Increased risk of unauthorised/ unapproved spend. School may not be able to reclaim VAT if the purchase is made using a personal bank card. The employer may face additional claims if the member of staff goes into debt or is unable to pay their bill due to such expense. In the event that the equipment needs to be returned for a refund, the school will be reliant on the member of staff to return the equipment and repay the reimbursement to the school.	
Recommendation School should refrain from using staff members' personal bank cards for purchasing items for the school use. School should contact LBB's Head of Finance, Children, Education and Families to arrange a Purchasing card for an appropriate officer nominated by the school. This will allow school to purchase items that are required urgently and reduce the number of reimbursements claims where staff members had to use their personal bank cards.	**Rating** **Priority 2**

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
We have contacted LBB's Head of Finance, Children, Education and Families on several occasion about this, dating back to 2019 and unfortunately, to date, we are still no further forward, as we have not received a reply. We will continue to pursue this as much as possible as it is an unfair situation for staff to have to use their bankcards to pay for school items, including paying for their training courses in some cases.	Ongoing

4. Contract Register

Finding

We selected 3 contracts from the Contract Register and examined if they are current, signed and were held by the school. We identified that:

- the school did not hold the signed copy of one of the contracts.
- the Contract Register included only the annual values and not the whole life values of the contracts which would support financial management and decision making.

Risk

The school may not be aware of its contractual agreements and payment liabilities.

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
The school should hold a signed contract onsite. The Contract Register should include all contractual and service level agreements with annual and whole life contract values. The school should use the Contract Register to assess if the contract is proving good value for money and a basis to review rolling contracts.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**
We are looking into moving to a new IT provider this year and will ensure that a copy of any new contract is held in school. – Head teacher	30 September 2022
In the Contract Register going forward, there will be a column to include whole life contract values. – Head teacher	30 April 2022

5. Monthly VAT returns
Finding As at 22 November 2021, VAT returns for September and October 2021 had not been submitted to the Council's Principal Accountant. The SAO confirmed that the outstanding VAT returns were submitted on 13 December 2021.

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Financial Regulations for Schools section 9.3.1 sets out that:

All schools should complete and return their monthly VAT returns to the Chief Executives Department by 15th of each month following the month in question (e.g. April's return due 15th May). In the event of any problem which may cause delay, schools should notify Schools Finance Team or the Chief Executives Department as soon as possible.

The timetable allows refunded VAT to be issued to the school the following month, delays therefore impact on the school's cashflow.

Risk

The school may not have an accurate projection of the cash flow. VAT cannot be recovered after four years from the HMRC.

Recommendation	**Rating**
School should submit the VAT return timely, in line with Financial Regulations to recover the VAT payment and have an accurate projection of the cash flow.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**
Mostly, VAT returns are sent to the LA within the monthly timeframe. From November 2020 to July 2021 and some of the Autumn Term 2021 sickness and then restricted working practices once the officer returned from sick leave delayed processing.	Implemented

In addition, FMS is very temperamental and when IT issues arise, there is always a setback to timeframes. This has been the case on two occasions at least since September 2021 and we currently have errors within FMS causing us delays. The school's bank was unable to respond to us and the LA Finance Team were unable to help when the August and September Bank Statement numbers were incorrectly issued. This caused several weeks of delay to our processes before knowing how to correctly move forward. To date, the school received no help with this and so we moved forward in the best way we could by adjusting the statement numbers manually, however not ideally. This allowed us to deal with the delay in sending any late returns to the LA.	

6. Lettings Policy
Finding The school's Lettings Policy was last updated in September 2017. The Lettings Policy incorrectly states that Council is the school's insurer. This will need to be updated to show the current insurers and confirm the insurance cover regarding lettings if a hirer does not have their own policy for Public Liability. Whilst there are currently no external hirings, the Lettings Form will need to be updated with current insurance arrangements before any lettings are accepted. **Risk** The school may be inadequately insured and may not have adequate insurance cover for any claim that is received in respect of Public Liability. This may lead to legal challenge and significant unexpected expenditure in the event that a claim is made. Income collected may not agree to approved fees and charges.

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
The school should contact their insurers and clarify the insurance cover regarding lettings if a hirer does not have Public Liability cover. The Lettings Form needs to be revised in line with this advice. The Lettings Policy, and Lettings Form need to remove any reference to the Council's Insurers as this is out of date information and inaccurate.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**
Confirmation of the school's cover was confirmed on 23rd November.	Implemented

7. Aged Debtors and Creditors Reports
Finding The Aged Debtors Report identified two debts outstanding for more than 91 days. One debt of £150 was for a cancelled service, which needed to be cleared by the school. The second debt was £1550. This invoice has been outstanding since 14 July 2020. The SAO had attempted recovery by e-mail to the contacts on the 14/07/2020, 10/11/2020 and 11/11/2021 but there had been no response and no escalation had been actioned by the school. The aged debtors and creditors report is run annually by the SAO. **Risk** Income may not be recovered in a timely manner which may impact the cash flow.

REDACT

REVIEW OF DOWNE PRIMARY SCHOOL

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
The school should regularly (we suggest termly) run aged debtors and creditors control reports to identify outstanding debts and payments and action recovery. School should have a process in place for chasing any outstanding debts. The school should follow up on the outstanding debt of £1550.	**Priority 3**
Management Response and Accountable Manager	**Agreed timescale**
The school does already have a process in place, which is to regularly visit the Age Debtor Report and chase outstanding payments. Unfortunately, on this occasion, the response has been very slow to any emails / phone calls when chased about £1,550 outstanding. I can now confirm that payment has been made to the school.	In place

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.

REDACTED

FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DEPARTMENT

FINANCIAL ASSESSMENTS 2021-22

Issued to:	**Assistant Director Exchequer Services**
	Contract and Operations Manager
	Assistant Director ASC Operations
	Head of Finance, Adult Social Care, Health and Housing
Prepared by:	**Senior Internal Auditor**
Reviewed by:	**Director**
Date of Issue:	**3 February 2022**
Report No.:	**CORP/03/2021**

INTRODUCTION

1. This report sets out the results of our internal audit of Financial Assessments. The audit was carried out as part of the work specified in the 2021-2022 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 the audit has highlighted will increase the associated risks and should therefore be addressed by management.
2. The audit looked to provide an objective independent opinion on the adequacy and effectiveness of the Financial Assessments system.
3. Financial assessments are undertaken for all persons where care is required. A financial assessment (FA) is required to take place when an individual first enters a placement as well as on an annual basis thereafter, at the start of each new financial year, as obligations for charging may differ if circumstances change.
4. At Bromley Council, FAs are carried out by a third-party contractor, the Council's Exchequer Contractor. All operational staff, including visiting officers and booking officers, are from the Council's Exchequer Contractor. The Council's oversight in this area is maintained via the Contract and Operations Manager and the Assistant Director of Exchequer Services.
5. The fieldwork for this review was completed remotely in place in response to COVID-19.
6. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

7. The scope of the audit was outlined in the terms of reference issued in September 2021.
8. The controls in place to mitigate the impact of the key risk areas were examined. Controls relating to corporate and departmental risks were also examined where applicable. The internal audit included a review of relevant documentation, interviews with key officers and testing of related procedures and processes.
9. The following were considered to be the key risks:
    - Adequate and up to date policies and procedures are not in place, or up to date with relevant legislation. The policies and procedures are not clear with regards to the calculation of the financial assessments for residential and non-residential service users. Relevant and up to date information is not made available to the public;

- Financial Assessments are not completed for all service users placed in residential care and those receiving non-residential services, or that these are not completed in a timely manner and in line with documented procedures;
- There is no adequate process for obtaining and reviewing evidence provided by service users, resulting in increased opportunities for fraud;
- Personal information retained by the Council is not used in line with GDPR; and
- A lack of management oversight and sufficient contract monitoring, resulting issues not being addressed in a timely manner and delays in levying and collecting client contributions.

AUDIT OPINION

10. Our overall audit opinion, number and rating of recommendations is 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

11. Detailed below we have set out examples of controls noted to be in place and working effectively, based on the audit testing conducted. In addition, where we have identified issues, we have also highlighted these below:

- The Council's Exchequer Contractor has documented procedure notes in place for undertaking FAs. Our review of the procedure notes indicated that these procedures had been updated to include the new 'Trust and Protect' assessment process introduced during Covid-19 and also included the procedure to be followed post-Covid. There was also a procedure note for completing full cost arrangements. Review noted that this included step-by-step instructions including screenshots from the case management system.

- The FAs are calculated automatically by the case management system. We confirmed via review of screenshots from the case management system that there were set system parameters on the case management system to calculate the FA. Benefit rates were entered manually on the system to aid the FA calculation. We were informed by the Assistant Director Exchequer Services and the Contract and Operations Manager that there was guidance for entering and editing the benefit rates on the system, however we were not provided with this. We were also informed by the Exchequer Services Operational Manager that there was no procedure on the input of the financial information on the case management system in order to calculate the FA *(see issue 1 in detailed findings)*. We acknowledge that at the time of writing the Council has migrated to new finance systems and so the case management system in this review is now no longer in use.
- The benefit rates are entered on the case management system via the System Administration area. We were provided with a list of personnel with access to the System Administration area and confirmed that access was limited to the officers in the case management Support Team and relevant personnel from the Research and Statistics, Finance, and Project Support teams. While we believe this access is appropriate, it might be beneficial for the Council to undertake a separate audit of this for the new finance systems.
- We were informed by the Contract and Operations Manager that procedure documents for the new finance systems had not been produced at the time of the audit in November 2021. Staff were being provided with training to use the new systems. We reviewed the calendar invites for the training and confirmed via interviews with staff that the training took place in mid-October 2021. It was explained that it was intended that the procedure documents would be created by staff after they familiarised themselves with the new systems.
- We confirmed the process for FA is on the Council's website and therefore accessible by the public. The website also includes information regarding the financial documents that will be checked, how the charges will be calculated, methods of payment and contact information of the Exchequer Services Recovery team.
- For a sample of ten current residential and ten current non-residential service users tested we confirmed that:
  - FAs were undertaken in 13 cases. Although for one of these cases, the FA took over a year from the date of referral to undertake, as the case had to be referred to the Appointee and Deputyship (A&D) team and due to the wait to receive information regarding the service user's money.
  - In four cases a FA was not required, these being S117 cases.
  - In the remaining three cases the FA had not yet been undertaken as the service users had not provided all the required the documents. The FAs have been outstanding for 2 ½, 12 ½ and 15 ½ months respectively.

- Prior to Covid-19, the financial information was collected by the Exchequer Services Unified Assessment Services (UAS) team. During Covid-19 a 'Trust and Protect' service was put in place, where service users were offered the required services without an FA as officers were unable to perform home visits. Service users were asked to send in their financial information to the Exchequer Services contractor via their preferred method (i.e. either postal or online). Financial information was then stored on the case management system and reviewed by officers in Exchequer Services.
- Service users who have not provided their financial documents are marked as 'Pended' on the system used by the Exchequer Services Contractor. A 'Pended' report was being run every two weeks to identify service users who have not submitted their financial information. We reviewed a sample of three 'Pended' reports (dated 1 October, 16 October and 28 October 2021) and confirmed these were stored on the Exchequer Services Contractor's shared drive. Where service users do not provide their documents by the deadline, they are marked as 'Expired Pended', chased for the documents and then marked as 'Pended' again with a new deadline to provide the documents. Review of the sample of 'Pended' service user reports confirmed that these list the users that are 'Expired Pended'. We reviewed the audit trails from the system for the sample of ten residential and ten non-residential cases above and confirmed that these had been chased for evidence and marked as 'Pended' and 'Expired Pended' when relevant.
- Our testing of the sample of ten residential and ten non-residential cases above confirmed that:
    - In five residential and seven non-residential cases the financial documents were evidenced as reviewed by relevant staff.
    - In one non-residential case the financial documents were not obtained from the service user as they did not wish to provide their documents and chose to pay the full cost for the service. Review of the FA form confirmed that this was correct.
    - Two of the residential cases and two of the non-residential cases were S117 cases and therefore no FAs were required.
    - In three residential cases the assessment has not been completed yet as the service user had not provided the documents. We reviewed the audit trail from the system and confirmed that the users had been chased for the documents and each user had been marked as 'Pended'. The FAs have been outstanding for 2 ½, 12 ½ and 15 ½ months since referral.

- We obtained copies of the Council's and the Exchequer Services Contractor's data protection policies. Review of the polices confirmed that these were recently updated (Council's policy was last updated on 14 May 2021 and the Exchequer Services Contractor's policy was last updated on 29 January 2021).
- We confirmed via review of calendar invites to GDPR training from February 2021 and interviews with staff that Exchequer Services Contract officers had been provided with mandatory annual online GDPR training. Although, we asked the Contract and Operations Manager for evidence of the Council's officers receiving annual GDPR training, we did not receive any evidence of this *(see issue 2 in detailed findings)*.
- There was a data breach in September 2021 where a printed benefit letter containing personal information was sent to the wrong customer. We reviewed an email to the Council regarding the breach and the Information Commissioners Office (ICO) report and confirmed that the breach was reported to the Council by the Exchequer Services Contractor. The relevant customers were informed of the breach and the importance of thoroughly checking any correspondence was reaffirmed to the Admin team. We understand this matter is now closed.
- Monthly key performance indicator (KPI) monitoring reports are produced by the Exchequer Services Contractor and presented to the Council during monthly performance monitoring meetings. Review of the July, August and September 2021 KPI monitoring reports confirmed that these were produced in line with the KPIs specified in the Exchequer Services contract and that the KPIs had been met during all three months. Review also noted that cases that have been pending for over 2 months are detailed in these reports. Review of the corresponding performance monitoring meeting minutes confirmed that these KPIs monitoring reports were discussed during these meetings. However, cases that were pending for over 2 months along with the related financial implications were not discussed during the meetings (*see issue 3 in detailed findings)*.
- We were informed by the Exchequer Services Operational Manager that the contractor undertakes monthly quality assurance (QA) checks on the FAs. We were provided with a copy of a report produced by the Exchequer Services Contractor detailing the results from the QA checks undertaken during 2021/22 and confirmed that the QA checks are undertaken monthly. This report is in turn used to inform the monthly KPI monitoring reports mentioned above.
- We were informed by the Contract and Operations Manager that the Council used to undertake quarterly spot checks of the FAs but these were put on hold due to Covid-19. The last spot check was undertaken in September 2020 (*see issue 4 in detailed findings*).

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 prioritised in line with the criteria set within Appendix B.

REDACTED

FINANCIAL ASSESSMENTS 2021-22

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No.	Finding	Risk	Recommendation and Priority	Management Response	Agreed Timescale and Responsible Manager
1	<u>Procedure Documents</u> The Council moved to new systems in October 2021. Although copies of the procedural guidance for these new systems were requested by Internal Audit, these were not provided. It was explained by the Contract and Operations Manager that staff, once familiar with the new systems, would be drafting appropriate procedural guidance. Since there was a lack of procedure documents for entering and editing the benefit rates on the system, and the input of the financial information on the system in order to calculate the FA for the case management system, it is important for	Where there is no procedural guidance, there is an increased risk that staff are unaware of the process leading to inconsistent and /or inappropriate practises.	Management should ensure that procedure notes are created for the new finance systems. These should include detail on how to input benefit rates and financial information on the new finance systems. Once produced, these should be made available to relevant staff. **Priority 2**	The procedure documents for entering and editing the benefit rates on the case management system were manual documents which were not available at the time of the audit. Annually the changes to the benefit rates and charging rates to the live were checked and signed off by a manager. Procedures for the new system to carry out financial assessments have been produced and have been provided to staff. Any outstanding procedures that are required will be produced and provided to staff	Operations Manager (Contractor) Contract and Operations Manager (Exchequer) 31 March 2022

FINANCIAL ASSESSMENTS 2021-22

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No.	Finding	Risk	Recommendation and Priority	Management Response	Agreed Timescale and Responsible Manager
	Management to ensure that procedure documents are created for the new systems and are accessible by staff.				
2	Data Protection We were provided with a copy of the Council's GDPR policy and were informed that Council officers were provided with GDPR training in 2018. Although, we asked the Contract and Operations Manager for evidence of the Council's officers receiving annual GDPR training, we did not receive any evidence of this.	Personal information retained by the Council is not used in line with GDPR.	Management should identify the Council officers who have not received GDPR training in line with the Council's policy and ensure that they are provided with GDPR refresher training. Completion of GDPR training should be monitored and actions should be taken to address non-compliance. **Priority 2**	Any staff who have not received GDPR training in line with the Council's policy will be identified and provided with the required training. Completion of GDPR training will be monitored.	Assistant Director Exchequer Services 30 April 2022
3	Pending Cases Monthly KPI monitoring reports are produced by the Exchequer Services Contractor and presented to the Council during monthly	Appropriate actions to deal with cases that have been pending for over 2 months are not taken. The Council is	Cases that have been pending for over 2 months along with the related financial implications and mitigating actions should be discussed during	Quality checking on pended documents will be carried out by the Exchequer Services Quality and Assurance Team to ensure that deadlines are dealt with appropriately.	Operations Manager (Contractor) Contract and Operations

FINANCIAL ASSESSMENTS 2021-22

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No.	Finding	Risk	Recommendation and Priority	Management Response	Agreed Timescale and Responsible Manager
	performance monitoring meetings. Review of the July, August and September 2021 KPI monitoring reports noted that cases that have been pending for over 2 months are detailed in these reports. Review of the corresponding performance monitoring meeting minutes noted that cases that were pending for over 2 months along with the related financial implications were not discussed during the meetings.	unaware of the financial implications of the pending cases.	the monthly performance monitoring meetings. **Priority 2**	An item will be added to the agenda to ensure this is captured at each service review.	Manager (Exchequer) 28 February 2022
4	<u>Spot Checks</u> We were informed by the Contract and Operations Manager (Exchequer) that the Council used to undertake quarterly spot checks of FAs but that these checks were put on hold due to Covid-19. The last spot check was undertaken in	The FA may not be undertaken correctly, and this may not be identified and rectified.	As planned, spot checks on FAs should be resumed as soon as possible. **Priority 2**	Spot checks will be resumed as part of the annual uplift process which takes place between February and April.	Contract and Operations Manager (Exchequer) 30 April 2022

FINANCIAL ASSESSMENTS 2021-22

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

No.	Finding	Risk	Recommendation and Priority	Management Response	Agreed Timescale and Responsible Manager
	September 2020. It was explained that Council officers were unable to undertake the spot checks because working remotely caused delays to the day-to-day work and because they had to prioritise the work they were undertaking. Further, that the Council was hoping to resume the spot checks between January and April 2022, following successful transition to the new systems.				

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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INTERNAL AUDIT FINAL REPORT

HOUSING, PLANNING AND REGENERATION DEPARTMENT

REVIEW OF HOUSING NEEDS, EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)

Issued to:	**Assistant Director, Housing** **Head of Housing Options and Support** **Housing Options Group Manager** **Head of Finance ASC Health & Housing (Final only)** **Director of Housing, Planning and Regeneration (Final only)**
Prepared by:	**Principal Auditor**
Reviewed by:	**Head of Audit and Assurance**
Date of Issue:	**20th January 2022**
Report No.:	**PLA/04/2021**

REVIEW OF HOUSING NEEDS, EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)

INTRODUCTION

1. This report sets out the results of our audit of Housing Needs, Early Intervention and Advice. The audit was carried out as part of the work specified in the 2021-22 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 Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local authorities to intervene at earlier stages to prevent homelessness in their areas. It also requires housing authorities to provide homelessness services to all those affected, not just those who have 'priority need.' These include:

    a) an enhanced prevention duty extending the period a household is threatened with homelessness from 28 days to 56 days, meaning that housing authorities are required to work with people to prevent homelessness at an earlier stage and,

    b) a new duty for those who are already homeless so that housing authorities will support households for 56 days to relieve their homelessness by helping them to secure accommodation.

3. The housing authority has a duty to provide advice and information about homelessness, the prevention of homelessness and the rights of homeless people or those at risk of homelessness, as well as the help that is available from the housing authority or others and how to access that help. The service should be designed with vulnerable groups in mind and authorities may provide it themselves or arrange for other agencies to do so on their behalf.

4. Housing authorities must give proper consideration to all applications for housing assistance, and if they have reason to believe that an applicant may be homeless or threatened with homelessness, they must make enquiries to see whether they owe them any duty under Part 7 of the 1996 Act.

5. Housing authorities have a duty to:

    a) carry out an assessment in all cases where an eligible applicant is homeless or threatened with homelessness; and,

    b) take reasonable steps to help prevent any eligible person who is threatened with homelessness, from becoming homeless.

6. In December 2019, the service went live with a new Housing Case Management Software system which contains a workflow system which guides officers to 'compulsorily update', in order to progress a case effectively.

7. Between April and September 2021, 1,704 approaches ('knocks on door') had been received, of which 655 required advice only and 1,049 resulted in a Homeless Application. The Performance Digest reflects that 'I am being evicted/asked to leave where I am staying', accounts for the highest number of approaches at 34% (575).

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

AUDIT SCOPE

9. The original scope of the audit was outlined in the Terms of Reference issued in October 2021 and the key risks reviewed within this audit were:- .

- Information, advice and guidance is not available to everyone who requires advice and assistance to resolve a housing issue, including being homeless or threatened with homelessness
- Housing Options Assessment forms are not processed in a fair, consistent, timely and correct manner
- Performance of the service is not monitored regularly, corrective actions are not taken to address any issues and the information/data is not used effectively to improve the quality and efficiency of the service
- Changes to service delivery and relaxation of governance arrangements may lead to weaknesses in the controls previously in place

AUDIT OPINION

10. Our overall audit opinion, number and rating of recommendations are as detailed overleaf:

REVIEW OF HOUSING NEEDS, EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)

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	3	1

SUMMARY OF FINDINGS

The Housing Options 'Front door' was adapted in light of COVID-19 with a greater emphasis on prompt on-line and telephone communication, with support available for applicants accessing the service via both channels. Procedures are documented and management support is available to the Housing Options officers via the Duty Manager system.

We would wish to bring the following four areas to Management's attention:-

Online Information

The current structure and content of the Housing Options and Advice section of the Bromley website www.bromley.gov.uk directs people requiring advice and general assistance with a query or problem regarding housing issues, to contact the Housing Options Team and complete a Housing Advice and Assistance Form. Signposting/Self Help information is negligible and does not effectively support people to make decisions about how to retain control over their housing situation, find solutions within the community and third sector or navigate the process to identify and understand the self help and support options available.

Quality standards and management oversight of cases

Although examples of comprehensive Personal Housing Plans were seen, there were also gaps in information and inappropriately completed Plans. Additionally, one Personal Housing Plan could not be located. Whilst all 21 cases sampled had been closed on the Housing Case Management Software system, only seven were at management level and, of those, one had been closed by the manager who had completed the Personal Housing Plan. One assessment reflected 76 days between the date of the application and the assessment with no identifiable cause for delay. Although it is noted that the Prevention and Relief Duty stages can exceed the 56 days stated in the Homelessness Reduction Act, over half (8/14), Prevention/Relief cases had remained open for longer than 56 days, with timescales ranging from 63 to 151 days.

ID/Passwords/Security Question and Answer

It was noted that an E mail had been sent to an applicant which contained their household ID, password, security question and answer, together with the link to the Housing Portal. This information could enable unauthorised third party access to the applicant's personal information on the Portal.

Agreement of the Applicant to the Personal Housing Plan

Whilst it is acknowledged that the applicant's verbal agreement to their Personal Housing Plan would be recorded in the relevant box on the Housing Case Management Software system, it would be best practice to routinely seek the applicant's tangible agreement (or lack of) to the Personal Housing Plan to confirm that they have (or have not) accepted the actions to be undertaken by them and the Housing department to support them to remain in, or to secure, suitable accommodation.

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 HOUSING NEEDS, EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Online information (www.bromley.gov.uk)	
Finding The current structure and content of the Housing Options and Advice section of the Bromley website www.bromley.gov.uk directs people requiring advice and general assistance with a query or problem regarding housing issues, to contact the Housing Options Team and to complete a Housing Advice and Assistance Form. Signposting/Self Help information is negligible and does not effectively support people to make decisions or find solutions within the community and third sector. An enhanced Housing Options and Advice Front Door Offer on the www.bromley.gov.uk website with Information, Advice and Guidance and details of specialist organisations, could divert some potential applicants, who are able to self manage, away from the Housing Options and Advice service and may also support those who may be reluctant to become formally known to the service. **Risk** The Information, Advice and Guidance offer may not enable people to make the best decisions about how to retain control over their housing situation or navigate the process to identify, and understand, the self help and support options available.	
Recommendation The structure and content of the Information, Advice and Guidance suite of pages and documents on www.bromley.gov.uk should be reviewed and enhanced, both as individual elements and the 'offer' as a whole. Ownership should be defined, together with ongoing responsibilities to ensure the information and advice published enables people to understand the self help and support options available and how these may be accessed.	**Rating** **Priority 2**
Management Response and Accountable Manager: Head of Housing Options & Support in liaison with Head of Compliance & Strategy This has been identified as a critical piece of work, for the department as a whole and is being led on by Compliance and Strategy. We recognise that as a minimum, housing advice needs to be available, accessible and clear to a wide audience to support them in finding a solution to their housing situation. The Compliance & Strategy Team has already begun work to benchmark against other LA websites to ensure that the updated information is in line with good practice and also reflects the current work and housing options provided by the service on a day to day basis.	**Agreed timescale** Whilst this will be ongoing the initial review and adjustments will be made by 31st March 2022.

2. Quality Standards Framework and management oversight of cases

Finding

During the course of the audit, issues of Personal Housing Plans containing sections which had either not been completed or had been inappropriately completed were identified in 6/21 cases. In a further case, the Personal Housing Plan could not be located.

14/21 cases had not been closed at management level on the Housing Case Management Software system and a further case had been closed by the same manager who had completed the Personal Housing Plan.

One assessment reflected 76 days between the date of the application and the assessment with no identifiable cause for delay.

By observation of the Case Outcome Prevention Duty data, it was established that 5/7 Prevention Duty cases had remained open for longer than 56 days and had not moved to the Relief Stage. Timescales ranged from 63 to 151 days.

By observation of the Case Outcome Relief Duty data, it was established that 3/7 Relief Duty cases had remained open for longer than 56 days and had not moved to Main Duty. Timescales ranged from 69 to 93.

Fuller details of the anomalies and the Sample Numbers to which they relate can be located in Appendix C on Pages 11 and 12.

Risk

Whilst it is noted that discussions have been had within the department to implement a programme of case file audits, at the time of the Internal Audit, this had yet to commence. Without management oversight of cases and a quality standards framework in place to measure and quality assure areas such as compliance with legislation, adherence to policy and ensure completion of casework to a minimum standard, gaps may not be identified, errors may occur and appropriate action may not be taken to improve quality and the efficiency of the service.

Whilst it is acknowledged that the data from the Housing Case Management Software system, which feeds into the quarterly statutory return to the Department for Levelling Up, Housing and Communities, is subject to a quality assurance process for missing data and obvious anomalies, management oversight of the cases would provide reassurance on areas such as dates input, which are of primary importance for fields which, for example, calculate the number of days a case remains open. Data provided to the Department for Levelling Up, Housing and Communities may be used as a factor in Grant funding calculations, therefore accuracy is paramount.

REVIEW OF HOUSING NEEDS, EARLY INTERVENTION AND ADVICE (OPTIONS AND ASSESSMENT)

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
A quality standards framework/management oversight process should be put in place to monitor performance standards, ensure decisions/closures are appropriate, timescales are adhered to and investigate deficiencies/variances. The resulting qualitative and quantitative performance data should be used to supplement the Housing Performance Digest to drive performance improvement.	Priority 2
Management Response and Accountable Manager: Housing Options Group Manager	**Agreed timescale**
PHP – Guidance has been re-issued to Housing Options Officers, (both existing and new) in regard to the quality of PHPs. In ensuring there is a consistent standard, a set of excellent PHP templates will be shared with Options Officers. Team managers will be asked to speak to Officers in Team meetings and 1-2-1's about improving the completion and quality of PHPs. Team Managers will be auditing PHPs on a bi-monthly basis.	31st January 2022
Performance Monitoring – work has been on-going to improve the quality of the performance data in the Housing Digest and also in the quality of the on-line data to support the statutory return. Whilst Performance management meetings have been implemented, this has been formalised with weekly officer and team leader reporting. This provides a weekly audit and overview of casework delivery. In addition, service wide performance meetings have been instigated, covering all aspects of the service including Housing Options, to ensure that the awareness of wider performance priorities and objectives across the department.	
Quality Assurance A quality standards framework/management process is being implemented and managed by Team leaders to monitor performance standards across all casework areas. Team Leaders are provided with performance data showing the length of time and amount of homelessness cases open to officers. Although the responsibility of this rests with the team managers, the Group manager monitors the data and outcomes, with the respective team managers to ensure the standards are maintained and to ensure timely intervention where necessary. The Monthly performance meetings held with the Senior Housing Leadership Team, provides an opportunity to ensure that the performance meets the qualitative standards and statutory requirements.	31st March 2022

3. ID/Passwords/Security Question and Answer	
Finding During the course of the Audit, it was noted that for Sample 1, an E mail had been sent to the applicant which contained the following information:- • Link to the Housing Portal • Household ID • Password • Security Question • Security Answer **Risk** These details could enable unauthorised third party access to the applicant's personal information on the Portal.	
Recommendation All Housing Options staff should be reminded of their Data Protection and Confidentiality Responsibilities.	**Rating** Priority 2
Management Response and Accountable Manager: Housing Options Group Manager in conjunction with Head of Compliance & Strategy A recent email has been sent to all officers, listing the agreed actions to working with customers who may need assistance with log ins, or renewing passwords. As a result of this audit a further email will be sent, setting out the procedures to ensure that we are GDPR compliant and also discussed with Officers in their 1-2-1 meetings with Team managers.	**Agreed timescale** 31st January 2022

4. Agreement of the Applicant to the Personal Housing Plan

Finding

The Homelessness Code of Guidance for Local Authorities (12th October 2021 update) states in section 11.29 that:-
'Housing authorities should make every effort to secure the agreement of applicants to their personalised housing plans. Identifying and attempting to address personal wishes and preferences will help achieve that agreement and improve the likelihood that the plan will be successful in preventing or relieving homelessness'.

Whilst it is acknowledged that the 'Does the Applicant Agree with the Plan' section on the Housing Case Management Software system would be recorded with 'Yes/No' on receipt of the applicant's verbal confirmation, and that lack of agreement to the Plan would not result in the suspension/withdrawal of support, it would be best practice to routinely seek the applicant's tangible agreement (or lack of) to the Personal Housing Plan.

Risk

Without tangible evidence, it cannot be confirmed that the applicant is/is not in agreement with their Personal Housing Plan and has accepted the actions to be undertaken by them and the Housing department to support them to remain in, or to secure, suitable accommodation.

Recommendation	**Rating**
Personal Housing Plans, available to the applicant via the Portal and sent via E mail as an attachment, contain a 'Does the Applicant and the Council agree on the above Personalised Plan' statement with Applicant and Officer signature boxes for either agreement with, or lack of agreement to, the Plan. Best practice would be to obtain the applicant's tangible acceptance of (or lack of agreement to) the Personal Housing Plan which, if this cannot be achieved electronically via the Portal, could be via E mail.	Priority 3
Management Response and Accountable Manager: Housing Options Group Manager An email will be sent to all Officers, advising them of the change to the current process. Officers will be asked to email the PHP to the customer, asking them to confirm their acceptance within a certain time limit, noting that no response will be viewed as acceptance of the plan. If there is no response to contest the PHP, it will be accepted that the Customer will be working towards the goals set out within the document.	**Agreed timescale** Meeting with Team being held 24th January 2022. To be implemented 1st February 2022.

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.

Finding 2 - Quality standards and management oversight of cases – Sample data

During the course of the audit, the following issues were identified amongst the sample of cases which had been accepted for Prevention, Relief or Main Duty assistance.

a) Personal Housing Plan anomalies

In 6/21 Personal Housing Plans reviewed, sections had either not been completed or had been inappropriately completed and in a further case, a Personal Housing Plan could not be located:-

For Sample 8, the 'Circumstances that caused applicant to be threatened with homelessness' section had been annotated with 'Refer to Assessment Notes'.

For Sample 11, none of the following sections had been completed:-

- Housing needs of the applicant
- Housing wishes of the applicant
- Support needs of the applicant to acquire and maintain accommodation.

For Sample 14, in addition to the sections above, the 'Circumstances that caused the applicant to be threatened with homelessness' had not been completed.

For Sample 17, In each of the following sections, the applicant's name had been put in the boxes with no other detail:-

- Circumstances that caused the applicant to be threatened with homelessness
- Housing needs of the applicant
- Housing wishes of the applicant
- Support needs of the applicant to acquire and maintain accommodation.

For Sample 20, the 'Support needs of the applicant to acquire and maintain accommodation' had not been completed.

For Sample 21, the 'Housing wishes of the applicant' had not been completed

For Sample 4, a Personal Housing Plan could not be located.

b) Case closures on the Housing Case Management Software System

14/21 cases (Samples 2 – 14 and 17) had not been closed by a Manager on the Housing Case Management Software system. A further case (Sample 1) had been closed by the same manager who had created the Personal Housing Plan.

c) Timeliness of Assessments

Sample 4 was reflecting 76 days between the date of the application and the assessment with no identifiable cause for the delay.

d) Cases exceeding the 56 day time scales.

By observation of the Case Outcome Prevention Duty data, it was established that 5/7 (Sample 1, 2, 3, 6 and 7) Prevention duty cases had remained open for longer than 56 days and had not moved to the Relief Stage. Timescales ranged from 63 to 151 days. The Performance Digest for September reflected that 'At the end of September 21, 83 Prevention Duties had been opened and not marked with an end date *of which 71% or 59 cases are out of time'.*

By observation of the Case Outcome Relief Duty data, it was established that 3/7 (Samples 8, 11 and 12) Relief duty cases had remained open for longer than 56 days and had not moved to Main Duty. Timescales ranged from 69 to 93 days. The Performance Digest for September reflected that 'At the end of September 21, 209 Relief Duties had been opened but not marked with an end date *of which 75% or 157 cases are out of time'.*

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THE LONDON BOROUGH
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FINAL INTERNAL AUDIT REPORT

CORPORATE SERVICES

REVIEW OF THE IT ASSET REGISTER

Issued to: Director of Corporate Services
Director of Finance
Head of Information System Services
IT Contract and Operations Manager
Head of Information Management

Prepared by: Principal Auditor
Trainee Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 28 January 2022

Report No.: CEX/01/2021

REVIEW OF THE IT ASSET REGISTER

INTRODUCTION

1. This report sets out the results of our audit of the IT asset register. The audit was carried out as part of the work specified in the 2021-22 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 contract framework agreement with the Council's IT contractor states that *'the Service Provider shall …. at all times during the Term, maintain an up-to-date register in a form agreed with the Authority which details all Assets used in the provision of the Services.'*
3. There is a Key Performance Indicator (KPI) in the contract framework agreement relating to asset management and the inventory accuracy of hardware and/or software. It was frozen during the pandemic but has now been lifted.
4. The Council's IT contractor has informed us that, in future, the IT asset register will move to a new asset management system which, unlike now, will have customer access.
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. The key risks identified were:

- Responsibility for the recording and management of IT assets may not be defined, documented and formally designated. An IT asset management policy may not be in place, up-to-date and available to all staff.
- The IT asset register may not be updated to record detailed records of all hardware, software and other IT asset acquisitions, modifications and lost equipment.
- The IT asset register may not be adequately maintained and reviewed periodically.
- IT assets disposed of may not be deleted from the IT asset register. Council data may not be erased from returned/old equipment before disposing of it. Destruction certificates may not be provided by the designated contractor.

N.B. Due to the COVID-19 pandemic, items of IT equipment have not been disposed of since January 2020. We were unable therefore to test the disposal process and confirm that destruction certificates had been provided by the contractor.

REVIEW OF THE IT ASSET REGISTER

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	**4**	**0**

SUMMARY OF FINDINGS

8. The IT contract framework agreement specifies the Council's IT contractor's responsibility for the recording and maintaining of an IT asset register. Two of the Council's IT policies state the personal responsibility of Council employees for any IT equipment issued, however the Council does not have its own overarching IT asset management policy or accompanying IT asset management procedures in place. These should clearly define the respective roles and responsibilities of the Council and the Council's IT contractor.

9. Our audit testing identified that the information recorded on the IT asset register register is not up-to-date, accurate or complete. The IT department do not have access to the asset register maintained by the Council's IT contractor. The monthly information reports run from it by the Council's IT contractor are not 'user friendly' with categories of information set out across 32 different headings. We found that the information is not reviewed periodically by the IT department e.g. to confirm that purchases of IT items have been added to it accurately and to identify any anomalies of information recorded in the register.

10. We were unable to find 17 out of our sample of 20 items shown on the register as being in storerooms. This was mainly because the storerooms had large numbers of 'old' laptops and desktops stacked high on trolleys or shelves, making it extremely difficult to identify our

sample items. Whilst we acknowledge that the Covid-19 pandemic has resulted in unused items being stored for longer than expected, it is unclear which of the items in storage are due to be re-used in future and which are due to be disposed of.

11. The IT department and the Council's IT contractor have started to carry out their own checks to confirm the current location and user of IT items shown on the IT asset register. With employees continuing to work from home, physical inspections are not possible and alternative ways of obtaining and checking this information are being trialled. Their checks have revealed numerous anomalies in the accuracy and completeness of the information recorded on the IT asset register. We are aware that the Council's IT contractor is putting in place an Action Plan to address the findings arising from our audit and it will include confirming with all staff the details of the assets which they currently hold.

12. Access to the IT equipment held in secure storage is restricted to a limited number of employees of the Council and the Council's IT contractor. IT equipment is tagged with an asset tag when issued to an employee, but not when originally received from the supplier and held in storage until issue.

13. The Council's IT contractor invoices the Council each month for services provided under the framework agreement. As part of this, the Council is charged per item for desktops, laptops and ipads supported by the Council's IT contractor and in use. Due to errors in the categories of assets recorded on the IT asset register, the total numbers of items charged each month is derived from information from the Microsoft System Configuration Console. We asked the IT Contract and Operations Manager if it would be possible to see the MSCC totals to confirm what we had been charged but we were told that it would not be possible to provide it.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

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

REVIEW OF THE IT ASSET REGISTER

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. IT asset register
Finding Our testing identified that the information recorded in the IT asset register is not up-to-date, accurate or complete. Separately, the IT department and the Council's IT contractor have started to carry out their own checks which have also revealed anomalies in the accuracy and completeness of the information recorded on the IT asset register. The asset register information provided to the IT department by the Council's IT contractor is in the form of an Excel spreadsheet of detailed records. There are 32 headings for different categories of information and the way the information is presented lacks clarity e.g. one of the site locations for assets recorded in the register is named 'LBB-Unknown" and another is 'Main Stores (Lodge)' but that building has not been used to store IT equipment for at least two years. We noted that for nine entries the allocated asset user is shown as 'Students' with the name of a Council employee alongside it. In one of the storerooms, we found a new ipad which had been asset tagged and was waiting to be collected, but when we checked the asset number against the details recorded on the asset register, it showed the item as a laptop allocated to a member of the Council's IT contractor's team. Subsequent enquiries revealed that, due to a transposition of numbers, the wrong asset had been updated on the asset register. During our visit to the storerooms, there were five laptops which were seen stored on shelves in the storerooms but only one had its location correctly recorded on the asset register. We also identified three laptops with asset tags (tag numbers 02027253, 0207371 and 020373) which we could not find an entry for on the IT asset register. **Risk** Management is not fully aware of what IT assets the Council holds or their whereabouts. Discrepancies relating to the IT asset register are not identified and resolved promptly, with misplaced assets not being identified and recovered.

REVIEW OF THE IT ASSET REGISTER

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
Management should put appropriate procedures and controls in place to enable them to gain assurance that the information recorded in the IT asset register by the Council's IT contractor is accurate, complete and up to date. This should include: (i) specifying to the Council's IT contractor what detailed information should be recorded, how it should be categorised and what management information is required and when, (ii) carrying out, periodically, an independent review of the information recorded in the register to identify any gaps in information or inaccuracies and confirming that assets purchased have been correctly added to the register.	Priority 1
Management Response and Accountable Manager	**Agreed timescale**
Covid-19 hit as the Council's IT contractor was starting the roll out of Windows 10 and Office 365. The whole project was planned with an on-site appointment-based approach. This was switched rapidly to a remote approach with the project team having limited time to prepare a large number of machines in order to help support Bromley Council users to work remotely, access to site due to lockdown rules was limited and time on-site was focused on key activities. Business as usual processes may have been overlooked during this period, causing some of the asset tracking data/stock control issues identified by the audit. The Council's IT contractor acknowledges however that this does not mitigate all of the issues found and as such have responded with a full end to end review of its processes, work instructions and accuracy of data to ensure confidence is restored in their ability to deliver the service they pride themselves on. The high-level view of actions taken includes: • A simple interactive survey of all LBB users by the Council's IT contractor to capture their latest data for all devices held (mobile/laptop/ipad/desktop pc).	31 March 2022 (for all actions required)

• A new audit process by the Council's IT contractor to ensure the data is monitored and reflected in the asset management SLA reported each month within the Council's IT contractor's service review. This audit will include both the database and the physical stock rooms. • Lack of clarity on the reporting of assets – the Council's IT contractor has moved out of the NAMS system (Old Asset Management System) to a new BFG platform (New Asset Management System. The Council's IT contractor will seek to review the current reporting that comes from BFG and work with LBB to ensure it is clear, understood and headers that hold no value are removed to enable a clearer view of assets. • Stock rooms have been audited by the Council's IT contractor and all rooms have been cleared of items for disposal, tidied and given defined area for allocation of different types of stock (new, retired, disposal etc). • All assets that are held within a stock room are under control of the Council's IT contractor (please note that LBB hold some items here that are not under control of the Council's IT contractor) have been asset tagged and added to the asset register. This is now a standard process for all new items before they get added to the stock room. During the Council's IT contractor's audit they confirm that no devices have been found to be unaccountable for. They did find that a number of devices had been marked up incorrectly on the asset tracker causing confusion during the audit process. This has been rectified, and the root cause of why has been rectified. In future, we will carry out periodically, as part of contract monitoring, a review of the information recorded in the register to identify any gaps in information or inaccuracies. A check will also be made to confirm that assets purchased have been correctly added to the register. Accountable Manager - IT Contract and Operations Manager	

REVIEW OF THE IT ASSET REGISTER

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

2. IT asset management policy and procedures	
Finding The contract framework agreement with the Council's IT contractor states the responsibility of the Council's IT contractor to maintain an IT asset register and the Corporate Information Security Policy and User Guidance for iPads and mobile phones state the personal responsibility of Council employees for any IT equipment issued. The Council does not however have its own overarching IT asset management policy or accompanying IT asset management procedures in place which details the processes in place, together with roles and responsibilities of the Council and IT. **Risk** Without regularly reviewed and updated policies and procedures, which are readily available, employees may not fully understand their responsibilities concerning IT asset management, leading to errors in operational processes and actions not being carried out.	
Recommendation An IT asset management policy should be introduced, with accompanying procedures for managing IT assets. This could include security of assets, responsibility and accountability if items are damaged, lost or stolen, depreciation of assets and asset disposal arrangements.	**Rating** Priority 2
Management Response and Accountable Manager We will introduce an overarching IT asset management policy for the Council, with accompanying procedures for managing IT assets. Accountable Manager - IT Contract and Operations Manager	**Agreed timescale** 31 March 2022

REVIEW OF THE IT ASSET REGISTER

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

3. Security of assets before they are allocated to employees	
Finding During our visit to one of the secure storerooms we identified five new laptops which had been purchased as part of the Windows 10 IT re-fresh roll out, but which had not yet been allocated. They were in their boxes but had not been included on the asset register because they had not yet been asset tagged. We also saw streaming/video equipment which had been purchased in July 2021 at a cost of £6,932. It was stored securely in a locked training room but had not been asset tagged or recorded on the asset register. Two other recent purchases of IT assets which we sampled could not be examined; a printer located in a locked office where the team was working off site and a desktop which the invoice description on Oracle indicated was for the evaluation unit, but which could not be located. **Risk** An item may not be identifiable as Council property if it is stolen or misplaced without being tagged. Valuable and portable items which are not tagged may be more susceptible to the risk of theft.	
Recommendation Management should ensure that all attractive, valuable, and portable items are tagged as soon as they are received from the supplier and are recorded on the asset register before they are issued to an employee.	**Rating** **Priority 2**
Management Response and Accountable Manager All assets that are held within a stock room are under control of the Council's IT contractor have been asset tagged and added to the asset register (please note that the Council IT team hold some items here that are not under control of the Council's IT contractor). This is now a standard process for all new items before they get added to the stock room. Accountable Manager - IT Contract and Operations Manager	**Agreed timescale** Implemented

REVIEW OF THE IT ASSET REGISTER

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

4. Identifying and separating those assets which will be re-used and those assets which will be disposed of.	
Finding Our testing of a sample of items whose location on the register was shown as a storeroom found that 17 out of 20 items recorded as 'stock' or 'retired' could not be verified. This was mainly because two of the storerooms visited had a significant number of laptops and desktops stacked high on trolleys and shelves with the asset tag numbers not visible, making it extremely difficult to find items in our sample. No disposals of equipment have taken place since the start of the Covid-19 pandemic. It was unclear which of these items in storage had been earmarked to be re-used and which ones were waiting to be disposed of. **Risk** A re-usable asset may be disposed of inadvertently, leading to a loss to the Council and a cost in replacing that asset.	
Recommendation Management should ensure that those assets which may be re-used in future are identified, earmarked and separated from those assets which are no longer required and are due to be disposed of.	**Rating** **Priority 2**
Management Response and Accountable Manager Stock rooms have been audited by the Council's IT contractor and all rooms have been cleared of items for disposal, tidied and given defined area for allocation of different types of stock (new, retired, disposal etc). During the Council's IT contractor's audit, they confirmed that no unaccountable devices had been found. They did find that a number of devices had been marked up incorrectly on the asset tracker causing confusion during the audit process. This has been rectified, and the root cause of why has been rectified. Accountable Manager - IT Contract and Operations Manager	**Agreed timescale** Implemented

REVIEW OF THE IT ASSET REGISTER

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

5. Reconciliation of monthly consumption data charge	
Finding The Council's IT contractor invoices the Council each month for services provided under the framework agreement. As part of this, the Council is charged per item for desktops, laptops and ipads as a consumption charge if the item is active. The monthly charge varies depending on whether or not the item is in or out of warranty e.g. laptop in warranty £24.09, laptop out of warranty £33.46. The IT Contract and Operations Manager told us that due to the inaccuracy of the information recorded on the IT asset register, the asset information totals on the invoice are derived from the Microsoft System Configuration Console (MSCC) run by the Council's IT contractor, which identifies items which are active. These totals are confirmed by the Client Services Manager from the Council's IT contractor during discussions about the invoice prior to payment. We were unable however to see any documented evidence of the information used to verify the monthly consumption data charge for IT assets included on the invoice. **Risk** The Council may be incorrectly charged by the Council's IT contractor each month if the monthly billing information derived from the details of desktops, laptops and tablets is not accurate and verifiable.	
Recommendation Management ensures that in future the monthly consumption charge paid to the Council's IT contractor is based on accurate IT asset information, which can be verified from supporting documentary evidence.	**Rating** **Priority 2**
Management Response and Accountable Manager The report is now added to the backing data. Accountable Manager - IT Contract and Operations Manager	**Agreed timescale** Implemented

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.

REDACTED

INTERNAL AUDIT FINAL REPORT

ENVIRONMENT AND PUBLIC PROTECTION/CHIEF EXECUTIVE'S/ADULT CARE AND HEALTH DIRECTORATES

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

Issued to: Assistant Director, Customer Services
Occupational Therapy Service Lead
Head of Shared Parking Services

Cc (Final only) Director of Environment and Public Protection
Director of Adult Services
Assistant Director Strategy, Performance and Corporate Transformation
Assistant Director Traffic and Parking
Assistant Director, Performance Management and Business Support
Assistant Director, Adult Social Care Operations
Head of Service, Finance, Environment and Community Services (ECS), and Corporate
Director of Human Resources and Customer Services

Prepared by: **Principal Auditor**

Reviewed by: **Head of Audit and Assurance**

Date of Issue: **1st February 2022**

Report No: **PEO/01/2021**

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

INTRODUCTION

1. This report sets out the results of our audit of the operation of the Blue Badge Scheme. The audit was carried out as part of the work specified in the 2021-22 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 Blue Badge (Disabled Persons' Parking) Scheme was introduced in 1971 under Section 21 of the Chronically Sick and Disabled Persons Act 1970. The aim of the scheme is to help people with severe mobility problems caused by visible and, since August 2019, non-visible ('hidden'), disabilities to access goods and services, by allowing them to park close to their destination. The scheme is open to eligible people irrespective of whether they are travelling as a driver or as a passenger.

3. The scheme provides a national range of on-street parking concessions to Blue Badge holders, who must be present on the journey. It allows them to park without charge or time limit in otherwise restricted on-street parking environments and on yellow lines for up to three hours, unless a loading ban is in place. The national concessions also apply, in Bromley Borough only, to car parks.

4. Under Bromley's Scheme of Delegation to Officers, the function of 'The issue and administration of the Blue Badge Scheme as provided for under the Chronically Sick and Disabled Persons Act 1970', has been delegated to the Director of Environment and Public Protection. Within the department, the scheme is owned by the Parking section.

5. Blue Badge administration processes, including approving both new and renewal applications which meet the 'eligible without further assessment' criteria, diary scheduling for applicants who require further assessment and collecting the £10 fee for badges issued, form part of the Customer Services Contract with Contractor A. The 'Expert Assessor' role for applications requiring further assessment is carried out by the Council's Occupational Therapy service. Badges are issued, on the Authority's behalf, by Contractor B.

6. The Service is 'Demand Led', with both the August 2019 Hidden Disabilities Legislation, for which an additional £6,585.67 Local Transport Revenue Block Funding was received to ease the administrative burden, and the impact of Covid, leading to an increase in the number of applications received. Between December 2020 and May 2021, volumes, as reported to

Executive, Resources and Contracts PDS Committee in June 2021, fluctuated between 290 and 461 applications (new and renewal) per month.

7. It should be noted that as a result of the Covid pandemic, the service delivery model transferred from a predominately paper based onsite service with a face to face assessment element, to a remote online service, almost overnight, including moving to an electronic system for Blue Badge workflow. This has presented both opportunities for innovative methods of assessment and also challenges in terms of workflow management and the production of real time management information, although it is acknowledged that significant improvements have been made to the manual reporting process. As at the time of concluding the Internal Audit, the service continued to evolve.

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

AUDIT SCOPE

9. The original scope of the audit was outlined in the Terms of Reference issued in August 2021 and the key risks reviewed were:-

- Applications/renewals are not processed at all or on a timely basis
- Applications are made by individuals who are not entitled to Blue Badges
- Changes to service delivery and relaxation of governance arrangements may lead to weaknesses in the controls previously in place

10. It should be noted that the scope of the audit is Operational and that Blue Badge Fraud (counterfeit badges, holders' deceased, expired badges and 'holder not present' etc.) is out of scope, being part of a separate Contract and data matching exercise.

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

AUDIT OPINION

11. Our overall audit opinion, number and rating of recommendations are as detailed below:-

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**	**5**

SUMMARY OF FINDINGS

12. As a result of the Covid pandemic, the Blue Badge service delivery model transferred from a predominately paper based onsite service with a face to face assessment element, to a remote online service, almost overnight. Information on the website is comprehensive and has been updated to reflect that due to necessary changes in procedures, some applications are currently taking longer to process.

    Innovative use of assessment tools has been evidenced with a range of methods used whilst face to face assessments were suspended and, in all cases sampled, the £10 fee for issuing the badge had been collected.

We would, however, wish to bring the following areas to Management's attention:-

1) **Service Delivery Model and Workflow; underpinning Policies/Procedures with supporting Key Performance Indicators and, Management Information**

The service, which has continued to operate during a period of intense change to its delivery model, is currently functioning without the benefit of a current, agreed and signed off set of Contractor A/Occupational Therapy workflow procedures and supporting key performance indicators for applications requiring further assessment, as both, whilst updated to take account of the impact of Covid on service delivery, remain in draft format. Additionally, there is not a current set of Contractor A operational procedures setting out the interpretation and application of the Government's Local Authority (non statutory) Blue Badge Scheme guidance.

Without this control framework in place, inconsistencies are occurring in terms of both Identification and Verification (ID&V) documentation accepted and the throughput of applications for screening by the Occupational Therapy service, i.e. prior to, or alongside, requesting additional valid documentation where insufficient accompanied the original application.

All Management Information supplied during the course of the Internal Audit (both from Contractor A and the Occupational Therapy service) was manually produced and collated via MS Word and Excel documents; there was no direct feed from the electronic workflow system. It is acknowledged that parties are aware of this issue and efforts have been made to rectify however, at the time of the audit, it remained unresolved, with the current methodology cumbersome, prone to error and not an effective use of resources.

Without real time information extracted from the electronic workflow system, the service is inhibited in its ability for strategic decision making and workflow management. With the move to a new Adult Social Care Software system, it would be timely to consider whether its functionality could also support/streamline the process.

Agreed policies/procedures, supporting key performance indicators and robust management information are fundamental to an effective service delivery model and workflow management. It is recommended that once the agreed, signed off underpinning framework is in place, that the resultant service model is evaluated as a whole, to establish whether this remains the most effective and efficient means of administering and delivering the scheme.

2) **Badge expiry date exceeding Personal Independence Payment (PIP) expiry date**

The standard period of provision for a Blue Badge is three years. One exception to this is if the Personal Independence Payment (PIP) is time limited, in which case the badge expiry date should be no later than the PIP expiry date. A Blue Badge for an applicant whose PIP Payment stated an expiry date of 16th May 2023 had erroneously been issued for the full three years, with an expiry date of 8th June 2024.

3) **Application approved under the 'eligible without further assessment' criteria without identifiable reason**

One application which had been approved by Contractor A under the 'eligible without further assessment' criteria did not appear to meet the criteria. On enquiry, it could not be established why this had not been referred to the Occupational Therapy service for screening and clinical evaluation, although it was confirmed by the Occupational Therapy service that the application would have been approved.

4) **Quality Assurance (Random Sampling) of cases referred for further assessment**

As part of the Appeals process, clinical decisions would be reviewed by Senior Occupational Therapy staff, and evidence was seen of cases being referred by Occupational Therapists during the assessment process for guidance. Whilst this demonstrates a mechanism for quality assurance, the cases reviewed are all as a result of having been brought to the attention of senior staff; there is not currently a process in place for random quality assurance sampling.

5) **Contractor's contractual Key Performance Indicator – Transparency of reporting**

The outturn of the Contractor's contractual Key Performance Indicator to 'Process 80% of Blue Badge applications and renewals within four weeks of receipt of a complete application form' is reported to the Executive, Resources and Contracts PDS Committee as part of the Customer Services Contract Monitoring Report. The latest report of June 2021 reflects 100% processed within timescales for the months December 2020 – May 2021. For absolute clarity, it is recommended that the report notes that this calculation excludes certain touchpoints e.g. when the application is with the Occupational Therapy Service for Assessment or when payment of the fee is awaited and whether the calculation is based on working or calendar days.

6) Publication of the scheme

a) Appeals Process

The published process for an application decision review directs appellants to write to the Council and provides the Civic Centre address; it does not currently include an E mail address.

b) Independent Living, Support and Care Directory

Whilst this publication contains a 'Getting around Bromley' section containing details of Freedom Passes, the 60+ Oyster Card, Disabled Freedom Passes, the Taxi Card scheme and Dial-a-ride, there is no reference to the Blue Badge scheme.

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. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Service Delivery Model and Workflow; underpinning Policies/Procedures with supporting Key Performance Indicators and, Management Information

Finding

Whilst it is acknowledged that the service continues to evolve and therefore the supporting governance framework remains live, the delivery model is not currently underpinned by either:-

- An agreed and signed off set of workflow procedures and supporting key performance indicators for applications requiring further assessment, as both remain in draft format and the subject of ongoing discussions and refinement, or
- A current set of Contractor A operational procedures setting out the interpretation and application of the Government's Local Authority (non statutory) Blue Badge Scheme guidance, or
- Management Information derived directly from the electronic workflow system.

a) Service Delivery Model and Workflow:- Policy, Procedures and supporting Key Performance Indicators

i) (Contractor A/Occupational Therapy for applications requiring further assessment)

Whilst a detailed suite of procedures is in place for the Contractor A/Occupational Therapy workflow and these have been updated to take account of the impact of Covid on service delivery, they, together with the accompanying suite of workflow key performance indicators, remain the subject of discussion and refinement between the parties and have yet to be agreed and signed off.

ii) (Contractor A Operational Procedures)

It was confirmed with Contractor A that the Scheme is administered in line with the Government non statutory guidance for local authorities however, there is not a current set of supporting documentation setting out how, for example, the guidelines on Identification and Verification should be applied, to ensure consistency of interpretation. In 7/20 cases sampled, areas were identified where Identification/Verification documentation accepted was either not defined within the Government (non statutory) guidance or the Local Authority 'request for supporting evidence letter' as acceptable or, in the case of Driving Licences, that they are acceptable for both Identification and Address validation. One address confirmation was by way of a check of the Council Tax records system however this check is not routinely recorded on the workflow system. In a further case, proof of address was by way of a Council Tax bill in the name of Mr X, whereas the application was in the name of Mrs. X.

Fuller details of the anomalies and the Sample Numbers to which they relate can be located in Appendix C, Table 1 on Page 21.

In the case of Sample numbers 8 and 16, the applications had been forwarded to the Occupational Therapy service for screening prior to issues with the Identification/Address verification provided having been resolved. For Sample 8, the Driving Licence expired in 2018 and for Sample 16 a

Gas Bill was provided, which the guidance for Local Authorities does not recommend is accepted, and the bill was dated 2019. It should be noted that in both these cases the applications were rejected and there was, therefore, no further Identification and Verification action required. Whilst the rationale of submitting applications for screening by the Occupational Therapy service prior to, or alongside, requesting valid Identification and Verification documentation in order to move the application through the process is understood, when the record is updated with the action (i.e. documentation received), it leads to the application in effect losing its place in the screening queue. This has implications for the accuracy of 'timeliness' data and the ability of the Occupational Therapy service to manage effectively its throughput.

iii) Occupational Therapy

Whilst it should be noted that the Contractor A/Occupational Therapy suite of key performance indicators remain in draft pending agreement, when benchmarked against the proposed ten working day indicator for 'undertaking screening/desktop assessment and return to Contractor A', it was noted that 6/10 cases referred to the Occupational Therapy service had exceeded the timescale although it is acknowledged that, as stated above, updates to the record can lead to an application effectively losing its place in the queue and difficulties in producing accurate workflow data. Notwithstanding these caveats, at the time of the Internal Audit, the sample reflected Screening as a pinch point in the process. The Occupational Therapy Service are aware of this and we were advised by the Occupational Therapy Service Lead that up until now, have been unable to redirect staffing resources from the wider service to support Blue Badges in the way they have done in the past. This is due to the increase in demand for occupational therapy services this year, due to people deconditioning in the community during the recent lockdowns. It has been necessary to prioritise the wider service work to reduce hospital admissions and support the wider sector. With additional temporary resource now available and appointed, commencing December, to reduce pressures, no further recommendation has been made in this report.

Fuller details of the anomalies and the Sample Numbers to which they relate can be located in Appendix C, Table 2 on Page 22.

b) Service Delivery Model and Workflow:- Management Information

All Management Information supplied during the course of the Internal Audit (both from Contractor A and the Occupational Therapy service) was manually produced and collated via MS Word and Excel documents; there was no direct feed from the electronic workflow system. It is acknowledged that parties are aware of this issue and efforts have been made to rectify it however, at the time of the audit, it remained unresolved, with the current methodology cumbersome, prone to error and not an effective use of resources.

Without real time information extracted from the electronic workflow system, the service is inhibited in its ability for strategic decision making and workflow management. With the move to a new Adult Social Care Software system, it would be timely to consider whether its functionality could also support/streamline the process.

Without an agreed set of workflow procedures, key performance indicators and robust management information, the service is less able to manage workflow or forecast pinch points. Agreed procedures would provide clarity around the order of steps in the process, with any deviation to be implemented only with the approval of all parties.

Agreed policies/procedures, supporting key performance indicators and robust management information are fundamental to an effective service delivery model and workflow management. It is recommended that once the agreed, signed off underpinning framework is in place, that the resultant service model is evaluated as a whole, to establish whether this remains the most effective and efficient means of administering and delivering the scheme.

Risk

Whilst the service delivery model is not underpinned by a framework of agreed policies and procedures, supporting key performance indicators and management information derived directly from the workflow system, the function may lack effective oversight and appropriate action may not be taken to improve efficiency.

Recommendation	Rating
Policy, Procedures and supporting Key Performance Indicators i) The workflow Policy and Procedures, which have been updated to take account of the impact of Covid, should be agreed by all parties, signed off and distributed to all relevant members of staff ii) Contractor A Operational Procedures should be reissued, taking into account the workflow agreed in the Contractor A/Occupational Therapy procedures and should include guidance on Identification and Verification documentation, detailing what is, and is not, acceptable, whether documents may be used for both Identification and Verification and stating any timescale restrictions (i.e. not older than one year). The requirement to note when Council Tax/Electoral Role registers have been used to validate an address should also be reflected. iii) Once the Policy and Procedures are agreed, deviations such as workflow order, should only be undertaken with the approval of all parties. iv) The Contractor A/Occupational Therapy key performance indicators underpinning the workflow should be agreed and the output kept under review and used to identity current and forecast pinch points. **Management Information** i) Further investigations should be made into the reporting functionality of the electronic workflow system as the current manual system is resource intensive and increases the risk of error.	Priority 2

ii) With the introduction of the new Adult Social Care Software system, it would be timely to consider also whether its functionality could support/streamline the process. **Service model evaluation** i) Once the agreed, signed off underpinning framework is in place, the resultant service model should be evaluated as a whole to establish whether this remains the most effective and efficient means of administering and delivering the scheme.	
Management Response and Accountable Manager **Policy, Procedures and supporting Key Performance Indicators** i) Original policy and procedures, periodically updated due to Covid restrictions and guidance, have been disseminated to all relevant officers at all times via email and meetings. These are currently being incorporated into a revised policy and procedure document to be signed off and distributed. Accountable Managers - Operational Manager (Contractor A) and Occupational Therapy Service Lead (LBB) ii) Final, revised policy and procedures to be reissued including specific acceptable date of verification documents and what is acceptable in terms of validity. System will be documented to confirm items used to evidence eligibility. Accountable Managers – Operational Manager (Contractor A) and Occupational Therapy Service Lead (LBB) iii) This currently occurs and will continue. Accountable Managers - Operational Manager (Contractor A) and Occupational Therapy Service Lead (LBB) iv) Contractor A key performance indicators are agreed with LBB and output reviewed monthly by LBB. Accountable Managers – Operational Manager (Contractor A) and Assistant Director, Customer Services (LBB)	**Agreed timescale** April 2022 April 2022 Ongoing Ongoing

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Information	
i) Pre Covid, Contractor A and the LBB OT investigated the reporting functionality within the electronic workflow system. However, due to the level of reporting required, it was difficult to create reports which met the requirement. Contractor A, in conjunction with the LBB OT, will revisit the reporting capability and establish what exactly can be reported and make plans to implement these.	May 2022
Accountable Manager – Operational Manager (Contractor A), in liaison with the Assistant Director, Customer Services (LBB)	February 2023
ii) We are keen to explore the possibility of moving the blue badge process onto the new Adult Social Care Software system having progressed from a paper-based system to electronic workflow system at the start of the pandemic. Although the electronic workflow system has significantly improved security of data shared between Contractor A and Occupational Therapy; the new Adult Social Care Software system brings new possibilities for further development and improvement.	
Accountable Manager – Occupational Therapy Service Lead (LBB)	June 2023
Service Model evaluation	
This will be done after all actions above have been completed.	
Accountable Managers – Occupational Therapy Service Lead (LBB) and Assistant Director, Customer Services (LBB)	

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

2. Badge expiry date exceeding Personal Independence Payment (PIP) expiry date	
Finding Whilst the standard period of provision for a Blue Badge is three years, one exception to this is if the Personal Independence Payment (PIP) is time limited, in which case the badge expiry date should be no later than the PIP expiry date. During the course of the audit, it was noted that for Sample 11, although the applicant's Personal Independence Payment (PIP) had an expiry date of 16th May 2023, the badge had been issued for the full three years, with an expiry date of 8th June 2024. **Risk** The holder of the Blue Badge may benefit from parking concessions to which they are not entitled during the period 17th May 2023 to 8th June 2024.	
Recommendation Operational staff undertaking the administration process should be reminded that in the case of time limited Personal Independence Payments (PIP), Blue Badge expiry dates should be no later than the PIP expiry date. This guidance should also be reflected in the Contractor A Operational procedures.	**Rating** Priority 3
Management Response and Accountable Manager Operational staff are aware – PIP award end dates are used to determine the expiry date of the Blue Badge under existing documented procedures. Adherence to this process is included in monthly quality checking. Notwithstanding this, PIP awards comprising the level of points needed to qualify for a Blue Badge are such that it is extremely unlikely that the PIP award would not be renewed. The impact on the authority of the expiry dates not being the same would not present a material loss. Operational staff have been reminded. Accountable Manager – Operational Manager (Contractor A), in liaison with the Assistant Director, Customer Services (LBB)	**Agreed timescale** Completed January 2022

3. Application approved under the 'eligible without further assessment' criteria without identifiable reason	
Finding During the course of the audit, it was noted that Sample 4 had been approved by Contractor A under the 'Eligible without further assessment' criteria, although on examination of the case, it did not appear to meet the criteria. On enquiry, although it could not be established why this case had not been referred to the Occupational Therapy service for screening and clinical evaluation, it was confirmed by the Occupational Therapy service that the application would have been approved. **Risk** Inappropriate decisions may be made by staff without the appropriate skills, knowledge and training. This could lead to Blue Badges being issued to ineligible applicants.	
Recommendation Operational staff undertaking the administration process should be reminded of the 'Eligible without further assessment' criteria and the need for all other cases to be referred to the Occupational Therapy service for clinical evaluation. This guidance should be reflected in the Contractor A Operational procedures (note, the Department for Transport Local Authority criteria guidance for 'Eligible without further assessment' cases is reflected in the draft Contractor A/Occupational Therapy workflow procedures). As per Finding 1, any deviations from the agreed Policy, Procedures and workflow process should only be undertaken with the documented agreement of all parties.	**Rating** Priority 3
Management Response and Accountable Manager Operational staff have been advised that all applications without a Form DS1500 need to be referred to the Occupational Therapy service for assessment. Such referrals are marked urgent in accordance with agreed procedures with the Occupational Therapy service. This is documented in the new draft guidance. Accountable Manager – Operational Manager (Contractor A), in liaison with the Assistant Director, Customer Services (LBB)	**Agreed timescale** April 2022

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

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4. Quality Assurance (Random Sampling) of cases referred for further assessment	
Finding Whist Senior Occupational Therapy service staff review clinical decisions as part of the appeals process and will also have insight into cases referred to them for guidance during the approvals process, there is not currently a process in place for random quality assurance sampling. As part of the Appeals process, clinical decisions would be reviewed by Senior Occupational Therapy staff and evidence was seen of cases being referred by Occupational Therapists during the assessment process for guidance. Whilst this demonstrates a mechanism for quality assurance, the cases reviewed are all as a result of having been brought to the attention of senior staff; there is not currently a process in place for random quality assurance sampling. **Risk** Without regular 'at random' quality assurance of approved and rejected cases, complete management oversight cannot be evidenced.	
Recommendation A process should be put in place to regularly quality assure a random sample of Occupational Therapy approved and rejected cases, to ensure consistent application of guidelines and decision making.	**Rating** **Priority 3**
Management Response and Accountable Manager A quality assurance process will be implemented and managed by an identified Team Leader or Senior Occupational Therapist, to monitor performance standards across blue badge assessment process for applicants who are not eligible under the automatic criteria. This will consist of a quarterly random sampled review of the following: • A minimum of 2 desk top assessments. This will ensure that decision making follows a clinically justified rationale, based on medical / professional evidence submitted by the applicant. • A minimum of 2 observed face to face assessments for each assessing member of staff. This will ensure that the observed functional assessment of mobility is accurately analysed and reported and that any further health / social care needs are appropriately identified and addressed (eg referral or signposting).	**Agreed timescale** April 2022

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

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• The decision review process continues to provide a further opportunity for management to audit decisions made in both desktop or face to face assessments, throughout the year. Accountable Manager – Occupational Therapy Service Lead (LBB)	

5. Contractor A's contractual Key Performance Indicator – Transparency of reporting	
Finding The outturn of Contractor A's key performance indicator to 'Process 80% of Blue Badge applications and renewals within four weeks of receipt of a **complete** application form' is reported to the Executive, Resources and Contracts PDS Committee as part of the Customer Services Contract Monitoring Report. The latest report of June 2021 reflects 100% of the 2141 new and renewal applications processed within timescales for the months December 2020 – May 2021. Whilst it is clearly stated that the report is 'Customer Service Contract Monitoring' and is presented by the Contract Owner, the definition of **complete** could be misinterpreted without further explanation that the calculation excludes certain touchpoints when the application is at a stage outside of the Contractor's control, such as when the application is with the Occupational Therapy Service for Assessment or when payment of the fee is awaited. It would also be beneficial to confirm whether the calculation is based on working or calendar days. **Risk** Without further explanation as to time excluded elements of the key performance indicator outturn calculation and the definition of 'complete', the reported figure could be subject to misinterpretation.	
Recommendation For absolute clarity, it is recommended that the Customer Services Contract Monitoring Reports to the Executive, Resources and Contracts PDS Committee note that the Contractor A's key performance indicator of 'Process 80% of Blue Badge applications and renewals within four weeks of receipt of a complete application form' calculation excludes certain touchpoints e.g. when the application is with the Occupational Therapy Service for Assessment or when payment of the fee is awaited, and also confirms whether the calculation is based on working or calendar days.	**Rating** Priority 3
Management Response and Accountable Manager The key performance indicator of 'Process 80% of Blue Badge applications and renewals within four weeks of receipt of a complete application form' relates to the time the application spends with Contractor A from start to finish. For transparency the following statement was added to the latest PDS report and will appear on future reports. 'The Council aims to process applications within 6-8 weeks of receipt of all requested information. The KPI and contractor performance is measured	**Agreed timescale** Completed January 2022

against the time taken for the activities required of the contractor. Time taken for any face to face assessments or further information requirements are not included in this calculation.' Accountable Manager – Assistant Director, Customer Services (LBB)	

REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

6. Publication of the Scheme	
a) Appeals Process The published process for an application decision review directs appellants to write to the Council and provides the Civic Centre address and does not include an E mail address. **b) Independent Living, Support and Care Directory** Whilst this publication contains a 'Getting around' section containing details of Freedom Passes, the 60+ Oyster Card, Disabled Freedom Passes, the Taxi Card scheme and Dial-a-ride, there is no reference to the Blue Badge scheme. **Risk** **a) Appeals Process** Without a publicised E mail address, application decision reviews may be sent though the post unnecessarily, leading to delays in processing. **b) Independent Living, Support and Care Directory** The publication does not currently provide a complete picture of the 'Getting around Bromley' options available	
Recommendation **a) Appeals Process** Consideration should be given to updating the website to include an E mail address to be used to submit requests for an application decision review. **b) Independent Living, Support and Care Directory** Consideration should be given to referring to the Blue Badge scheme in the 'Getting out and about' section of the next Bromley Guide to Independent Living, Support and Care Services (2022/23)	**Rating** **Priority 3**

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REVIEW OF THE OPERATION OF THE BLUE BADGE SCHEME

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
a. The email address has been added to the website for applicants who wish to submit requests for an application's decision to be reviewed. Accountable Manager – Assistant Director, Customer Services (LBB)	Completed January 2022
b. Contact has been made with the Web Owner for the Directory and they have agreed to add the link for applying for a disabled badge in the next edition of the document which is due in June/July 2022. Accountable Manager – Head of Shared Parking Services (LBB)	August 2022

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.

OPERATION OF THE BLUE BADGE SCHEME

APPENDIX C

DETAILED FINDINGS

Table 1

Finding 1a ii) Service Delivery Model and Workflow:- Policy and Procedures (Identification and Verification)

For Sample 3, (please note that this application was on behalf of a Minor), proof of address had not been taken. Operational Procedures should reflect the requirement to validate the address of the child.

For Sample 5 and Sample 6, a Driving Licence had been used as evidence of both Identity and Address as it contains both a photograph and address (and also date of birth). Operational Policies should reflect that it is acceptable to use a Driving Licence for both.

For Sample 8, the Driving Licence accompanying this application was dated 20th September 2018. Whilst the application was rejected on assessment by the Occupational Therapy Service, therefore a badge was not issued and it was confirmed advised that in the event of the application being approved, Contractor A would have contacted the applicant for up to date identification prior to issuing the badge, this does have implications for the workflow on the system and increases the risk of error.

For Sample 13, Contractor A advised that the Council Tax Register had been checked to confirm proof of address however it could not be evidenced that this had occurred.

For Sample 16, the Gas Bill accompanying this application was dated 19th July 2019. Whilst the application was rejected on assessment by the Blue Badge Service therefore a badge was not issued and Contractor A advised that in the event of the application being approved, they would have contacted the applicant for up to date identification prior to issuing the badge, this does have implications for the workflow on the system and increases the risk of error. It was also noted that the Gas Bill is a form of identification 'not recommended' by the Department for Transport in the guidance.

For Sample 19, the Council Tax Bill submitted as proof of address is in the name of **Mr**. X whereas the application is in the name of **Mrs**. X.

OPERATION OF THE BLUE BADGE SCHEME

APPENDIX C

DETAILED FINDINGS
Table 2

Finding 1a ii) Service Delivery Model and Workflow:- Policy and Procedures (Timeliness of Screening)

Sample number	Date sent for screening	Date screened
Sample 2	21st June 2021	27th July 2021
Sample 3	18th June 2021	27th July 2021
Sample 5	25th June 2021	30th July 2021
Sample 12	7th June 2021	13th July 2021
Sample 15	11th June 2021	20th July 2021
Sample 20	30th June 2021	5th July 2021

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INTERNAL AUDIT FINAL REPORT

PEOPLE DEPARTMENT

REVIEW OF SUPPORTED LIVING PLACEMENTS

Issued to: John Harrison, Head of Service for Adult Learning Disabilities Service,
Trevor Thompson, Head of Service Cover for Adult Learning Disabilities Service,
Kim Carey, Director, Adult Social Care,
Colin Lusted, Head of Service, Complex and Long Term Commissioning,
Sean Rafferty, Assistant Director of Integrated Commissioning Adult Services,
Ruth Wood, Head of Service, Placements & Brokerage,
James Mullender, Head of Finance, Adult Social Care, Health and Housing.

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

Date of Issue: December 7th 2021

Report No.: PEO/03/2020

REVIEW OF SUPPORTED LIVING PLACEMENTS 2020-21

INTRODUCTION

1. This report sets out the results of our audit of Supported Living Placements. The audit was carried out as part of the work specified in the 2021-22 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. Supported living is an arrangement whereby someone who has their own tenancy also has assistance from a Care and Support provider to help them live as independently and safely as possible.
3. Applicable legislation includes the Care Act 2014; Human Rights Act 1998; Mental Capacity Act 2005, Mental Capacity (Amendment) Act 2019.
4. This service in included within the learning disabilities service in respect of budget monitoring. The total net budget for 2020-21 was £35,387,620 and the total actual spend was £35,976,621. There are two types of supported living placement, those on a spot contract and those schemes that have been commissioned, for which the Authority have nomination rights. Costs are monitored by each individual service user for the year rather than each contract. The block contract is with the provider A. The block contract payments are fixed and paid in 12 equal monthly instalments.
5. We would like to thank all staff contacted during this review for their help and co-operation. It is acknowledged that the pandemic was an unprecedented time and services across most areas of the Council were impacted.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 24/11/20.This audit was postponed during periods of restrictions caused by the Covid 19 pandemic. The scope was to review the contract management and monitoring of the contracts to provide supported living schemes. This audit was due to look at the reprovisioning, but due to the current contracts being extended due to the pandemic, this was not possible.

REVIEW OF SUPPORTED LIVING PLACEMENTS 2020-21

7. The key risks to be reviewed as part of the audit were :-

- Contract management is not effective; management information is not timely, accurate, complete or as detailed within the contract. Robust governance arrangements are not in place for contract monitoring.
- Contract performance is not measured against performance indicators. Performance issues are not identified promptly or dealt with appropriately.
- Payments are not supported by relevant documentation. The amount charged for the service by the contractor does not reconcile to the cost in the contract and the amount paid by the Council and/or client contribution.
- Any changes to processes, due to the pandemic have not been consistently applied, which may weaken controls previously in place. Intended outcomes may not be achieved and there is an increased risk of irregularity.

AUDIT OPINION

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

AUDIT OPINION	
Reasonable	**(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	0

REVIEW OF SUPPORTED LIVING PLACEMENTS 2020-21

SUMMARY OF FINDINGS

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

- Monitoring of voids. Enquiries were made with Commissioning to determine whether the monitoring of voids is undertaken by the service. It was confirmed by the Head of Complex & Long Term Commissioning that *'Commissioners would be aware of where voids are through contract management. If a scheme had a particular issue with voids, commissioners would expect to be made aware to understand if there were specific reasons, if corrective action with the provider was needed or to determine longer term viability. Commissioners do not maintain a list of the voids and there is not a specific procedure / process for the treatment of voids within my service area'*. The Council does not automatically pay providers in the event of a void and has not chased providers to submit invoices. There were a number of voids in Q1-4, it should be noted that some of them were in excess of 18 months, due to remedial works having to be undertaken.
- Audit testing identified 3 cases whereby during the pandemic, the service users returned to their family home for various reasons and payments for the 1:1 care continued to be paid. The department are aware of this and are clawing back monies totalling £33,164.50 in respect of these 3 cases. A further case was reviewed separately, resulting from other work undertaken in Internal Audit. The Project Manager, Strategy, Performance, Corporate Transformation Division, is undertaking a piece of work to identify high cost placements and is monitoring overpayments and changes in circumstances. Internal Audit has been advised that there are 14 supported living cases whereby clawbacks have been made totalling £131,392.48 for 2021-22 and only 1:1 costs have been clawed back. Shared care costs were not recovered due to the impact on other service users at the individual units.
- The current contracts for provider A, B or C that were reviewed have no specific requirement for performance monitoring of key performance indicators.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

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

1. Monitoring of Voids

Finding

Enquiries were made regarding the monitoring of voids within the block contract with provider A. It was confirmed by the Head of Complex & Long Term Commissioning that *'Commissioners would be aware of where voids are through contract management. If a scheme had a particular issue with voids, commissioners would expect to be made aware to understand if there were specific reasons, if corrective action with the provider was needed or to determine longer term viability. Commissioners do not maintain a list of the voids and there is not a specific procedure / process for the treatment of voids within my service area'.*

Reviewing the contract monitoring reports for provider A for 2020-21, the report identifies that there were 3 voids in Quarter 1, 4 voids for Quarter 2, 5 voids in Quarter 3 and 5 voids in Quarter 4. It should be noted that two voids remained empty for more than of 18 months due to remedial works having to be undertaken. At the time of audit testing, the Quarter 4 contract monitoring report was not provided to the Authority although this has since been provided along with Quarter 1 2021/22.

The cost of these voids depends upon the costs of the individual service user per week. It was confirmed by the Head of Complex & Long Term Commissioning, that '*the providers are aware that they can recover the core costs relating to voids but they do not always invoice the Council for them. The Council does not automatically pay providers in the event of a void and has not chased providers to submit invoices. When invoices are submitted, they have to be approved for payment'*. '*The cost of a void varies for each scheme depending upon the number of core hours and the hourly rate and the invoice amount would be checked against this before authorisation'.*

'*Under the contract the Authority 'will continue to fund the vacancy for a period of up to 8 weeks by paying the cost of the shared and core hours to ensure the services continue at that location'.*

'Whilst the Council can withdraw payment for voids after 8 weeks, the council recognises that providers will continue to incur full core staff costs whilst a void exists. It is not in the Council's interest to withdraw this funding as it would wish to retain sole nomination rights into the scheme and the Council has a duty under the Care Act to ensure that care providers are funded to remain viable'.

Enquiries were made by Internal Audit regarding the average void weekly cost to determine the total costs for the voids identified. It was confirmed by the Head of Service, that '*in relation to provider A contract, the scheme costs were not individually identified at the commencement of that contract'.* **Risk** Unnecessary costs incurred by the Authority/poor value for money.	
Recommendation Management should ensure that a voids monitoring process is implemented by Commissioning, to regularly monitor voids to keep them at a minimum to ensure that unnecessary costs are not incurred by the Authority. Void costs within the supported living service should be easily identifiable. An agreed process should be in place for the monitoring of voids which should be undertaken by an officer identified by management. The average void weekly cost will need to be determined for contracts going forward, in order to determine the total costs for the voids identified at each unit.	**Rating** Priority 1
Management Response and Accountable Manager A voids monitoring process has now been implemented by commissioners. A spreadsheet, detailing voids, will be populated monthly by the Strategic Commissioner post who will contact all supported living providers with whom the Council has block contracts and update the void information on the spreadsheet. The updated spreadsheet will be sent to the Head of Service, Placements & Brokerage, the Team Leader, Central Placements Team, the Head of Service (also Budget Holder), Learning Disability Service and the Head of Service, Long Term & Complex Commissioning. The Central Placements Team will use the spreadsheet as a list of LD supported living provision that Brokers will prioritise for matching referrals they receive. The Learning Disability care managers will know these services (from reviews they have undertaken) and will be asked to propose suitable schemes when making referrals to the Central	**Agreed timescale** Implemented.

Placements Team. The Central Placements Team will be responsible for monitoring progress and will chase Care Managers / supported living block providers to speed placements. In the event CPT are unhappy with responses or response speed, they will notify the Head of Service, Learning Disability Service if there is a concern with a Care Manager or the Strategic Commissioner if there is a concern with the provider. The Strategic Commissioner, following monthly engagement with the providers, will notify the Heads of Service if the provider identifies issues with communication / speed of process with Council officers. If voids remain unfilled for more than 8 weeks, the Strategic Commissioner will highlight this within the spreadsheet and escalate to Heads of Service to take appropriate action. A bi-monthly meeting will take place to review progress, highlight issues and seek improvements to process. In relation to Supported living service user costs. All contracts let since January 2019, have package costs split between core and 1:1, this makes the identification of core costs in the event of a void straightforward. The breakdown between core and 1:1 costs will be established in advance of the new supported living contracts being implemented on 25 January 2022. An example of this is attached as a spreadsheet and relates to the implementation of provider D supported living contract on 1/4/2021. In addition to the above, a waiting list of potential clients will be developed by the Learning Disability (care management) service and shared with the Central Placements Team. The following table sets out the accountabilities and responsibilities for each person: PLEASE SEE APPENDIX C	

DETAILED FINDINGS AND ACTION PLAN **APPENDIX A**

2. Clawbacks of 1:1 Care	
Finding Audit testing identified 3 cases whereby during the pandemic, the service users returned to their family home and payments for the 1:1 care continued to be paid totalling £33,164.50. The department are aware of this and are in the process of clawing back monies. A further case was reviewed separately, resulting from work undertaken in Internal Audit. The Project Manager, Strategy, Performance, Corporate Transformation Division, is undertaking a piece of work to identify high cost placements and is monitoring overpayments and change in circumstances. Internal Audit has been advised that there are 14 supporting living cases where clawbacks have been made totalling £131,392.48 (This relates to financial year 2020/21). Only 1:1 costs have been clawed back but shared care costs have continued to be paid to the providers due to the impact on other service users at the individual units. **Risk** Unnecessary costs incurred by the Authority. Recovery of monies are not undertaken.	
Recommendation All monies should be recovered without delay if further cases are identified during the annual review assessments.	**Rating** Priority 2

DETAILED FINDINGS AND ACTION PLAN **APPENDIX A**

Management Response and Accountable Manager	**Agreed timescale**
Response; If cases are discovered, immediate action is taken to recover any outstanding monies. This is linked to the Transformation Plan, Action 4, Ensuring Efficiency and Effectiveness. The responsible Officer is the Head of Service for Learning Disabilities. a) Seniors Practitioners have been made aware of the Audit findings. Care Managers have been informed that support plans must be amended to reflect the change in support and the Finance section must be updated.	Achieved

DETAILED FINDINGS AND ACTION PLAN **APPENDIX A**

3. Performance Indicators – KPI's	
Finding It was found that there are no specific requirements for key performance indicators contained within the current contracts with provider B and provider C and both do not have a requirement for the provision of KPI data. These services should have been retendered by now but because of the pandemic the Authority have needed to extend them until January 2022. **Risk** Lack of regular performance monitoring information in key areas.	
Recommendation Contracts should include key performance indicators going forward to assist in the monitoring of the contracts.	**Priority 2**
Management Response and Accountable Manager Commissioners recognise that it is best practice for contracts to be managed using key performance indicators to monitor performance standards. Key Performance Indicators are now used as part of contract management as a core standard. The contracts reviewed as part of the Audit were long-standing contracts that had needed to be extended beyond their expiry dates due to the pandemic. One of the contracts has already been replaced (provider A contract) with a contract operated by provider D (from 1 April 2021) which has KPI's used as part of the management arrangements. The other 2 contracts, with provider B and provider C, are being replaced with new contracts commencing 25 January 2022. These new contracts also incorporate KPI's (please see attached) as part of their contract management arrangements. The accountable officer in relation to this is the Strategic Commissioner post.	**Agreed timescale** Already implemented for the replacement of the provider A contract that was audited. The other audited contracts will be replaced on 25/1/22 with contracts monitored using KPI's.

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.

RECOMMENDATION 1 – MANAGEMENT ACTION PLAN

APPENDIX C

Responsibilities / Roles within Voids Management Process	Frequency
Responsible Officer - Strategic Commissioner	
Roles:	
1. Maintains Voids Register for LD Services	Ongoing
2. Contacts all supported living providers (with whom LBB has block contracts) monthly and updates the Voids Register	Monthly
3. Send Updated Voids register to all Heads of Service and the Team Leader CPT	Monthly
4. If notified by CPT of poor response from supported living provider, take the matter up with them to resolve	As required
5. During monthly contact with supported living providers, if they notify post holder of poor response / communications with Council officers, notify relevant Head(s) of Service	As required
6. If voids remain after 8 weeks, highlight issue to Heads of Service to agree appropriate action	As required
7. Arrange bi-monthly voids meeting with all responsible People (detailed in this table) to review position.	Every 2 months
Responsible Officer - Head of Complex & Long-Term Commissioning	
Responsible for:	
ensuring the Learning Disability Voids Register is maintained	
taking appropriate action as required	
ensuring provision of core costs for each client in the event of a void	
Roles:	
1. Review monthly voids performance using updated Voids Register sent by Strategic Commissioner	Ongoing
2. Receive and action resolutions to issues arising from the Voids Register as and when notified	Monthly
3. If notified by Strategic Commissioner of concerns from supported living providers of poor response / communications of Council officers, monitor / take action as required	As required
4. Attend bi-monthly voids management meeting taking actions / monitoring progress as required	Every 2 months
5. Making the core cost available for each client	As required

RECOMMENDATION 1 – MANAGEMENT ACTION PLAN

APPENDIX C

Responsible Officer - Head of Service, Placements & Brokerage Responsible for: • ensuring effective progression of service user referrals / matching / placements within the Central Placements Team • ensuring a Waiting List of potential LD placements, received from the care management service, is consulted regularly and discussed at the bi-monthly meetings Roles: 1. Review monthly voids performance using updated Voids Register sent by Strategic Commissioner 2. Receive and action resolutions to issues arising from the Voids Register as and when notified 3. If notified of issues of poor response / communications by CPT officers via Strategic Commissioner (from supported living provider) take appropriate action. 4. Attend bi-monthly voids management meeting taking actions / monitoring progress as required	Ongoing Monthly As required Every 2 months
Responsible Officer - Team Leader, Central Placements Team Roles: 1. Maintain a Waiting List of clients requiring placements over the coming 12 months with information provided by LD Care Management Service. 2. Central Placements Team will use the Voids Register spreadsheet as a list of LD supported living provision that Brokers will prioritise for matching referrals to 3. The Central Placements Team will monitor progress and will chase Care Managers / supported living block providers to speed placements. 4. Attend bi-monthly voids management meeting taking actions / monitoring progress as required	Ongoing Ongoing Ongoing Every 2 months
Responsible Officer - Head of Service (Budget Holder), Learning Disability Service Responsible for: • ensuring effective progression of service user referrals / matching / PRG / placements	

• establishing a waiting list of potential LD placements in conjunction with the Central Placements Team	
Roles:	
1. Ensures care managers compile a Waiting List of service users who will require placements over the coming 12 months (e.g. through transition / leaving adult education) or arising from a life event (e.g. carer illness / health deterioration) and share the Waiting List on a monthly basis with CPT. Information to include a basic needs profile	Ongoing
2. Ensures care managers refer service users to CPT for placement as soon as possible, using local knowledge and client information to recommend suitable placements / facilitate Care Manager / CPT interaction	Ongoing
3. Ensures Care Managers progress placements through PRG and manage placement activities in a way that minimises void time.	Ongoing
4. Attend bi-monthly voids management meeting taking actions / monitoring progress as required	Every 2 months