PART 1

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DATE: 26 June 2023

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Tuesday 4 July 2023

QUESTIONS ON THE INFORMATION BRIEFING

The Briefing comprises:

INTERNAL AUDIT REPORTS (Pages 3 - 152)

1. Housing Schemes (Governance of Partnerships)
2. Quality of Placements (External): Children's Social Care
3. Adult Social Care Residential Placements
4. Appraisals
5. Complaints (2022/23)
6. Virtual School
7. Referral and Assessment ASC
8. Revenue Budget Monitoring (2022/23)
9. Sickness Management
10. HMO Licensing (2022/23)

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

PLACE DEPARTMENT

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

Issued to: Director of Housing, Planning and Regeneration
Assistant Director, Housing
Head of Finance, Adult Social Care, Health and Housing
Head of Corporate Programmes and Projects

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 3rd May 2023

Report No: PLA/08/2022

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

INTRODUCTION

1. This report sets out the results of our audit of Housing Schemes (Governance of Partnerships). The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management 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 objective of the Housing Acquisition Partnership Schemes is to purchase good quality properties which can be let as affordable homes to people nominated by Bromley and to help reduce the use of nightly paid temporary accommodation.
3. This function supports the Making Bromley Even Better ambition for 'people to make their homes in Bromley' and to 'enable Bromley residents to thrive in the borough by having access to high quality and affordable homes', as described in the Council's Housing Strategy.
4. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

5. The original scope of the audit was outlined in the Terms of Reference issued on 9th January 2023. During our fieldwork, we reviewed and tested the following key risks:-

- If Governance arrangements for the scheme do not take account of recommendations made, 'lessons learnt' or challenges identified from previous Housing Acquisition Partnership Schemes, effective oversight may not be maintained. This may result in the Scheme not progressing as agreed and failing to secure, and move households into, settled accommodation as projected.

- Property acquisitions are not completed in the expected timeframe and purchase prices exceed those in the financial envelope. Projected savings on the cost of nightly paid temporary accommodation may not be achieved.

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

- The Council may be exposed to reputational risk if properties are not brought up to, or maintained to, Decent Homes standards. Tenants' issues may not be fully resolved which may also lead to complaints, and potentially failed tenancies.

6. At the time of the fieldwork, Phase 1 of Scheme A was moving from the Acquisition to Operational phase. Commencement of Acquisitions under Phase 2 was imminent. Our testing focused on the Governance arrangements in place for Phase 2, taking into accounts lessons learnt from Phase 1.

AUDIT OPINION

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

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

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

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

SUMMARY OF FINDINGS

8. Our fieldwork highlighted a number of key strengths. We found that the Governance structure is set out in the Limited Liability Partnership Agreement suite of documentation. Executive and Operational Board meetings are held regularly and the format is structured. Minutes and supporting papers are available. A suite of Key Performance Indicators is in place and risks to the schemes are documented and kept under review.

9. Lessons learnt from Phase 1 have been implemented to accelerate the conveyancing process and progress is monitored.

10. Our audit review has, however, identified the following two areas which we would like to bring to management's attention. We recommend that these are considered in connection with all current and future Housing Acquisition Partnership Schemes.

Governance – Roles and Responsibilities

The LBB Members of the Executive and Operational Board are highly skilled and knowledgeable within their roles. Neither of the schemes, however, benefit from the ongoing Monitoring/Oversight equivalent of a Contract monitoring function to ensure that all duties are discharged and standards are met.

Whilst the obligations of the Limited Liability Partnership parties are documented and a Terms of Reference (TOR) has been drawn up for the Operational Board, understanding is not consistent as to the parameters of the Operational Board's responsibility and escalation process, specifically that for Key Performance Indicator outturns.

Governance – Record Keeping/Good Practice

(i) **Operational Board meeting minutes.** These are currently held on the 'Shared drive' however, the Terms of Reference for both Phase 1 and 2 states that these should be held on the Scheme's Sharepoint site.

(ii) **Insurance.** The LBB Executive Board members do not currently satisfy themselves, on an annual basis, that all relevant policies are in place with an acceptable level of cover and that premiums have been paid to date.

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

11. We acknowledge that the scheme, being a Limited Liability Partnership Agreement, is recorded on the Contracts Database as headline information only, with the full suite of documentation held in the scheme's Sharepoint site. Access to this site should be kept under review to ensure that it is sufficient and continuous should personnel change on the scheme.
12. Additionally, we have been made aware of a forthcoming change of LBB Executive Board representative. Whilst we understand that a handover is in place, this may result in a loss of scheme specific knowledge.
13. We have highlighted the risks here so that officers can ensure appropriate mitigations are in place, but have not made any associated recommendations.

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, 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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HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Governance – Roles and Responsibilities

Finding

The LBB Members of the Executive and Operational Board are highly skilled and knowledgeable in their roles, with delivery of the Housing Acquisition Partnership Schemes absorbed into 'Business as Usual'. Once property acquisition commences, this creates a pinch point at the Nominations stage and an ongoing Operational monitoring requirement for the term of the scheme.

There is a separate Executive Board for each scheme providing Strategic oversight and one Operational Board scrutinising all Contractor A schemes. Neither of the schemes reviewed benefits from the ongoing Monitoring/Oversight equivalent of a Contract Monitoring function.

Whilst the primary duties and obligations of the Limited Liability Partnership parties are documented and a Terms of Reference (TOR) has been drawn up for the Operational Board, understanding is not consistent as to the parameters of the Operational Board's responsibility and escalation process, specifically that for scrutiny and monitoring of Key Performance Indicator outturns.

Risk

Without an ongoing Monitoring/Oversight function:-

(i) There could be an inconsistent approach to evaluating delivery of the schemes. Efforts may be concentrated on resolving issues at individual Household level and not at scheme level. This could lead to declining performance/delivery failures at scheme level not being identified/dealt with at an early stage and the objectives not being met.

(ii) Skilled and knowledgeable Operational staff resources may be diverted away from meeting the needs of Households.

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HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
We recommend that:- (i) It is confirmed that all parties to the scheme have had sight of the Governance documentation setting out their roles and responsibilities and that these, together with escalation procedures, are understood. The extent of each remit should be clarified and include the parameters for substantiating and challenging other parties to ensure that all duties are discharged and standards are met. This should include ensuring that there is no duplication (or gaps) between the work of the Executive and Operational Boards, for example in the monitoring of Key Performance Indicators. (ii) Consideration is given to how the ongoing Monitoring function of the Housing Acquisition Partnership Schemes is delivered to maintain effective oversight and assure that all duties are discharged and standards met.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
The governance is being reviewed in conjunction with the Head of Housing Schemes. The current management contract expires on the 31/3/24. The role is to have the oversight of the governance and interface between the Executive and Operational boards in order to ensure consistent monitoring and avoid duplication. Resource requirements will need to be considered as this role and the team around it expands. **(Head of Housing Schemes)**	Within 2023/24: Likely Q4 (31st March 2024)

2. Governance – Record Keeping/Good Practice	
Finding During the course of the audit, we identified two areas where the efficiency or effectiveness of the control environment could be improved. (i) **Operational Board meeting minutes.** These are currently held on the 'Shared drive' however, the Terms of Reference states that these should be held on the Scheme's Sharepoint site. (ii) **Insurance.** The LBB Executive Board members do not currently satisfy themselves, on an annual basis, that all relevant policies are in place with an acceptable level of cover and that premiums have been paid to date. **Risk** (i) Should personnel on the workstream change, documentation, or evidence of actions taken, may not be accessible. (ii) In the event of a claim, lack of recourse to an insurer would increase financial exposure.	
Recommendation (i) **Operational Board meeting minutes.** In line with the Group's Terms of Reference, these should be held on the relevant scheme's Sharepoint site. (ii) **Insurance.** Whilst it is acknowledged that Insurance is a condition precedent of the Funding Agreement, the LBB Executive Board members should satisfy themselves on an annual basis that all relevant policies are in place with an acceptable level of cover and that premiums have been paid to date.	**Rating** Priority 3

HOUSING SCHEMES (GOVERNANCE OF PARTNERSHIPS)

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
(i) These will be uploaded onto the relevant site. (ii) This has already been added to the standing agenda item for the Board so is complete. **(Head of Housing Schemes)**	The uploading of relevant documents with be done within 3 months. (31st July 2023)

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.

FINAL INTERNAL AUDIT REPORT

QUALITY OF PLACEMENTS (EXTERNAL) – CHILDREN'S SOCIAL CARE

PEO/12/2022

13th June 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of Children's Services
Assistant Director, Children's Social Care
Head of Service (Care and Care Leavers)
Team Leader, Children's Commissioning Team
Assistant Director of Integrated Commissioning
Integrated Strategic Commissioner
Assistant Director Strategy, Performance and Corporate Transformation
Head of Finance, Children, Education and Families

Executive Summary

Audit Objective	The objective of this audit was to review how the Council receives assurance on the quality of Children's Social Care external placements. Our testing focussed on Semi-Independent and Residential Care placements (including those coded as Children's Homes placements).

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	2	0

Key Findings

1. The service is often required to find placements at speed (e.g. emergency placements) and parameters such as geographical exclusions mean that options are limited.
2. Placement Commissioning Checklists and Trackers were available for all cases sampled and the process for ensuring ratification of the placement at Panel is effective.
3. Reporting on Quality Assurance site visits undertaken as part of the Contract Compliance function is comprehensive. Action Plans are agreed with the provider and a follow up process in place. This relatively new role continues to develop and the long-term vision of a database of Quality Assurance documentation will streamline the process at the point of placement.

4. **Governance and Quality Assurance** (Priority 2) – ***See Recommendation 1.***

   The Quality Assurance Framework comprises three distinct functions:- Contractor A's accreditation scheme (for unregulated placements), quality assurance undertaken in house at the point of placement and, ongoing contract compliance. We could not evidence the 'Golden Thread' through the functions to ensure the adequacy of the Framework as a whole and that there is no duplication or gaps in the checks required. Sample testing identified some gaps where we could not evidence that checks had either been completed or deemed as not relevant.

5. **Policy and Procedures** (Priority 2) –. ***See Recommendation 2.***

   The Procedure notes for the function were last updated on 5th June 2019 and do not include the more recent Contract Compliance function. We acknowledge that the department has identified this as a weakness however, without up-to-date detailed procedures, consistency, and the ability of staff to perform their tasks efficiently and effectively will be impacted. The risk of placing a child in an unsuitable placement will also be heightened.

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority rations are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Governance and Quality Assurance
Finding We found that the Quality Assurance process comprises three distinct functions being:- • Contractor A's accreditation scheme for unregulated establishments • Quality Assurance undertaken by the Placement Officers at the time of placement • Ongoing Contract Compliance undertaken primarily post placement. Whilst there is tacit understanding and acknowledgement of the links between the functions, we could not evidence the 'Golden Thread' to ensure that there are no gaps or duplication in the quality assurance checks undertaken and the evidence retained of these for each placement. Opportunities exist to both streamline and enhance the effectiveness of QA by reviewing the above functions as a whole, to ensure that there are no gaps and/or overlaps that do not add further value. We could not evidence that all checks had been undertaken for each placement in our sample, and we saw examples of out of date documentation e.g Electrical Certificates, and missing documentation e.g. Portable Appliance Testing (PAT) certificates. Some providers are frequently used and consequently relevant checks may be held/evidenced with a previous placement or have been obtained as part of a Contract Compliance visit. Similarly, in some instances checks such as references may have been deemed not applicable, as the provider is known. However, we could not evidence from the notes on file whether these checks had been considered and a conscious decision had been made not to obtain them. The purpose, parameters of the information required and criteria for some checks was not fully clear. For example, Buildings and Public Liability insurance certificates are requested, but once received, there is no further guide as to the level of cover deemed adequate for placement purposes. Similarly, evidence of PAT testing is required, but one provider in our sample had declared that 'We don't need PAT testing as we replace yearly' and this explanation had been accepted without further clarification. A further provider had submitted details of all DBS results for their staff including historic convictions but it was not clear whether these were appropriate or necessary to share. We noted that where providers are registered (e.g. Children's Homes/Residential provision), consideration is given only to the overall Ofsted judgement and not the three sub categories. Conditions of Registration are also not considered (e.g. the requirement to provide Ofsted with 8 weeks' notice prior to the admission of a child to the home), although we acknowledge that it will be the responsibility of the provider to ensure that these are fulfilled.

Contractor A has established an accreditation scheme for unregulated provision. Members of the scheme providing such services will, therefore, be subject to a level of checks in line with the level of accreditation awarded. These may duplicate some checks that the Placement Officers undertake. We are aware that the Children's Placement service moved reporting lines on 1st February 2023 and recommend that the service leads review the Agreement as a whole and consider how the accreditation scheme fits with the Quality Assurance work conducted by the Placement Officers, to identify any gaps or duplication.

Risk

Inadequacies in the quality of accommodation may not be identified and placement breakdowns may occur. Inefficient use of resources if duplications exist.

Recommendation	**Rating**
We recommend that:- i) A Strategic review of the Quality Assurance process is undertaken to map the end-to-end process identifying any duplication and potential gaps. This should evidence the Golden Thread back to Legislation, National Guidance and internal policies and procedures. As part of this process, each quality control check should be reviewed to ensure that both the purpose and the criteria of the check is clear. The service could seek advice from specialist areas of the council, such as health, safety, and insurance, when considering the criteria for each check. ii) Ofsted 'Sub Category' judgements of below Good should be considered as part of the placement quality assurance process, as should any Conditions of Registration. iii) A review of the deliverables under the Agreement with Contractor A should be undertaken as a whole, to establish whether reliance can be placed on quality assurance work undertaken as part of this agreement.	Priority 2
Management Response and Accountable Manager i) All quality assurance and compliance checks will be reviewed with the relevant sections of the council to update the policy and ensure they remain relevant, for example checking outcomes of PAT testing expected compliance within council accommodation to ensure we are applying the same standards to commissioned placements. **(Team Leader, Children's Commissioning Team)**	**Agreed timescale** End of July 23

ii)	Sub category judgements that are below good will be highlighted to the placing SW team and the provider will be asked to provide evidence of work undertaken to mitigate potential risk in this area. **(Team Leader, Children's Commissioning Team)**	End of July 23
iii)	Contractor A has recently published new KPI data. The Children's Commissioning team lead and Commissioning lead will set up quarterly contract compliance meetings with Contractor A to evaluate the effectiveness of the service. **(Team Leader, Children's Commissioning Team)**	End of August 23

2. Policy and Procedures	
Finding We found that the Procedure notes for the function were last updated on 5th June 2019 and were at high level, consisting primarily of flow charts. The documentation is silent on how Trackers and Checklists should be completed and does not guide the Placement Officer to consider each piece of documentation in the checklist, annotate when this is not required and the rationale. We noted that the document referred to the previous Social Care Information System and did not refer to either Contract A or the ongoing Contract Compliance function, both of which have links, in terms of process and Quality Assurance documentation, to the placement function. We acknowledge that the department had identified this as a weakness, however, without up-to-date detailed procedures, consistency, and the ability of staff to perform their tasks efficiently and effectively will be impacted. This is particularly pertinent in supporting the new member of staff. **Risk** Without comprehensive procedure notes providing a standardised guide to completion of the process, there is a risk that assumptions may be made when completing the process and forms, leading to inconsistencies and oversights. The risk of placing a child in an unsuitable placement may also be heightened.	
Recommendation The Procedure notes should be reviewed and updated ensuring that the end-to-end process undertaken by the Placement Officer and the Contract Compliance function are comprehensively documented.	**Rating** Priority 2
Management Response and Accountable Manager The Children's Commissioning team leader will update the processes to create an end to end guide for all placement and contract compliance staff to ensure consistency of approach for all staff. **(Team Leader, Children's Commissioning Team)**	**Agreed timescale** End of August 23

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority Ratings

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

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • If the quality of support and accommodation is inadequate, placement breakdowns may occur, leading to instability and a negative effect on education, physical and mental health. • If placements are not safe, secure and consistent in meeting the needs of children, life chances and the shaping of adult lives may be detrimentally impacted. • An increase in demand and complexity of placements, together with the cost of provision rising above budgeted inflation rates in a provider led market, results in budget pressures and overspends will occur. Our scope included the following:- • Governance, including organisational management, roles and responsibilities • Reviewing policies and procedures and guidance to ensure these are robust • Quality assurance undertaken prior to placement for individual cases, both those solely procured through Contract A and those concluded outside of the Framework • Arrangements for ongoing quality assurance • The completeness and accuracy of individual placement information recorded on the Social Care Information system We did not include a specific review of Contract A however did consider the level of work undertaken outside of the Framework and the impact on the service achieving its objectives. Our testing focused on the placement of Children into Semi-Independent and Residential Care Placements (including those coded as Children's Homes placements) since April 2022.

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FINAL INTERNAL AUDIT REPORT

ADULT SOCIAL CARE RESIDENTIAL PLACEMENTS

PE/01/2022

16 June 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of Adult Services
Assistant Director, Safeguarding, Practice and Provider Relations
Assistant Director, Operations, Adult Services
Head of Service, Placements and Brokerage
Team Leader, Central Placements Team

Executive Summary

Audit Objective	The objective of this audit was to review the effectiveness of the controls in place over the placement of adults in residential care, to ensure that placements are made timely, taking into account the needs and wishes of the client whilst also being cost effective.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	5	0

Key Findings

We noted the following areas of good practice:

1. Prior to making a placement the client's needs and wishes are taken into account as part of the assessment process.
2. Residential care was the appropriate option, following assessment, for all of the clients in our sample.
3. There was sufficient information in the assessment for the Central Placements Team to work with when placing a client.
4. Any specific health needs or conditions which may impact on the Council's options when selecting a residential home to place the client, had been identified.
5. There are procedures for placements which are current, available on the Team's Sharepoint site, with a named owner and a review date of September 2023.

Our audit highlighted the following areas where controls need to be improved:

6. **Time taken to place clients** (Priority 2). Two of the placements in our sample of 15 had not been made timely. In one other case the process of making the placement permanent took over 11 months. ***See Recommendation 1.***
7. **Explaining the placement process to the family prior to the placement.** (Priority 2).

   In two cases, explanations about the placement process and paying for care had either not been sent to the client's family or had not been sent prior to the placement. The Team leader has now instructed the team to complete the email notifications to the family or whoever placed the client e.g. Oxleas, straightaway. ***See Recommendation 2***

8. **Accuracy of information recorded, and action taken, including escalation procedures.** (Priority 2). We noted that some information recorded for clients was incomplete or incorrect. Whilst it may not be the responsibility of the Central Placements Team, there was no evidence that actions required following a placement had not been escalated, taken and matters resolved. ***See Recommendation 3***
9. **Engaging new providers for residential placements.** (Priority 2). We were unable to see evidence that the procedures for engaging new providers had been followed correctly, and that all checks required had been undertaken. ***See Recommendation 4***
10. **Accuracy and completeness of the records of providers.** (Priority 2). We found that the providers used for residential placements were not all recorded on the Central Placement Team's spreadsheet record of providers. The information for existing providers recorded on the spreadsheet was incomplete and, in some cases, notes made up to nine years ago about providers had not been updated or removed. ***See Recommendation 5.***

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority rations are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Time taken to place clients	
Finding Two of the placements in our sample of 15 had not been made timely. For one of these, the placement took 63 working days and there were two monthly periods when nothing happened. For the second client, the case had to be re-assigned because it had not been actioned by a former Placement Officer for over three months. For another client, the process of making the placement permanent took 11 months. We noted an email from the home stating that they were happy to make the placement permanent, but this was not progressed for another five months. At the time of writing this report, the agreement has still not been signed by the provider and next of kin. The last case note on Liquidlogic is an email from another Placement Officer dated 25 Sept 2022 with relevant documents attached for the next of kin and provider to sign. **Risk** Clients may not receive the residential care which they need if they are not placed promptly, leading to a deterioration in their health. Suitable residential provision may not be available leading to the Council having to find more expensive residential care. The lack of a signed agreement between the provider, Council and next of kin may lead to a lack of clarity as to what residential care is expected to be provided and received.	
Recommendation Management review their arrangements for ensuring that placements are made timely, reviewed, progressed to conclusion and signed off on Liquidlogic. Any placements which are outstanding and have not been progressed are identified timely and addressed.	**Rating** Priority 2
Management Response and Accountable Manager A change of management and change of tracking system meant that it was reliant on checking with the Placement Officers during supervision. For the first client referred to in the findings section, whose placement took 63 days, this was a learning disability service user with complex needs. In the case of the second client, he varied in capacity. When he had capacity he would be uncooperative and refuse a placement. The Placement Officer involved would not engage in the supervision process. Once she had left it was found that a number of cases allocated to her had been intentionally hidden or masked to be made to look as if she had completed the work. This resulted in a total change of the tracking using the new allocation spreadsheet.	**Agreed timescale** Implemented

For the third client referred to, this seems to be an oversight on changing the service line from temporary to long term – enhanced by the cut over period between CareFirst & Liquidlogic LAS. The service user was in a care home and no move was required. There could be a small financial loss to the Council, not a care and support issue. There are now separate tabs for each Placement Officer on the tracking spreadsheet and weekly reviews take place between the Head of Service, Placements and Brokerage and the Team Leader to ensure that the allocations that Placement Officers have are limited. We are working towards ensuring that Placement Officers have no more than 18 cases at any one time. Any cases not placed within 45 days are identified and then discussed with Placement Officers. Team Leader, Central Placements Team	

2. Explaining the placement process to the family prior to the placement.	
Finding In two cases out of 15 in our sample there was no evidence that the placement process and information about paying for care had been sent to the client's family. In three cases the notification had not been sent promptly, prior to the placement. In one case in our sample the client's next of kin was wrongly told by a locum Care Manager that the residential placement was all funded by the NHS. **Risk** The client's family may not be aware of the placement process or the funding arrangements, leading to possible misunderstandings, and a reputational risk to the Council.	
Recommendation Ensure that Placement Officers, Care Managers and any other stakeholders involved in the placement process are made aware of the process and arrangements for paying for care.	**Rating** Priority 2
Management Response and Accountable Manager Placement Officers have now been instructed to complete the email notifications to the family or whoever placed the client e.g. Oxleas, straightaway. Team Leader, Central Placements Team	**Agreed timescale** Implemented

3. Accuracy of information recorded on placements and action taken, including escalation procedures.

Finding

Through review of documentation for our sample of 15 placements, we identified the following exceptions where information was incomplete, inaccurate or where there were outstanding and overdue actions on the case:

The 'tracker document' on Liquidlogic for one of the clients in our sample was for a different client. The document was subsequently removed and corrected by the Central Placements Team. However, the Commissioning Checklist contained some errors including incorrectly recording the LB Croydon home as 'in borough' and stating that a Third Party Top Up had not been agreed, which contradicted the email exchange on file where the next of kin had agreed a top up. Furthermore, it had not been signed off.

For one client where we queried during our audit why a third party top up was not in place, the Team Leader explained "Not eligible as home met needs, no alternative offered, Oxleas Mental Health plan. Budget holder authorised the placement & cost March 2022' Whilst a costed care plan had been completed, on Liquidlogic this had been signed off by the Business Support Officer; not by the budget holder.

For one client the information recorded on Liquidlogic shows that he has been in the home since 31 May 2022 and, as a 'disputed line' case, the Council are responsible for funding since that date. This is an on-going issue as his brother who is the next of kin was incorrectly told by the locum Care Manager that it was all funded by NHS. However, the Team Leader stated that the Care Act Assessment had not been completed and therefore the CPT were unable to progress the case.

For another client, the Council agreed to fund her, but an email sent by the Assistant Director on 8 Aug 2022 asked for a third party top up to be explored and to ensure that a financial assessment is in place. There is no evidence on Liquidlogic to show that these actions have been completed and the matter resolved.

Whilst it may not be the responsibility of the Central Placements Team, we could not see evidence that instances like these are identified and escalated to whoever in the Directorate should take ownership and responsibility for resolving them.

Risk

Where information is not recorded accurately, complete or timely there is a risk that operational and financial decisions made and actions are either not taken, or are incorrect, leading to a deterioration in health outcomes or increased expenditure for the Council.

Recommendation	**Rating**
Management review their quality assurance arrangements to ensure the accuracy of information recorded on Liquidlogic for placements, and that actions to be taken are identified and escalated as required. This should include signing off the Commissioning Checklist and reviewing high cost placements.	**Priority 2**

Management Response and Accountable Manager	**Agreed timescale**
The Central Placements Team do not monitor services prior to Care Act assessment, or the length of time people are on DISP/D2a lines. For the two cases highlighted in paragraphs 4 and 5 of the findings above we will however raise the issue with the appropriate team manager in ASC. There are now weekly reports sent out by the Performance Team regarding this for monitoring and review of the longer length services. Oxleas cases are entered to Liquidlogic and signed off by the Business Support Officer as per the Oxleas PRG process as Oxleas do not use LAS. The Oxleas Budget holder sign off on Liquidlogic would need to be considered by the Assistant Director for Operations. Information is stored on SharePoint, as of May 2023, relating to cases so that monitoring of the Placement Officer Trackers can occur in real time. Prior to this implementation the tracker could only be reviewed ad hoc. We are working towards ensuring that Placement Officers have no more than 18 cases at any one time to ensure they have the capacity to improve recording. The service provision (CPLI) is not authorised by the Team Leader until the checklist is complete and signed off - this will assist to ensure the documentation is recorded, accurate and in the correct place. The procedure has now been updated. Head of Service, Placements and Brokerage.	Implemented

4. Engaging new providers for residential placements.

Finding

There was evidence that the procedures for engaging new providers had not been followed correctly, and that all checks required had not been undertaken. One of the providers had been identified by the Care Co-ordinator, prior to the Central Placements Team receiving the case. Another provider was a respite placement. For those two cases we saw emails to the ECHS Contracts Team for that team to progress, with a completed pre-contract due diligence document and Spot Contract request form. We were provided with the Companies House checks carried out on these two providers, but there was no evidence of references obtained or management sign off that all the checks required had been completed.

There would be merit in carrying out open source internet checks to identify any issues highlighted with the provider/home.

Risk

The Council may engage with providers who are not suitable and who do not have the necessary financial and other resources to provide the amount and standard of residential care required. This could lead to clients receiving poor quality are which results in a deterioration of their health, or the need to be relocated in another residential care home.

Recommendation	**Rating**
Review the due diligence process for engaging new providers of residential homes, with management sign off that this had been carried out correctly and complete. This should include references, financial checks, open source internet checks and Companies House information and where this information should be stored, so that it is accessible to those who need it. When reviewing the due diligence process seek advice from the Council's Procurement Team.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
Storage of documentation is not centralised as the N: Drive is used for contractual checks, whereas the person's file or SharePoint would hold the relevant checks completed at the time of placement. Currently the documentation can be stored on SharePoint, N: Drive, the contract database or potentially Controcc. The Central Placements Team carries out checks on new providers that includes Companies House, Health and Safety documentation and references. The contractual documentation storage is currently under review and is linked with the upcoming review of contracts. This has been discussed with the Council's Procurement Team. Head of Service, Placements and Brokerage.	31 December 2023

5. Accuracy and completeness of the records of providers.

Finding

The Central Placement Team' has a spreadsheet of providers which is used as a reference point when looking for a placement. It is not comprehensive, consistent in information recorded, or up to date.

Four providers from our sample of 15 placements were not recorded on the spreadsheet. The information for existing providers recorded on the spreadsheet was incomplete and, in some cases, notes made up to nine years ago about providers (including limitations on using them) had not been updated or removed. It was therefore unclear whether or not these were still relevant.

Further, the MH and LD providers the tabs are lacking in information (e.g. a link to the last CQC inspection report is not included), and are of a different format and content to the Bromley, Croydon and Greenwich tabs.

We were informed by the Head of Service, Placements and Brokerage, that Controcc is a preferable means of sourcing information about current and previously used providers, including financial information.

Risk

Officers making placements may rely on information which is inaccurate or incomplete, leading to a risk of incorrect placements being made.

Recommendation	**Rating**
Review how information about current and previously used providers will be recorded and maintained, to ensure that it is complete, accurate and readily available for any Placement Officers seeking information about a provider prior to making a placement.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The list of providers is not a contractual list or binding but used as a point of reference/ reminder for the team when carrying out searches in neighbouring boroughs. The team have access to information from Liquidlogic and Controcc reports to verify any contracts held. A point of reference is useful, and the spreadsheet of providers will be retained, as the team uses it appropriately. The historic notes about limitations on using providers will be removed. Head of Service, Placements and Brokerage.	30 June 2023

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority Ratings

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

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Eligibility criteria for residential placements may not be complied with. • The Council is unable to make residential care placements timely, due to a competitive market and a lack of suitable residential places, including those which are able to meet the specialist needs of a client. • Expenditure on residential care placements may not be cost effective for the Council, particularly where it involves paying above the Council's ceiling rate or requires funding from other parties which is not collected at all or in a timely manner. Our scope included the following: • Governance, including organisational management, roles and responsibilities • Reviewing policies and procedures and guidance, • The arrangements to assess clients' needs and wishes, and secure appropriate and timely placements, • Individual placements, including decision making and authorisation, • The completeness and accuracy of individual placement information recorded on Liquid Logic We have excluded from our findings, on the decision making for placements, those placements which were made by other interested parties as a result of mental health assessments, the Covid discharge, or discharge to assess schemes. In those cases (six) from our sample we were unable to evidence that contracted residential care homes were contacted as a first option, or the timeliness of the placement made by that party, before notifying the Central Placements Team.

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FINAL INTERNAL AUDIT REPORT

Appraisals

AUDIT REFERENCE

CEX/05/2022

23 June 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of HR, Customer Services and Public Affairs
Head of HR Business, Systems & Reward
Assistant Director HR, Organisational Development

Executive Summary

Audit Objective	The objective of this audit was to review the effectiveness of the appraisals process, including the quality of appraisals undertaken.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	5	0

Key Findings

1. The sample of staff we interviewed who had an appraisal in the last 12 months confirmed they were satisfied with the discussion at their appraisal meeting which included
   - Performance assessment of previous objectives and feedback
   - Objective setting and alignment of individual objectives with service/corporate objectives and values
   - Identification of training and development needs

2. An appraisal framework is available with written guidelines to ensure the relevant areas are covered. We interviewed a representative sample of 15 staff, and they told us that they found the guidance useful. Discuss guidance for managers new guide August 2022 and Discuss 2021 for staff details how each discussion is tailored to the individual and is designed to be a dialogue between staff members and their line manager to help achieve the objectives of the council, the service, the team and the individual. Some limitations of the guidance were noted which are detailed in Appendix A below.

3. Training is available to both staff and managers on the appraisal process. All managers and staff are required to complete mandatory 'Discuss' training as part of the Council's induction process and every two years after that. We asked the Project & Training Coordinator to check if the sampled staff and their managers have completed the training. She interrogated the Training and Development online platform and advised that 14/15 staff in the sample and 12/15 managers have not completed the training in last 2 years. Please refer to Appendix A below.

4. The HR system has limited functionality to record appraisal outcomes, retain appraisal documents and report on completion of appraisals.

5. Appraisals were not completed for 25% of staff in our sample in the last 12 months. Of the 11/15 appraisals completed, 4 managers did not record the appraisal outcome on the HR system and 4 managers did not confirm if they had recorded the outcome on the HR system.

6. Some discrepancies were noted between the online training and the Discuss guidance which are detailed in Appendix A.

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority rations are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Recording and reporting of appraisals on the HR system	
Finding The HR system has limited functionality to record appraisal outcomes, retain appraisal documents and produce reports to evidence completion of appraisals. This was confirmed by the Head of HR Business, Systems & Reward. The HR system does not allow the recording of the journey of individuals' performance. Following appraisal when a manager updates the performance grid on the HR system, the performance grid is overwritten, history of past performance in not retained and date of completion is not recorded. Therefore, performance cannot be tracked from the grid. Appraisal notes cannot be uploaded on the HR system and if managers leave and do not hand over previous appraisal notes there is no record of an individual's performance history. There is a lack of transparency as the performance outcome recorded by the manager on the HR system is not visible to the staff. **Risk** Poor record keeping is a risk, especially where performance is an issue and evidence is needed of discussions and agreed training/supervision needs.	
Recommendation HR should explore the options to improve the functionality of the HR system to record appraisal outcomes, retain appraisal documents and produce reports to evidence completion of appraisals. The performance outcome recorded by the manager on the HR system should be made visible to the staff. Where a technical solution is not available, other hybrid options should be explored.	**Rating** Priority 2
Management Response and Accountable Manager These comments all relate to the old HR self-service system but in part reflect the feedback from managers and employees when the previous appraisal form was on HR self-service. At that time Manager's views were that they found the old electronic form/process too rigid. With the new system, we do need to review the functionality of the	**Agreed timescale** December 2023

Talent Management module (phase 2 item) but in the first instance we would be able to upload appraisal documents against employee records. Please note though, when uploading documents there would be limited reporting of the actual detail on the forms other than recording that a form has been uploaded. Managers and staff are however able to keep their own notes generally in electronic format. **In terms of risk,** Managers are expected to keep their own management records to refer to in the instance of staff performance/capability. This could include a variety of evidence including supervisory notes as well as appraisal discussions. Accountable Manager: Head of HR Business, Systems & Reward	

2. Completion and recording of Appraisal

Finding

A stratified sample of 15 staff, 5 in each department and covering different levels (pay grades) was selected from the payroll report. On enquiry 4 of 15 managers advised that they have not completed an appraisal with their staff in the last 12 months. Managers cited the following reasons for not completing appraisals:

- they have regular 1-to-1 meetings
- no issues with staff performance
- appraisals no longer feed into pay considerations
- no significant changes to the role
- staff on fixed term contract

Of the 11/15 appraisals completed, 4 managers did not record the appraisal outcome on the HR system and 4 managers did not confirm if they had recorded the outcome on the HR system.

Risk
Sections and departments may fail to achieve their objectives due to inadequate staff management.

Recommendation	**Rating**
Managers should be reminded by HR to complete their staff appraisals annually and record the outcome on the HR system. HR should plan further engagement with managers to promote the reasons and value of appraisals.	Priority 2

Management Response and Accountable Manager	**Agreed timescale**
It is important to note that ensuring that Managers undertake appraisals is not a direct function or responsibility of HR. HR works collaboratively with the Senior Leadership of the organisation to provide support, guidance, and training in this subject area and to assist senior leaders in this area of accountability. It is also recognised that the sample assessed was very small in terms of the total workforce of the council as a whole and it is not clear regarding how representative compared to the size of departments the samples were. It is nevertheless disappointing to note Manager's responses regarding completion of appraisals. Both the Guidance and Training are clear regarding what the scheme is and how it is used for supporting staff's development and assessing performance, demonstrating how individual objectives ultimately support the achievement of wider corporate council objectives. The DISCUSS Appraisal process is also one of the Core Business operations offered as part of the Corporate Training faculty. At a Manager level therefore, it is difficult to understand the reasons given for not completing appraisals and these views should be subject to challenge and further training/support provided. For the sake of completeness, please see direct comments below in relation to the views of Managers:	December 2023

They have regular 1-to-1 meetings
It is made clear in the Training that the DISCUSS sessions are not the same as 1:1 meetings. The guidance also states Discuss is Bromley's coaching approach to **staff development** which uses structured conversations to set short- and long-term objectives for staff at all levels.

It is therefore difficult to understand why a Manager would think that a 1:1 supervision meeting is the same.

They have no issues with staff performance
The guidance and training refer to **staff development as well as performance** and talk about setting objectives linked to the corporate objectives. Regardless of whether someone is a high achiever or strong performer they still need to be set objectives and their performance recorded.

Appraisals no longer feed into pay considerations
They never did previously under the PADS system for those staff below management grade. Whilst Bromley does not have a formal performance related pay system in place, appraisals can help a manager to determine whether to put an employee forward for consideration of a merited award and a Manager could choose for example to accelerate someone within their grade in terms of progression if this is warranted and there is sufficient headroom flexibility.

There are no significant changes to the role
Appraisal is not linked to changes in a role and never has been it is therefore difficult to understand how a manager would reach this view.

Staff are on a fixed term contract
All staff should be appraised even if they are on a fixed term contract. The exception to this is agency staff who are not Bromley employees although good practice determines that a discussion should still take place.

In terms of recording outcomes, it is recognised that individual notes could not be uploaded onto the previous System and that the new HR System is currently being explored with regard to this although it is likely that similar limitations would apply. It is worth noting however that previously under the old appraisal process Manager feedback was that they did not like the rigidity of completing a form.

The DISCUSS appraisal process provides for both managers and staff to record their own notes but importantly agree and sign off on the conversation and resultant actions proposed and to set a date for review. Notwithstanding this a template form is provided should managers wish to use this. Recording and capturing the detail of the DISCUSS appraisal process is featured in slides 20, 21, 26, 27, 28, 29 and 30 of the DISCUSS appraisal training. Whilst forms are not logged onto the HR System it is strongly advised that notes are kept by both parties and overall, the actual performance rating should be logged. **In terms of Risk** Due to the hierarchical nature of management structures, it is likely that poor performance would be identified to prevent significant failure of objectives. This would also be supported through the monitoring of KPI's. Whilst an annual reminder email is sent to managers regarding undertaking appraisals for staff, in light of the findings in this report Organisational Development has taken the opportunity to remind Managers through a direct email communication and through the Manager's Briefing mechanism of their responsibility for appraising staff and to remind them of the value and importance of appraisals and how these contribute to the Council's wider corporate objectives and its REAL leadership values. Accountable Manager: Assistant Director HR, Organisational Development	

3. Guidance
Finding: The guidance is comprehensive and covers key areas such as frequency of discussions, consistency of assessment, guidance on assessment criteria and how they should be recorded. However, in terms of disputes and disagreements the Discuss guidance for managers new guide August 2022 states that *'Clearly if a team member disagrees with your view, their Discuss session is the place to resolve this and reach a compromise.'* The Discuss 2021 for staff also states that *'Clearly if you disagree with your line managers view, their Discuss session is the place to resolve this and reach a compromise'.* The Discuss online training for staff says that the Manager's decision is final. The Head of HR Business, Systems & Reward advised that there is no HR involvement or input in Discuss however any issue/disagreement should be raised by the staff with their manager's manager (grandparent) for moderation. The guidance document for both managers and staff does not satisfactorily cover dispute resolution and the moderation process.

Risk: Sections and departments may fail to complete staff appraisals, miss deadlines, or undertake poor quality appraisals. There may be inconsistency in how the ratings are applied across the organisation.	
Recommendation: Learning and Development should review the Discuss guidance for managers and staff to ensure that it details dispute resolution and moderation process so that they both know what to do if the staff member disagrees with the manager's assessment of their performance.	**Rating** Priority 2
Management Response and Accountable Manager Whilst the aim is always to try to agree on the appraisal scoring, ultimately, the Manager's decision is final. However, if agreement cannot be amicably reached then each party should record the detail of the disagreement and reasons/explanations given for the final scoring. They should then record this in the notes that they are advised to take. In the Training delivery for both Managers and Staff, emphasis is placed on both parties presenting evidence to support their assessment thereby assisting in resolving any difference of opinion at an early stage. Appraisal processes generally do not have an appeals process built in as decisions should be based on an evidential and objective basis including measurement against SMART objectives. In the event however that a staff member disagrees with the rating given by their manager or feels that their appraisal process was not carried out fairly they can raise this through the Grandparent Manager or if the matter is deemed sufficiently serious, through the staff grievance procedure. In light of the suggested recommendation the current guidance will be reviewed, and further clarity provided in circumstances regarding a difference of assessment rating between the appraiser and appraisee.	**Agreed timescale** December 2023

In terms of risk The DISCUSS appraisal system is designed to be flexible so the Manager and the staff member decide together when to meet. Therefore, there are no formal deadlines except we advise that performance ratings should be set by the end of year (31st March) with the new appraisal year starting on 1st of April. This is clearly set out in the training therefore the risk of missing deadlines is mitigated. It should also be noted that the guidance around the timing of appraisals i.e., 4-6 weeks or 2-4 weeks etc is just that, it is guidance illustrated clearly in the guide by the following statement **"The recommended frequency of discussion is also a guide and can be varied by agreement in the discussion."** Some managers may wish to meet with staff more or less frequently and that is the merit of the flexibility of the scheme, it also means that any difficulties with performance can be addressed, and a staff member supported at an early stage. Training and Guidance should also mitigate the risk around poor-quality appraisals. Managers are supported in how to conduct an appraisal (both in terms of written guidance and in the training provided) and are provided with prompt questions to use. They are also provided with descriptors of what type of performer an individual may be aligned to in terms of the performance grid ratings which means that inconsistency around ratings should be reduced. Managers can also seek advice from HR at any time if they are unsure or require further support and this is made clear to them. Accountable Manager: Assistant Director HR, Organisational Development	

4. Training completion
Finding All managers and staff are required to complete mandatory 'Discuss' training as part of the Council's induction process and every two years after that. We asked the Project & Training Coordinator to check if the sampled staff and their managers have completed the training. She interrogated the Training and Development's training records and the online platform and advised that 14/15 staff in the sample and 12/15 managers have not completed the training in last 2 years.

Risk A lack of appreciation among staff and managers of how performance appraisals will help the organisation achieve its objectives and help them personally in the work they do and their development.	
Recommendation: Managers and staff should complete the Discuss training every two years to ensure that they both understand how it works, how the behavioural framework links to the model and the roles of coaching, recognition, and support in individual & team development. Completion of training should be monitored by Learning and Development, with non-compliance identified and reported to their manager in a timely manner.	**Rating** Priority 2
Management Response and Accountable Manager In light of the findings in this report Organisational Development has taken the opportunity to remind Managers through a direct email communication and through the Manager's Briefing mechanism, of their responsibility to ensure that they and their staff have attended the mandatory DISCUSS appraisal training and undertake refresher training every two years. It also alerts Managers to the fact that attendance is monitored through KPI reporting and details the value and importance of appraisals and how these contribute to the Council's wider corporate objectives and its REAL leadership values. Accountable Manager: Assistant Director HR, Organisational Development	**Agreed timescale** December 2023

5. Training content

Finding

The following discrepancies were noted between the guidance and online training:

1. The Discuss online training for staff says that "there are no formal deadlines apart from the 1st of April and 31st March when your manager will need to ensure that your DISCUSS rating is recorded on the grid in HR self-service." This is not included in the Discuss guidance.

2. The online training states three steps to follow – assess, have the conversation, and capture the conversation (and set a date for the next review). These do not fully align to the guidance which says that Discuss format is:

- Define – what should we be looking at together?
- Investigate – what it the evidence about what is happening or has happened?
- Standards – are we clear about what is required and what you are achieving?
- Competence- are we clear about the skills needed for the task? Understanding and agreement – have we reached an agreement about the way forward?
- Smart solutions- have we captured the agreement in written objectives
- Sign off – have we covered everything we need to and when should we talk again?

3. The actions 4, 5 and 6 on the training summary slide also do not align to the guidance

    - Review should be done frequently, and at least every six weeks
    - Staff categories should be recorded in HR Self Service
    - Action should be agreed between both the manager and the individual and signed off.

Risk

Sections and departments may fail to complete staff appraisals, miss deadlines or undertake poor quality appraisals.

Recommendation

Learning and Development should review the Discuss guidance for managers and staff and the online training to ensure that the training aligns to the written guidance.

Rating

Priority 2

Management Response and Accountable Manager

DISCUSS is an acronym for the structured conversation element of the appraisal process. There are just three steps to carry out the appraisal as outlined, and it is the "have the conversation" element where the structured discussion takes place using the DISCUSS format.

The DISCUSS appraisal system is designed to be flexible so the Manager and the staff member decide together when to meet. Therefore, there are no formal deadlines except it is recommended that performance ratings should be set by the end of the financial year (31st March) with the new appraisal year starting on 1st of April and an ongoing dialogue between the appraiser and appraisee ensuing in between with the frequency of discussion determined and agreed by both parties.

With regards to the alleged inconsistency between the Training and the Guidance regarding actions being agreed and signed off the following statements are made in the Guidance:

"At the end of the Discuss session a set of objectives will be agreed by line managers and individual staff members for review at agreed period. These objectives may be short-, medium- or long-term objectives."

Understanding and agreement	Ties down what objectives and actions have been	**So, if we are clear on what you need to do, how could we word this in your objectives?**

Agreed timescale

December 2023

	agreed by the staff member	

Sign off	Summarises the conversation	So, If I have this right what we've agreed is….(list) Is that right? **So can we sign off on that, and can we upload the objectives so we can both access them on the xxxxxx date?**

In addition, slide 20 of the Training refers to the same i.e.

- Make sure you capture the conversation
- Agree and sign off on the actions to be taken
- Set a date for review
- Managers may need to adjust the HR Grid Record if necessary, throughout the year but definitely at the end of March each year.

In terms of risk please refer to the management response detailed in Finding 3 above.

The guide and training are due to be reviewed as part of best practice processes and the findings of this audit review together with consistency of materials will be considered as part of this and the guide/training strengthened where this is necessary.

Accountable Manager: Assistant Director HR, Organisational Development

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority Ratings

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

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • A lack of appreciation among staff of how performance appraisals will help the organisation achieve its objectives and help them personally in the work they do and their development. • Sections and departments may fail to complete staff appraisals, miss deadlines or undertake poor quality appraisals. • Training and development that seems to have little or no relationship to a person's role or future role. Our audit included a review of the relevant documentation, interviews with key officers and testing of related procedures, processes and systems. We focused our testing on the most recent set of Appraisals completed. A random sample was selected from the payroll report and then tested against available information and interviews with sampled employees. Documents relating to the individual's appraisal where reviewed where provided. Interviews were undertaken with HR management as necessary and/or other HR staff (Head of HR Business Systems & Reward), Workforce Development and individual line managers. We included the following as part of our scope: • Policies and procedures • Training available for managers and staff • Objective setting and alignment of individual objectives with service / corporate objectives • Identification of training and development needs • Completion and quality of appraisals • Recording of outcomes

REDACTED

FINAL INTERNAL AUDIT REPORT

AUTHORITY WIDE

COMPLAINTS 2022/23

Issued to:	**Assistant Director Strategy, Performance and Corporate Transformation**
	Head of Customer Engagement & Complaints
	Head of Performance Management & Business Support
	Director of Children, Education and Families
	Director of Environment and Public Protection
Prepared by:	**Internal Auditor (Mazars LLP)**
Reviewed by:	**Manager (Mazars LLP)**
	Partner (Mazars LLP)
Date of Issue:	**10th May 2023**
Report No.:	**AW/06/2022**

INTRODUCTION

1. This report sets out the results of our internal audit of Complaints. The internal audit was carried out as part of the work specified in the 2022-23 Internal Audit Plan. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Council has a two-stage complaints procedure as set out below:
   - *"**Stage 1**: Please report your complaint to us. You can use our online complaints form to do so and can attach documents or photographs if you wish. Your complaint will be acknowledged within three working days. The Manager of the service concerned will investigate the complaint and reply to you within 20 working days. If the issue is more complicated it may take longer, but we will let you know if we need more time to investigate and respond. Timings may be different for complaints about Children's Social Care.*
   - ***Stage 2**: We can usually resolve complaints at Stage 1, but in the unfortunate event that you remain dissatisfied with the Council's response, you can contact the Local Government Ombudsman. This independent organisation investigates complaints against Councils. There is no charge for this service, but the Local Government Ombudsman will usually only consider your complaint after you have given us the opportunity to resolve matters for you."*
3. Members of the public raise complaints through various mediums, such as the online form within the complaints section on the Council website, an email to the service area, letters, and phone calls.
4. Complaints are handled mainly by the designated Complaints Team. However, complaints concerning Environment and Public Protection and Neighbourhood Management are logged and responded to by their respective internal teams.
5. We would like to thank everyone contacted during this review for their help and cooperation.

AUDIT SCOPE

6. The original scope of the internal audit was outlined in the Terms of Reference issued on 15 February 2023.
7. We reviewed and tested controls over the following key risks:

- If internal procedures setting out responsibilities and lines of accountability are not documented, there is a risk that the Complaints Team and service lines do not handle all complaints consistently to a satisfactory standard or promptly.
- If internal procedures do not set out escalation protocols, there is a risk that complaints are not dealt with promptly.
- A lack of an adequate centralised case management system could lead to ineffective management of complaints and customer dissatisfaction.
- Complaints not referred to in time to the relevant area could present reputational damage to the Council due to inadequate responses or delayed actions.
- Where poor performance is not identified and/or addressed promptly, there is a risk that underperformance continues leading to poor customer service.

AUDIT OPINION

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

AUDIT OPINION	
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.

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

SUMMARY OF FINDINGS

9. Our audit identified areas of good practice and sound controls, as well as areas for development. These are set out below:

Policies and Procedures

- Policies related to complaints are available on the Council's website for the public to access. Both the Corporate Complaints Policy (CCP) and the Children's Statutory Complaints Policy (CSCP) are available for members of the public to download.
- The CCP was last reviewed in April 2017. Although there have been ad hoc instances where the Policy has been discussed and reviewed, the Policy is not subject to formal reviews.

- Information regarding complaints is available for staff on the Council's SharePoint. This includes policies and guidance on writing replies and signposting to the Local Government and Social Care Ombudsman (Ombudsman) where necessary.
- We confirmed that the Head of Customer Engagement & Complaints provided training to staff members supported by a complaints training course presentation. A further PowerPoint named 'Children Act Complaints Training for Complaints Managers' from 2021 was reviewed, where an external speaker gave training on children's complaints and relevant legislation.
- We confirmed that there are clear lines of accountability and responsibilities for the Corporate Complaints, Environmental and Public Protection and the Neighbourhood Management teams. These are laid out in either structure charts or process maps.

Receipt, Recording, and Allocation of Enquiries

- We selected a sample of 14 corporate complaints received between April and December 2022 to assess whether they were accurately recorded and acknowledged.
    - In 12 cases, the complaints were recorded accurately. Two complaints were recorded after the Corporate Complaints Team had received the complaint. In response, management advised us that this was due to the directorate not informing the Complaints Team of the complaint.
    - We found that 12 cases had been acknowledged within three working days per the Policy.
- We selected a sample of ten Environmental and Public Protection complaints from April to December 2022 to assess whether they were recorded and allocated appropriately and in line with the CCP. Of these ten complaints, six were related to public protection, two were concerned with highways, and one each for parks and traffic.
    - All ten cases were recorded on the tracker. However, some of these were not closed accurately. The Head of Performance Management advised us that not all cases have a reference number if raised directly with service areas.
    - All ten complaints were acknowledged per the three working days timescale on the Policy.
    - One was recorded on the tracker late, and four had been closed before the response was sent.
- Similarly, for Neighbourhood Management complaints, we selected a sample of ten complaints from August 2022 to January 2023. Seven complaints were related to waste, and one each for enforcement, drainage, and street cleansing.
    - We noted that six of these neighbourhood management complaints were not acknowledged. Furthermore, whilst two did have an acknowledgement, this was not within the three working day timeframe.

- On the neighbourhood management complaints log, we could not locate a column for when the response to the complaint was due.

- We also tested and raised a 'dummy' complaint to assess whether a corporate complaint would be captured via the website form. This dummy complaint was concerned with Housing and Adult Social Care.
  - Shortly after filling details of the complaint on the Council website, we received a receipt email with a reference of 81587.

    An acknowledgement email was received within three working days per the Policy.

Investigation

- Our sample testing of the samples mentioned above confirmed that all 34 complaints tested had a designated Officer responsible for monitoring and dealing with the complaint.
- From the sample of 14 corporate complaints, we found examples of good practices where allocated Officers would send reminders to service areas when the response date was nearing.
- The Corporate Complaints Team sends weekly status reports to service areas across the Council. These detail the reference number, the title of the complainant, the service area, and its due date. For example, from a weekly report to Education dated 21 February 2023, we noted that one complaint was 64 working days late.
  - We noted the automated weekly emails sent out by System A, to Education, Housing, Planning and Carelink on 24 February 2023. The emails are sent to various members of staff within the respective divisions.
  - We noted that one complaint for planning and regeneration is 221 working days overdue, and a housing complaint is 235 working days overdue.
- We conducted a dummy test complaint for Greenspaces and Parks on the Council's website and confirmed it was captured with a reference number provided. We also received confirmation that the report had been logged and that it would be addressed as part of routine grounds maintenance. The Head of Performance Management advised that contract complaints would be escalated to the Council by the relevant contractor.

Review and Issue of Responses

- From our previously selected sample of complaints, we assessed whether the complaints were responded to within the 20 working days timescale stated on the Policy and if holding replies were sent when responses were late.

- Two environmental and public protection complaints and two neighbourhood management complaints were responded to late without a holding letter.
- We noted that six corporate complaints were responded to late.

- Furthermore, we selected nine cases from April to December 2022 with an Ombudsman reference on System A. We confirmed that each case had an allocated Officer, and no issues were noted in eight of these escalations. In the remaining case, we noted an allocated Officer, but this was dealt with late and led to a query by the Ombudsman.

Performance Monitoring and Reporting

- A monitoring framework is evident in the complaints process, with data being collated and shared quarterly and annually.
  - Environment complaints data showed the number of complaints received and differentiated between Highways, Neighbourhood Management, Public Protection and Traffic. For example, the below shows the three quarters for 2022-23.
    - Quarter 1: 50 complaints with 100% response in 20 working days;
    - Quarter 2: 44 complaints with 100% response in 20 working days, and
    - Quarter 3: 38 complaints with 100% response in 20 working days.
- We cross-referenced the environmental and public protection reported quarterly complaints with the environmental complaint tracker. We noted that on the annual complaints report 2021-22, once excluding neighbourhood management complaints, the total number of complaints was 41. However, on the complaint's tracker, only 40 could be located. This was a missing public protection complaint. Once we raised this, we were advised that this was due to reclassification.
- We cross-referenced the neighbourhood management complaints for each quarter on the quarterly reports to the neighbourhood management log. We found that there were discrepancies for quarter two and quarter three. When we raised this, management advised us that the Officer had recounted and that there was one extra neighbourhood management complaint for both quarters on the reports due to reclassifications undertaken post-reporting.
- From the annual complaints report, we confirmed that other divisional annual statistics and trends are given separately for Adult Social Care, Children's Social Care, and Education. Compliments and a summary of the Ombudsman cases for each service area report were stated within the reports.

- Within System A, we confirmed there is also a requirement for the Officer to answer, yes or no, whether there have been any lessons learnt from handling the complaint. We found that out of 347 Corporate complaints from April to December 2022 on System A, 42 cases had the Officer noting that lessons were to be learnt.
- As part of the monitoring framework, a monthly Customer Engagement and Complaints team meeting is held with senior members of the complaints, freedom of information, and subject access request team attending. We were provided monthly meeting minutes for October, December 2022 and January 2023, which showed consistently that complaint handling is agenda item four and specific cases are item six.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

10. The findings of this report and an assessment of the risk associated with any control weaknesses identified are detailed in the Detailed Findings / Management Action Plan. Any management recommendations are prioritised in line with the criteria set within Appendix B.

1. Review of the Corporate Complaints Policy	
Finding We noted that the CCP, which outlines how the Council handles complaints, was formulated in April 2017. We were provided evidence that this Policy has been reviewed ad hoc and informally. For example, we reviewed the minutes of an EPP management meeting on 3 February 2022, where the environmental aspect of complaints was reviewed. Matters discussed in this meeting included the website and forms to request a complaint, adding information to our ECS system for members to submit complaints and corporate complaints management. However, the Policy does not have version control indicating when it was last reviewed and the next review date. There is no evidence of a formal periodic review of the processes and the Policy. We noted within section seven of the Policy that a holding letter would be sent to the complainant if the Council cannot send a response within a 20 working day timescale. However, as detailed below, a holding letter was either not sent or sent late on numerous occasions. **Risk** If the CCP is not formally reviewed internally, it may become outdated or may no longer reflect the procedures that are carried out when handling complaints at the Council. Therefore, inconsistent and unprofessional processes may be followed when dealing with complaints.	
Recommendation The Council should ensure the CCP is reviewed periodically and this exercise is captured/documented within the Policy. This should include documented version control to assess when it was last reviewed.	**Rating** Priority 3
Management Response and Accountable Manager Whilst our policy and procedures are informally discussed annual to ensure ongoing suitability, it is acknowledged that there is not currently a formal review process reported to PDS. Starting from 2023 and biannually thereafter, a review of the policy/ies will be put in place will be incorporated into the covering report to the Council's Annual Report on Complaints as it goes through its committee stages. Head of Customer Engagement & Complaints	**Agreed timescale** Est. July 2023

2. Neighbourhood Management Log	
Finding We reviewed the master log for complaints concerning neighbourhood management as of 20 February 2023. This includes waste, street cleaning and drainage complaints. Within the log, we confirmed there are details regarding the complainant, the date the complaint was raised, and by whom it was resolved. However, unlike the System A used for Corporate complaints, we noted no column for when the response was due. This may lead to late responses as below: ○ Waste Complaint: Received on 01 December 2022 but not formally responded to until 23 February 2023. ○ Waste Complaint : Received on 25 January 2023 but not formally responded to until 21 February 2023. **Risk** Neighbourhood Management complaints may not be monitored well and may be sent late.	
Recommendation Management should enhance the Neighbourhood Management Log to include the timescales of when neighbourhood management complaints are due.	**Rating** Priority 3
Management Response and Accountable Manager It is unfortunate that the NM complaints log that was viewed by the auditor had no due date SLA captured. NM agree with the auditor that this is a fundamental requirement for tracking responses within SLA and the column was always present on previous versions as the screen shot shows.	**Agreed timescale** Immediate effect

The 'due by' SLA column has now been included on the latest log, with a 'resolved date' and 'final letter' date sent column also included. Head of Performance Management & Business Support.	

3. Recording of Environmental and Public Protection (EPP) Complaints

Finding

We selected a sample of ten environmental and public protection complaints received between April and December 2022 to assess whether they were recorded appropriately.

We noted that in one complaint relating to public protection, although the service area received the complaint on 27 July 2022, it was recorded on the tracker as being raised on 4 August 2022.

Furthermore, in the following four cases, we noted that the dates on the tracker for when the complaint was closed did not match the date the response was sent:

- A public protection complaint that was responded to on 10 November 2022 and stated as closed on 04 November 2022;
- A public protection complaint that was responded to on 10 January 2023 was stated as closed on 05 January 2023;
- A public protection complaint that was responded to on 08 September 2022 was stated as closed on 31 August 2022, and
- A public protection complaint responded to on 11 July 2022 was stated as closed on 08 July 2022.

When we raised this issue, we were advised by a member of the EPP team that this was due to human error.

We also noted that the EPP performance data for the three quarters of 2022-23 was as follows:

- Quarter 1: 50 complaints with 100% response in 20 working days;
- Quarter 2: 44 complaints with 100% response in 20 working days, and
- Quarter 3: 38 complaints with 100% response in 20 working days.

However, within our sample of ten EPP complaints received between April and December 2022, we found two in which a late response was given. Therefore, the performance information may be inaccurate.

Risk

The wrong performance information may be sent out quarterly, which informs the proportion of complaints that have been responded to on time. Inaccurate recording may lead to inefficiencies when dealing with complaints which may bring reputational damage to the Council.

Recommendation	**Rating**
The Council should ensure that EPP complaints are recorded accurately on the complaint tracker. Team members should be reminded to close a complaint after the response is issued. Concerning performance information, the Council should consider re-evaluating the data for EPP complaints to ensure that there are not any inaccuracies.	Priority 2

Management Response and Accountable Manager	**Agreed timescale**
Agree to this. Coordinator and Service Confirming Response Date: • To ensure accuracy on the EPP complaints tracker the Complaints Coordinator and relevant service will ensure the correct response date is added to the tracker. When the original complaint is sent to the service, the coordinator will ask the service for a response and for the service to confirm the 'Response/Closed date' in the body of the email. This ensure the Service and Coordinator are in agreement with the correct date in the tracker. Quality check before quarterly report submitted:	Immediate - by June 2023

• Prior to the completion of the quarterly report, the Complaints Coordinator will sample check the complaints tracker with the service response to ensure the correct response date has been entered into the tracker. This sample check of 5% will then be reviewed by another member of the EPP team. This will be completed in advance of sending to the corporate complaints team. This will reduce inaccuracies on the response date. Head of Performance Management & Business Support	

4. Neighbourhood Management Complaints Acknowledgment

Finding

From a sample of ten neighbourhood management complaints received between August 2022 and January 2023, we assessed whether they were acknowledged within three working days per the Council's Policy. We noted that the following six did not have an acknowledgement sent out:

- Waste complaint: received on 01 December 2022;
- Waste complaint: received on 25 January 2023;
- Waste complaint: received on 31 January 2023;
- Waste complaint: received on 13 August 2022;
- Waste complaint: received on 24 August 2022, and

- Drainage complaint: received on 25 November 2022.

Furthermore, we noted two instances in which an acknowledgement was sent but after the three working days timeframe:

- Waste complaint: received on 08 February 2023 and acknowledged on 21 February 2023, and
- Waste complaint: Received on 05 January 2023 and acknowledged on 27 February 2023. A reference for this was not stated on the log.

Risk

Neighbourhood Management Complaints do not follow the Council's Policy. Service users may not receive a satisfactory response within the allocated timeframes.

Recommendation	**Rating**
Neighbourhood Management Officers (NMO's) should be reminded of the Policy requirements for acknowledging complaints. Management should consider delivering training and/or implementing regular spot checks to assess whether acknowledgement notifications were sent within the agreed timescale.	Priority 2
Management Response and Accountable Manager As well as the excellent corporate training offered by colleagues in corporate complaints, Neighbourhood Management (NM) have arranged for Neighbourhood Officers (NO's) to undertake a bespoke training session on 24/05/2023 titled 'How we manage complaints'. This two hour in person session will be a refresher and update meeting to address how NM currently manage complaint, as well as discussing the audit recommendations. It will be an opportunity to look at the current corporate policy, the difference between an enquiry and a complaint, NM's current process, how we respond to customers and how we record this. We will also look at any specific issues that NOs may require assistance with, how we manage difficult enquiries and our escalation routes.	**Agreed timescale** By end of June 2023

Senior Neighbourhood Officers have also been tasked with undertaking checks as recommended to ensure satisfactory responses have been sent, and the introduction of a 'final letter' from HOS will be introduced giving details of stage 2 LGO complaint route to the customer. Head of Performance Management & Business Support	

5. Recording and Acknowledging Corporate Complaints

Finding

We selected a sample of 14 corporate complaints received between April and December 2022 to assess whether they were accurately recorded and acknowledged. We found that in 12 cases, all corporate complaints were recorded. However, in two instances, we noted that the complaint was recorded after the receiving date:

- Received on 15 August 2022 but is stated to have been received on 23 August 2022, and
- Received in the housing mailbox on 22 July 2022, however, the Complaints Team were only made aware of this complaint on 23 August 2022 by the Housing Team.

In both these cases, the Housing team did not notify the Corporate Complaints Team of the complaints on time.

Furthermore, we also found that two corporate complaints did not have an acknowledgement sent within three working days as per the Policy:

- We could not locate an acknowledgement for this. However, management advised us this was a longstanding complaint where the complainant directly contacted the Assistant Director regarding trees.
- This was received by the Corporate Complaints Team on 23 August 2022 but acknowledged on 06 September 2022.

Risk

Complaints may not be recorded accurately on System A leading to responses sent out after the 20 working days a service user has submitted a complaint. This may lead to greater user dissatisfaction and complaints to the Local Government Ombudsman. This could increase the risk of reputational damage to the Council.

Recommendation	**Rating**
The Council should consider adding a task or system prompt on System A, to ensure that acknowledgements are tracked for corporate complaints. Management should consider implementing spot checks to identify cases that were not acknowledged on time.	Priority 2
Management Response and Accountable Manager Management will implement an electronic task on System A to monitor the timeliness of acknowledgements, by the end of July 2023. Head of Customer Engagement & Complaints	**Agreed timescale** By end of July 2023

6. Environmental and Public Protection and Neighbourhood Management Complaint Responses

Finding

We assessed a sample of ten EPP complaints received between April and December 2022 to assess whether they were responded to in allocated timeframes. We found that two were not responded to within the 20 working days, as stated in the CCP:

- A public protection complaint due on 07 November 2022 was responded to on 10 November 2022. No holding letter was given to the complainant per page 11 of the Policy, and
- A further public protection complaint was due for a response on 31 August 2022. However, it was responded to seven working days late on 08 September 2022. As mentioned above, no holding letter was given to the complainant informing them of the lateness.

Moreover, in one response relating to a case regarding CCTV footage, the response letter read “Letter Head Template Response”, which may not look adequate to the complainant.

We also noted that in one case, which related to a physical letter being sent out regarding a parking complaint raised on 21 November 2022, there was no signposting to stage two of the complaint, which is the Ombudsman.

Similarly, from the neighbourhood management sample of ten, we noted that two were not responded to within 20 working days:

- Waste Complaint: Received on 01 December 2022 but not formally responded to until 23 February 2023, and
- Waste Complaint: This was received on 25 January 2023 but not formally responded to until 21 February 2023

The Head of Neighbourhood Management advised us that Neighbourhood Management complaints on some occasions may be handled via phone call or a site visit. Therefore, there may not be any formal written response. Thus, none of the Neighbourhood Management complaints had signposting to stage two of the complaints process if the complainant was not satisfied with the Council's response.

Risk

Responses to complainants may be late, leading to further complaints and potential escalation to the Ombudsman. Complainants unsatisfied with the Council's response may not know how to escalate to stage 2.

Recommendation	**Rating**
The Council should ensure staff members are given further training on monitoring and responding to complaints. The Council should ensure that EPP and Neighbourhood Management complaints are monitored so that timely responses can be given.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
Agree to this. Monthly: Complaints Coordinator to produce the complaints tracker to management with all overdue and outstanding cases highlighted. This will then be escalated to management and Assistant Directors for each service.	June 2023.

Training: The Performance Management team will encourage staff to attend the corporate complaints training session. Departmental Management Team: Review of outstanding Complaints to ensure services are completing on time. Head of Performance Management & Business Support	

7. Corporate Complaints and Ombudsman Responses

Finding

From a sample of 14 corporate complaints, we assessed whether they were responded to within defined timescales. We found that the following six were not responded to within the 20 working day timeframe stated on the Policy:

- Received on 03 November 2022, and the response was one working day late. Reminders to the service area were sent on this occasion;
- Received on 21 December 2022 and responded to on 10 February 2023;
- Received on 23 August 2022 and responded to on 21 September 2022;
- Received on 24 November 2022 and responded to on 28 December 2022;
- Received on 25 July 2022 and responded to on 23 August 2022. This was one working day late, and
- Received on 19 December 2022; the response was due on 20 January 2023. However, a holding reply was sent on 23 January 2023, after the response was due.

Furthermore, concerning Corporate Complaints, we found in the following two cases that there was no signposting to stage 2 of the complaints stage to the Ombudsman:

- This complaint was dealt with by Contractor A and included a refund. However, although a refund was issued, there was no signposting to stage 2.

- This complaint was dealt with directly by the care provider without the Bromley letterhead, thus, there was no signposting. The Officer explained to the individual that they should ensure that responses are sent from the corporate complaints mailbox in the future.

Lastly, we assessed whether these cases were handled effectively from a sample of nine cases with an Ombudsman reference. We found that in one case, the complaint was still outstanding:

- This complaint was received on 19 October 2022, the first part of the response was not given until 16 November 2022, and the second part is still outstanding as of 23 February 2023. The Head of Customer Engagement advised us that this was due to the relevant Officer being unavailable. Due to this, it was challenging to respond to the complaint, leading to late responses. After the first response was issued, there was a query from the Ombudsman on 04 January 2023 and a further reminder on 16 January 2023 to respond to their queries. This was responded to on 24 January 2023, and we confirmed that the Head of Service did chase colleagues to garner a response.

Risk

Complaints may not be handled as per the CCP, and service users may not receive the level of service from complaints that they expect.

Stage 2 escalations could be made when no contact is made via holding letters to complainants.

Recommendation

The Council should ensure that staff are reminded of their obligations to send out holding replies when they expect a complaint to be late.

Management should remind staff of the importance of responding to complaints within the 20 working day timeframe stated on the Policy.

The service area should ensure that signposting to stage 2 of the complaints stage to the Ombudsman is included in all relevant cases.

Rating

Priority 2

Management Response and Accountable Manager	**Agreed timescale**
The importance of a timely complaint response is emphasised across the Council on a regular basis at all levels. Corporate Complaints pending are circulated weekly to all relevant Managers. A general reminder of the Complaints policy expectations will be sent out to all Managers by the end of June 2023. Head of Customer Engagement & Complaints	End of June 2023

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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REDACTED

FINAL INTERNAL AUDIT REPORT

PEOPLE DEPARTMENT

VIRTUAL SCHOOL

Issued to: Headteacher, Bromley Virtual School
Assistant Director for Children's Social Care
Head of Finance, Children, Education and Families
Director of Children's Services

Prepared by: Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 13 June 2023

Report No.: PEO/05/2022

INTRODUCTION

1. The objective of the audit was to review the Council's arrangements for using the Pupil premium Plus (PP+) funding for looked-after children, provision of information and advice to children previously looked after and information sharing and security.
2. Prior to our work, the service was also subject to an independent review in preparation for Ofsted. Consequently, we have placed reliance on the outcomes of this review and focused our work on areas where there was less alternative assurance.
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 and subsequently we tested the following key risks:

- Non-compliance with statutory guidance.
- Use of resources does not align with needs or desired / agreed outcomes
- Information is not shared with partners effectively or securely in order to ensure the best outcomes for children

AUDIT OPINION

5. 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	2

SUMMARY OF FINDINGS

6. The audit has identified the following controls in place and working as expected:

- The independent review carried out prior to our work identified a number of strengths including high quality Personal Education Plans (PEPs), good use of data to inform practice and strong support provided to schools which is valued by headteachers and which has helped improve attendance.
- Virtual School staff demonstrated that they robustly monitor school attendance for children on a Child Protection Plan and evidenced appropriate action they had taken where their review of attendance data highlighted concerns.
- The Annual Report 2020/21 submitted to Children, Education and Families PDS Committee on 25 January 2022 included the statutory information on Looked After Children (LAC).
- Pupil Premium Plus (PP+) funding was spent in accordance with the statutory guidance published by the DfE.
- There is a robust process in place to assess whether PP+ should be paid directly to the school for individual LAC. For our sample of LAC, there was good supporting evidence for the decisions made, including evidence of educational achievement where applicable.
- Grant funding for the extension of the Virtual School Head role to all children with a social worker had been spent in accordance with DfE guidance and the Council had complied with associated reporting conditions.

7. Management should consider the key findings summarised as follows:
    - PP+ payments had not been made to schools for In-Borough Looked After Children for the Summer term 2022 and this omission had not been identified by the Schools Finance service provider or the Council.
    - There are insufficient controls in place to ensure that vouchers issued to purchase laptops for children are fully spent in accordance with the intended purpose.
    - There was insufficient evidence to support that one to one tuition had been delivered as invoiced and paid for one child in our sample.
8. We would like to thank all staff contacted for their help and cooperation during the audit.
9. The Management Action Plan is set out in Appendix A and Appendix B defines the audit opinion and recommendation ratings.

1. PP+ payment process	
Finding Relevant In-Borough schools did not receive their PP+ payment for the Summer term 2022. This was due to human error / oversight at the Council's contracted Schools Finance service provider and we acknowledge that this was a one-off occurrence. However, the error was only identified through our audit testing and there is no process in place to reconcile actual to expected payments. The Virtual School Head advised that they no longer receive sufficiently detailed information from the Schools Finance service provider to undertake this reconciliation effectively. **Risk** LAC may not receive the support required to achieve desired outcomes if funding is not provided to schools in a timely manner. Errors, exceptions and discrepancies may not be identified, investigated and rectified timely.	
Recommendation The Virtual School Head and the Contract Manager (Schools Finance Service) should agree a robust process for reconciliation of actual to expected payments to schools, including the information to be provided from the contractor to facilitate this process.	**Priority 2**
Management Response and Accountable Manager There is a process now to check payments have gone out and we will keep the email response from finance. Virtual School Head	**Agreed timescale** Already in place and ongoing

2. Laptop Vouchers	
Finding PP+ funding can be used to purchase laptops for LAC. Currently, the service provides £500 vouchers of supplier A to the child's school, social worker or carer when the need to purchase a laptop is identified and agreed. We reviewed the process for purchasing laptops and a sample of 3 vouchers issued. We found that: • Records to confirm the receipt of voucher by the school were not kept for one sample. • There is no process in place to confirm that the voucher has been used to purchase the laptop, including the value of the laptop purchased and therefore any amount due to be returned to the Council. There is also no process in place to claw back any remaining balance on the voucher. • As the laptops are not purchased directly by LBB, VAT cannot be reclaimed which may not represent best value for money. • Due to the level of cumulative spend with one provider which is not subject to market testing, there is a risk of non-compliance with contract procedure rules. **Risk** There is a risk that all or part of the voucher may not be spent in accordance with the intended purpose, or that unused funds are not reclaimed. There is also a risk of failure to secure value for money and non-compliance with contract procedure rules.	
Recommendation The Virtual School Head should: • Discuss arrangements with the Procurement team to ensure compliance with Contract Procedure Rules and value for money. • Put a process in place for ensuring that the full amount of the voucher is used for the intended purpose and any remaining balance is clawed back. • Remind staff the need to record information accurately.	**Rating** Priority 2

Management Response and Accountable Manager	Agreed timescale
We are in the process of writing an exemption report after discussion with procurement. In the meantime we are asking schools / social care to purchase laptops. Virtual School Head	Report to be written and agreed by the Director of Children's Services by the end of the summer term

3. Tuition for LAC	
Finding We could not evidence that there is a consistently robust process in place for ensuring that tuition has been provided prior to the payment of invoices. We reviewed two payments made to tuition providers; for one of these, neither the service nor the tuition provider was able to provide a tuition report for the child / date selected. **Risk** Payment is made for services that have not been provided.	
Recommendation The Virtual School Head should review the process for paying tuition invoices and ensure that there is a system for checking that tuition has been delivered prior to paying the invoice. This should include a formalised process of spot checks where it is not possible to check for all children.	**Rating** Priority 2

Management Response and Accountable Manager	Agreed timescale
We already have an informal system of meetings and checking but a formal process for auditing 10% of the children accessing tuition will be developed with records kept and then the process enacted Virtual School Head	By the end of the summer term

4. Website	
Finding The Virtual School team evidenced support, guidance and advice provided regarding Previously Looked After Children (PLAC). However, we noted that information on the Council's website regarding Virtual School is minimal and does not explain that such support, guidance and advice is available. **Risk** Children, carers and parents may not be aware that the Council can offer support and guidance and therefore may not access services that would help them achieve desired outcomes.	
Recommendation The Virtual School Head should review the information available on the Council's website to ensure that available services are promoted and accessible.	**Rating** Priority 3

Management Response and Accountable Manager	**Agreed timescale**
This is a capacity issue. The website will need to be updated with some basic information for parents and carers Virtual School Head	Initial update this summer and thereafter annually it will be reviewed.

5. Information security arrangements
Finding We reviewed the arrangements in place for sharing data against those set out in paragraphs 46, 47 and 48 of the statutory guidance. We did not see evidence fulfilling the following requirements from the Department of Education's published guidance, that specific arrangements on data sharing should be in place to set out: • how children and parents are informed of, and allowed to challenge, information that is kept about them; • how carers contribute to and receive information; We noted that the Service Specification for school attendance and attainment of data collection, references the Data Protection Act 1988 in section 5.3 (Page 5). However, this has now been replaced by the Data Protection Act 2018. **Risk** Lack of clarity on their stored information to children, parents and carers. Non-compliance with the statutory guidance "Promoting the education of looked-after and previously looked-after children" published by the Department of Education.

DETAILED FINDINGS AND ACTION PLAN

Recommendation Review existing Children's Services policies against the published statutory guidance on information sharing by the Department of Education to identify and address any gaps.	**Rating** Priority 3
Management Response and Accountable Manager Virtual Head should be following social care policy / protocols around this. Information is sent out either with social worker permission or by the social worker. Working with the Assistant Director for Children's Social Care to establish social care policy / procedures and ensure Virtual school is following Virtual School Head & Assistant Director for Children's Social Care	**Agreed timescale** To work on and have something in place by end of summer

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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REDACTED

INTERNAL AUDIT FINAL REPORT

PEOPLE

REFERRAL AND ASSESSMENT ASC

Issued to:
Assistant Director of Adult Services
Director of Adult Services
Principal OT and Service Lead
Operations Manager, Short Term Intervention
Operations Manager, Assessment and Care Management
Head of Service (LD)
Head of Mental Health
Head of Strategy and Performance ACS
Assistant Director for Safeguarding, Practice and Provider Relations, ASC

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

Date of Issue: 25 May 2023

Report No.: PEO/03/2022

REFERRALS AND ASSESSMENT

INTRODUCTION

1. This report sets out the results of our audit of Adult Social Care Referral and Assessment. The audit was carried out as part of the work specified in the 2022/23 Internal Audit Plan agreed by Audit and Risk Management 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. Referral and Assessment for Adult Social Care delivers Ambition 2 of our Making Bromley Even Better strategy, "*For adults and older people to enjoy fulfilled and successful lives in Bromley, ageing well, retaining independence and making choices".*

3. Under the Care Act 2014 and associated regulations the Council is required to provide information and advice (Sect 4), complete an assessment of an adults needs for care and support (Sect.9) and apply the eligibility criteria (Sect.13). We considered compliance to the Act with our review of the Initial Contact Team, referral to the locality and Learning Disability Teams and completion of the Full Care Act Assessment.

4. This audit has been included in the 2022/23 plan to review an element of Adult Social Care following the Strengths and Outcomes Based Practice launched in July 2021 and the migration from a care management system to a new case management system in November 2021. The audit review will also support the Department in their preparation for an external inspection due from 2023.

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

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 10 October 2022.

7. We identified the following key risks:

- All referrals submitted are not captured, processed and passed to the appropriate team for action
- The care assessment does not meet the requirements set out in the Care Act 2014
- Delays in processing referrals and completing the assessment.
- ASC partners and providers charged with referral and assessment responsibilities do not meet the standards demanded.

REFERRALS AND ASSESSMENT

8. Our scope included:

- Review of Initial Contact Team (ICT) including the availability and quality of procedures; a walk through test with the Senior Initial Contact Officer (ICW) and sample testing for contacts received since April 2022.
- Review of the information available on the case management system (LAS) including the generation and distribution of reports specific to contacts, referrals and assessments
- Review of the Full Care Act Assessments (FCAA) undertaken by the five locality teams and the Learning Disabilities team to ensure accuracy, timeliness and compliance.

9. During fieldwork, we reduced the audit scope to exclude the hospital team and Mental Health. The processes and procedures used by the hospital team will be evaluated as part of the Discharge to Assess audit review, planned for March 2023. Mental Health assessments are completed by our Mental Health provider's care managers and held on their system. The Assistant Director ASC (Operations) (AD ASC Op) confirmed that the Council are looking at options to access client information held on this system or for client information to be uploaded directly to LAS.

10. We acknowledge that there has been a change in terminology between care management systems, referrals and assessment. For clarity we have reviewed and tested the initial contacts processed by the ICT and then once accepted by the service team and referred to an allocated case worker, the completion of the FCAA.

AUDIT OPINION

11. 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
0	**7**	**0**

REFERRALS AND ASSESSMENT

SUMMARY OF FINDINGS

12. The audit has identified areas of good practice and sound controls as set out below:-

- There is a designated performance team to generate LAS reports for contacts, referrals and assessments. There is also a designated Practice Development and Systems Lead to link the LAS helpdesk/performance team and the practitioners/users
- Comprehensive weekly reports are distributed to managers to allow monitoring, oversight and planning. There is an ongoing dialogue with ASC colleagues to develop the reports available to the service to support effective delivery.
- Tracking of all data between reports to allow reconciliation of contacts, referrals and assessments to ensure all cases are accounted for.
- There are formalised working groups to receive, discuss and monitor the weekly performance reports and cascade information and actions back to the users. Membership of these groups is at an appropriate level and involves key officers, system (IT contractor's helpdesk and Project Officers) and practitioners.
- Comprehensive ACS Operating Procedure and Guidance were finalised in January 2023 and online practice guidance is available to all staff supported by a programme of LAS training and access to a help desk.

13. We acknowledge that ASC has experienced a period of significant change; a restructure of service teams as part of the Transformation programme, a relaunch of Social Worker practice in July 2021, migration to a new care management system in November 2021 and the challenges for a front line service during the COVID pandemic. We therefore took our testing sample from April 2022 to December 2022 to allow adequate time for new processes and procedures to be embedded.

14. Audit review, interview and testing has identified the following areas for ICW that require management attention:-

- Local procedure notes specific to the ICT were not available. The LAS procedures for ICW show that officers receive, create, triage and close a contact as "NFA", "Information Given" or "Signposted". This is not happening as in practice, ICWs refer to the service teams to complete and close.
- The ICWs close a contact with NFA if it becomes obvious during the initial contact that the service user does not require or qualify for Bromley services. Any advice or signposting that is imparted before a contact is opened is not captured as ICT activity or measured for performance.
- Forty eight hours is the accepted turnround time from initial contact to referral but this is not stipulated in the ACS Operating Procedures. There is no formal monitoring of contact processing time although LAS could be used to identify this information. There

is no escalation process if time thresholds are reached. There is no sample checking or quality assurance checks completed for the ICT's performance and output.

- The eligibility of any service user should start with their address confirming them to be an LBB resident. ICWs are prompted to check on Gov.UK address checker but LAS does not hold a LBB gazetteer of Bromley only addresses. The project Team have confirmed that there are plans to link to the Council's mapping system will improve this control.
- We asked the performance team to run a report on the LAS data held since April 2022 to identify temporary client information; estimated date of birth and unknown addresses shown as post code UK 99. As at 30.11.22, 5,437 records had the address as UK 99 and 8,066 records do not have the actual date of birth.

15. Audit review, interview and testing has identified the following areas for FCAA that require management attention:-

- There was no evidence that the FCAA had been sent to the service user for 16 out of our 20 FCAAs sampled. For two of these cases, the case notes on LAS show an "intention" to send but no evidence that this was completed.
- The date section on the FCAA template is confusing, there are system generated dates, requested and required and actual dates input by the user. This information is then pulled through to the digest reports. For the sample of 20, the reason for any delay over 28 days had not been consistently recorded by the user or prompted by the system.
- There is no specific target for the senior to sign off the FCAA or budget holder to authorise the funding. Authorisation and approval dates are not captured on the weekly digest report for assessments, timely authorisation is a control that should be monitored.
- The sample testing of 20 FCAA identified issues regarding entry of basic demographic information, incomplete and unsatisfactory entries identified by the Operations Manager at budget approval stage, chronology of approval, interpretation and representation of answers to ambiguous questions for direct payments and financial assessments.
- For 3 locality teams and Learning Disabilities a "pending" spreadsheet/document is maintained outside the system to record risk assessed FCAAs that need to be allocated.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

16. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and time scales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

1. Initial Contact Team (ICT) – Procedures

Finding

The ACS Operating Procedures and Guidance (ACS OP&G) finalised in January 2023 is a comprehensive document setting out how ASC operates in practice. The Initial Contact Team (ICT) procedures are set out in section 4. The LAS training guides are held on the IT Training SharePoint site and there are designated notes and workflow diagrams for ICT. We used both documents to measure against a "walk through" test with staff and further sample testing. The main issue arising were:-

- There were no locally agreed procedures held by the ICT to specify team tasks, target times or a "script" for ICW to follow
- The LAS process map for ICT sets out that ICW receive, triage, create and close a contact with an outcome of either No Further Action (NFA), signposting or advice given. In practice the ICT are only closing a contact if the outcome is NFA, advice and signposting is not being captured on LAS. This LAS process map does not agree to the ASC OP&G.
- There is a lack of clarity around the completion of the "Conversation" section of the contact form as ICWs are not completing the strength based conversations but leaving this to the duty teams.
- The ACS OP&G does not set out a target turnround time for ICT but does refer to "*all contacts must be worked on and finalised within **48 hours** of receipt"* in section 5, Community Locality Teams. It is not clear how the time is shared between the two teams, measured or recorded.
- For each month since April 2022, the number of contacts exceeds the number of people indicating possible duplication of contacts. The walk through test with ICT evidenced that our sample case was referred to the locality team duty and a new contact created.
- ACS OP &G state, "***most contacts***" come into ICT, LAS procedures state, "***All staff***, *not just ICT will create contacts*" The LAS Contacts report for September 2022 showed that 65% were received by the ICT team.

Risk

Inefficient use of resources and duplication of effort.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
Local procedures should be developed to support the operational duties of the ICT. These procedures should agree to the LAS guidance notes and the ACS O P and &G to reflect actual service delivery. Clarify the role of the ICT to complete the LAS contact template specifically the conversation field. Clarify the need to create a new contact form when referred to the locality teams to avoid duplication.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
• Local Procedures to be developed setting out the operational duties of the Initial Contact Workers (ICW's) and clarifying their role alongside the role and functions of the Initial Contact Centre (ICC). Pathways to also be reviewed and updated. These are to include timescales for closing a contract. The responsible manager will be ensuring that these align with the Departmental Operational procedures and the LAS guidance. **Accountable Managers:** Initial Response Manager/Principal Occupational Therapist and Service Lead	31st August 2023
• Following feedback about the Contact form on LAS as part of this audit. The form has been reviewed with the ICW's input. The previous contact form in LAS was supposed to be the Initial Contact Workers 'Script' as it leads the workers through the questions that need to be asked when taking a phone call. However, this audit has highlighted that the ICW's were defaulting to note taking during phone calls rather than using the contact form in LAS as it was intended to be used. As a result of the review, we now have a shorter contact form that contacts the basic information required for the ICW's to pass to the Duty teams and also to enable Duty teams to risk assess and allocate work. The New Contact form in LAS went live May 2023. **Accountable Managers:** Practice Development and System Lead /HoS/AD Adult Services	12th May 2023
• Reminders were discussed with the Team Leads in JOT and in team meetings about the process around conversation and the duplication of Contact forms.	April 2023

2. ICT - Capturing activity and performance

Finding

We established from our interviews and the walk through test that ICW only complete the contact form if the outcome is NFA. Advice or signposting to other agencies issued to contacts **before** a LAS contact is created is not recorded and not reflected in ICT performance.

Similarly our sample testing for 10 ICT contacts with a NFA outcome, evidenced that 3/10 contacts were signposted to another agency and 3/10 were referred to Occupational Therapy or Assistive Technology (another process outside of LAS contacts and referrals).

There are no second checks or spot checks on completed contact forms to confirm performance, appropriateness of closure or compliance to agreed procedures.

The ICT Manager has used a turn round target of 24hours for staff appraisals but this has not been set down in locally agreed ICT procedures. There is no escalation process within the team for contacts open to ICW beyond an agreed threshold. There is no specific LAS reporting available to measure performance and to support the ICT manager.

Risk

All ICT service activity is not captured or measured to allow the team to assess and improve performance where required.
Delay in processing the contact and assessment

Recommendation	Rating
Consider a process to capture advice and signposting delivered by the ICT before a LAS contact is created. Remind all ICW that a referral to another agency is not a NFA outcome. Formalise a target turnround time for ICW and a LAS based report for ICT management to monitor and support an escalation process. Consider spot checks on ICW contacts for management to monitor quality, consistency and compliance to agreed procedures.	Prioritv 2

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
• The new Contact form in LAS should enable the workers to capture advice and signposting as an outcome of a contact. **Accountable Manager:** Practice Development and System Lead /Initial Response Manager	August 2023
• Team Manager to advise ICW's that referral to another agency is not an NFA outcome. **Accountable Manager**: Initial Response Manager/ Principal Occupational Therapist and Service Lead	August 2023
• Team Manager will be developing policy and procedures and pathways for the end-to-end pathways in the Initial Contact Centre. **Accountable Manager:** Initial Response Manager/Principal Occupational Therapist and Service Lead	August 2023
• Team Manager with the support of the Head of Service and the quality assurance team will develop a quality assurance framework for the ICW's once the procedures are completed. **Accountable Manager:** Initial Response Manager/Principal Occupational Therapist and Service Lead/Quality Assurance Manager	September 2023

3. ICT – Address Checker, Basic Demographic Information and GDPR

Finding

A primary requirement for ASC is that the service user resides in the Borough and as such a check on their address should be at the initial contact stage. The ICW is prompted to by a link to Gov.UK address checker but there is no system control. The gazetteer loaded onto LAS is not restricted to Bromley addresses, an example being BR1 which also includes Lewisham but will show as Bromley on LAS. We discussed the address issue with our IT contractor and suggest that a link to the Council's mapping system could be considered.

If the address is unknown at the point of contact UK 99 is entered as the post code as a temporary measure. We asked the ACS performance team to run a LAS report to show all UK 99 addresses. As at 1/12/22 there were 5,437 records without a permanent address.

We asked for similar exception reports to be run for Date of Birth that was **not** Actual and records that did not have a "Yes" in the consent field. As at 1/12/22 8,066 records did not have the actual DoB and 9,305 records showed either "no" or "not known" for the question relating to consent. These reports have been left with the service for filtering, review and investigation to cleanse this data and identify any current cases, receiving service on temporary or incomplete information.

One of our samples tested related to a deceased client (2020) but the contact was created for a FOI received from a family member. The request for information should not have been linked to our service user's record.

Risk

Incomplete or inaccurate information is held for service users.
Management decisions are based on incomplete or inaccurate data.
Information Governance protocols are not met and service user information is inappropriately shared.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
The three exception reports, UK 99 postcode, estimate DoB and affirmed consent should be added to the management suite of reports. Further filtering of these exception reports will improve data quality and identify any current service users with temporary demographic information. All LAS users to be reminded that any estimates and non-factual data must be updated at the earliest opportunity. Remind staff of their responsibility to comply to data handling protocols and information governance guidelines specifically when attaching documents to a client record.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
• Team Manager to liaise with Performance team. **Accountable Manager:** Initial Response Manager	August 2023
• HOSOM & JOT Team Meeting April 2023, **Accountable Manager:** Team Lead's & Heads of Service for all areas.	April 2023
• Operational Managers and Staff have been reminded about their duties around GDPR. We are also updating the departmental recording policy. **Accountable Manager:** Operations Manager, Short Term Intervention/Operations Manager, Assessment & Care Management and ASC Policy and Resource Development Officer	June 2023

4. Full Care Act Assessment (FCAA) - – Issue of Completed Assessments to the S/U

Finding

We selected a sample of 20 Full Care Act Assessments (FCAA) that had been completed between April 2022 and January 2023. Our sample was distributed across ASC, proportional to assessments completed by the 5 locality teams and Learning Disabilities.

The Care Act 2014 Section 12 states that *" The local authority must give a written record of a needs assessment to a) the adult whom the assessment relates".* The ACS OP&G section 5.1.2 states that "*once completed the practitioner/assessor should provide the adult and carer a copy of the assessment, either send via a secured e-mail or by mail/post. A case note should be made to evidence this.* The Operations Manager (Short Term Interventions) confirmed that the assessment should be evidenced in LAS Case Notes or Case Files – Documents.

For our sample of 20 FCAA:-

- 14/20 cases did not have supporting evidence in either Case Notes or Case Files on LAS that the FCAA was sent to the client
- 2/20 cases evidenced an "intention" to send the assessment but confirmation that it was sent was not seen
- 1/20 case related to a LB Sutton client and a FCAA should not have been completed by Bromley
- 2/20 the client died soon after FCAA completion and it is accepted that it may not have been appropriate to issue
- 1/20 the FCAA was cancelled at the initial assessment stage as the family withdrew.
- 2/20 cases had 4 and 2 FCAA's on LAS for the sample period

Risk

The care assessment does not meet the requirements of the Care Act 2014
The assessment does not accurately reflect the needs as the service user does not have the opportunity to review and challenge.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
Remind all ASC assessors that the completed FCAA needs to be issued to either the service user, their carer or nominated adult. Consider adding a prompt to the Outcome section of the FCAA template to ensure this Care Act requirement is delivered. Alert LAS trainers to emphasise this requirement and agreed LAS location in future training sessions for assessments.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
• All staff have been reminded of the need to send a copy to the Care Act Assessment and Support Plan out to clients via HoSOM, JOT and Team Meetings. This is being routinely checked at the Practice Review Meetings by Heads of Service for their responsible areas. **Accountable Managers:** Head of ALD Service, Head of Mental Health, Operations Manager, Short Term Intervention/Operations Manager, Assessment & Care Management • A review of the modules within LAS is underway this year. We will add a prompt within the review and the assessment modules. **Accountable Managers**: Practice Development and System Lead, HoSOM, AD of Adult Services	April 2023 July 2023

5. FCAA – Dates and Authorisation

Finding

The date section of the FCAA template is confusing as there are system generated dates, requested and required and actual dates input by the user. These dates are then pulled through to the digest reports.

We acknowledge the assessment digest report to be a good control informing managers of elapsed time to monitor the 28 day target but we could not establish the source of this data to confirm which start and end date are used to populate the report.

The "completed" date in the FCAA template (date section) should represent the date that the allocated caseworker met with the service user and undertook the assessment. "Completed" also needs to represent the time span between the *initial contact* and *the assessment and any resulting service provision* (ACS OP&G section 3.3). Our interviews, observations and testing highlighted a lack of clarity around terminology, particularly "completion". The LAS "wiki" pages, accessed by the Practice Development and System Lead identified a number of "date" fields which, when populated, interlink with templates and reports.

Without clear definition and understanding of the "completion date", confirmation of the source data on the assessment digest monitoring of the 28 day target is limited.

For the sample period April 2022 to January 2023, 1,443 FCAA were completed, we randomly selected a sample of 20 service users, proportional to the assessments to each of the Locality and Learning Disabilities Teams. The two issues relating to dates are-

- The "date required" is system generated 28 days after the "date requested". There should be a drop down option to enter a reason for a completed date exceeding the target however this was not consistently applied. 10/20 had been completed in time but for 7/20 no reason had been prompted or entered for 1/20 the required date had been changed.
- There is no formal target for approval/sign off to end the FCAA. The date of the approval and authorisation is not captured and reported on the weekly assessment digest. 2/20 cases exceeded the 28 day target. For 1/20 the budget was approved before the senior had signed off the assessment.

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REVIEW OF REFERRALS AND ASSESSMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Risk Completion of the FCAA does not meet the nationally and locally agreed target of 28 days for services to be arranged to meet service users assessed needs.	
Recommendation Include approver and authorising dates on the assessment report to identify "log jams" or pressure points in the assessment workflow. Consider a target for approval post assessor completion to ensure timely workflow for assessments. Clarify the source of dates in LAS to confirm the elapsed time as this is currently used to monitor against the 28 day target. Similarly confirm that there are LAS process maps, developed by the project implementation team, to track data input through the system.	**Rating** Priority 2
Management Response and Accountable Manager To be picked up at the LAS Operational group and project Lead for action. **Accountable Manager:** AD of Adult Services/ Practice Development and System Lead,	**Agreed timescale** June 2023

6. FCAA – Checks and Ambiguous Questions

Finding

- Our sample testing of 20 completed FCAAs highlighted that: 1/20 cases related to a FCAA completed on the 22/4/22 was for a LB Sutton client; this was not identified until the senior reviewed the assessment in June 2022.
- 2/20 cases were for clients now deceased so their address shows the Civic Centre, the historic address was not available and therefore not checked
- 1/20 case gave contradictory answers to closed questions in the communication section. This was also the case with Direct Payments questions before the template was changed in July 2022 and Financial Assessments.
- 1/20 case was cancelled at the initial assessment stage but was showing as a completed FCAA

Although the use of closed questions simplifies the assessment this does then rely on the assessor's correct interpretation. Text boxes have been used to give extended answers or explain "other" to drop down options but this relies on a specialist report to decode the data.

Risk

The care assessment does not meet the requirements set out in the Care Act 2014
The completed care assessment does not accurately or fully reflect the work that has been undertaken by the assessor.

Recommendation	**Rating**
Continue the work in progress by the ASC Performance Team and LAS Project officer to develop LAS to simplify the FCAA template and to deliver accurate complete and useful data including location and all attendees for the FCAA Liaise with the LAS trainer to ensure all changes to the assessment template are included in future training events and that the LAS training guides reflect current practices and requirements.	Priority 2

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
• A review of LAS is underway. The contact form and Review form is complete. We will move onto the Assessment form next. The intention is to review all modules in LAS this financial year. All changes to the system are tested by staff and are picked up at the LAS Operational issues group attended by the internal trainer. (Organisational Development Officer) **Accountable Manager:** Practice Development and System Lead/Organisational Development Officer/AD Adult Services	July 2023

7. Allocations Pending and Reconciliation

Finding

The walk-through test for the assessment process was completed with a Locality Team Leader. The referrals to Duty are triaged, risk assessed and added to an excel spreadsheet as "pending". This document is then used at the weekly allocations meeting to match pending cases to resources. A check with the other Teams confirmed that three of the Locality Teams and the Learning Disabilities are using a spreadsheet or word document to record pending allocations. There were several reasons cited by Team Leaders for needing this record; that it gave a summary overview without having to go into the individual client record; it was easier to handle a high number of pending cases and as back up if LAS was not available.

Records maintained outside of the care management system must be regularly reconciled to LAS to ensure we are accounting for all cases. As at 13.2.23 Learning Disabilities had 19 cases (allocated and to be allocated) on their spreadsheet but the LAS showed 33. The maintenance of these records does represent duplication of effort and handling data on spreadsheets risks error and compromise.

Although the weekly digest reports track contacts, referrals and then assessments by source and destination as totals across the report tabulations, LAS cannot track an individual contact through the workflow to delivery of service. This functionality was anticipated when LAS was implemented but is not yet available. The ACS Performance Team Manager is currently working with the system provider and liaising with other Local Authorities to develop this client tracking. This would allow the service to identify "log jams" and pressure points.

Risk

- Management decisions are based on LAS data not actual service activity.
- All referrals submitted are not captured, processed and passed to the appropriate team for action.
- Delays in processing referrals and completing the assessment.

Recommendation	Rating
If LAS does not currently meet the needs of the client teams to monitor assessments pending, development work should be requested to extract data and present in an acceptable format.	Priority 2

In the interim, all teams using a separate document to record pending allocations should be regularly reconciling to LAS. Any variance to be investigated and resolved to ensure all service users referred to assessment are accounted for and secondly to ensure LAS is current, complete and accurate. Continue the work of the ASC Performance Team to develop LAS to track a client from contact, referral, assessment and service.	
Management Response and Accountable Manager • All Team Leads have been asked to stop using spreadsheets to record incoming work to the team. The system is sufficient for Team Leads to manage the workflow and allocations. **Accountable Manager**: Head of ALD Service, Operations Manager Assessment & Care Management, Operations Manage Short Term Intervention.	**Agreed timescale** April 2023

OPINION DEFINITIONS

APPENDIX B

Assurance Level

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

Recommendation ratings

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

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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DIRECTORATE

REVENUE BUDGET MONITORING 2022/23

Issued to: Director of Finance
Head of Finance – Adult Social Care, Health and Housing
Head of Finance – Children, Education and Families
Head of Finance – ECS and Chief Executive's

Prepared by: Internal Auditor (Mazars LLP)

Reviewed by: Manager (Mazars LLP)
Partner (Mazars LLP)

Date of Issue: 4th May 2023
Report No: AW/09/2022

INTRODUCTION

1. This report sets out the results of our internal audit of Revenue Budget Monitoring. The internal audit was carried out as part of the work specified in the 2022-23 Internal Audit Plan. 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 London Borough of Bromley (Council) currently operates with a draft budget of £177 million which was finalised in conjunction with the estimated council tax at band D of £1,736.72 on 12 January 2022 and was formally approved by the Executive Committee on 9 February 2022 and full Council on 28 February 2022.
3. The Council moved to System A in April 2022 (their main Financial Management System) and planned to operate with System B planning and forecasting. However, the planning and forecasting module for System A was unavailable until September 2022 with Finance staff using it for the 2023/24 draft budget production between October and March 2023. Limited rollout to budget holders started in January 2023.
4. We would like to thank everyone contacted during this review for their help and cooperation.

AUDIT SCOPE

5. The original scope of the audit was outlined in the Terms of Reference issued on 6 January 2023.
6. We reviewed and tested controls over the following key risks:
   - There is no central budget holder procedure, and staff are unaware of how to access guidance documents;
   - Budget holders are unaware of the deadlines required for reports and the value of circulating them promptly;
   - There are no tools or report templates to support budget holders in the creation of quarterly reports;
   - Budget holders are undertrained and have not received the appropriate amount of guidance to ensure they can fulfil their role effectively and efficiently;
   - The budget reporting process is inefficient, and the reports do not contain the full range of spending analysis data;

- Virements and contingencies are not approved per the scheme of delegation;
- Virements and contingencies are not reported to Committees; and
- Reporting to Executive and Policy Development and Scrutiny (PDS) Committees is infrequent and does not contain consistent budget reporting.

AUDIT OPINION

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

AUDIT OPINION	
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.

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

SUMMARY OF FINDINGS

8. Our audit identified areas of good practice and sound controls as well as areas for development. These are set out below:

Policies and Procedures

- We reviewed the Financial Regulations (last reviewed in 2020). The Financial Regulations state that '*it is the responsibility of the Director of Finance to review and update the financial regulations document every three years'*. The next review of the Financial Regulations should therefore take place in 2023.
- Among others, Financial Regulations include information on strategic responsibilities, system and procedures, the scheme of virement, accounting arrangements which are relevant to budget monitoring.

- In addition to the Financial Regulations, the Council's Policy Development and Scrutiny Committees (PDS) are governed by budget books such as the Adult Social Care Budget book (ASC Budget) or the Resources, Commissioning and Contracts Management Portfolio Budget Book. These were approved in 2022/23 and, among others, detail budgets by cost centres whilst referencing changes to old cost centre codes.
- We were provided with System B Budget Holder Guidance which was approved in November 2022. The document's purpose is to supply instructions to users of System B. In review, we confirmed that it contained information relating to specific Officer roles (including budget holders, accountants, budget viewers and system administrators), and also details concerning system navigation and budget forecast.
- The above documents are accessible by staff through the Council's local intranet.

Budget Monitoring and Forecasting

- We confirmed that there is a timetable detailing the quarterly financial monitoring reports for the 2022/23 financial year. It notes what each report should include and who they should be submitted to before Committee viewing.
- As part of our testing, we aimed to comment on the robustness of the current budget monitoring process and the subsequent production of monitoring reports. Whilst we were able to review all Executive Committee meetings and confirmed that each budget report was produced and supplied as required by the timetable in the FY 2022/23, we noted inconsistencies in the production of these reports.
- Through discussion with the Head of Finance, Budget Holders, and Senior Accountants, it was noted that whilst quarterly reports were being produced consistently by the budget holders for review by the Finance Team, there was no standardised approach implemented by all budget holders in formulating the reports. Three Budget Holders interviewed noted that they were left to their own approach/preferences to ensure funding and income were distributed and tracked appropriately.
- Through further discussion with the Senior Accountant, it was noted that the CEF Budget document allows budget leads to input potential alterations to draft budgets and notify the Finance team, these are then amended and confirmed through the Committee Allocations document, which is then re-circulated to budget leads. Any errors are highlighted and resolved before confirmation.
- We assessed whether any additional training was arranged by Finance or received by budget holders since April 2022 to compensate for the lack of the specific System B module. Interviews with the sample of three budget holders above indicated

that they had received no significant extra guidance on how to operate and were predominantly allowed to operate their own approach and methods.

Virements

- The Head of Finance, Senior Accountant and Director of Finance advised Internal Audit that whilst virements are rare, the main principal adjustments are made through contingencies approved in Executive Committee meetings. To confirm that contingencies and virements in quarterly reports are approved following the Council's Financial Regulations and Procedures (2020 version), we selected a sample of five random contingencies with values ranging between £73,000 - £1,868,000, presented in reports in the 2022/23 financial year up to the time of our fieldwork.

  Our testing confirmed that all showed evidence of approval within the Executive Committee meeting minutes. Furthermore, the approval of each aligned with the approval threshold noted in the Financial Regulations whereby any contingency or amendment valued over £250,000 required Director approval. Moreover, across the sample of five random contingencies, we confirmed that four had been accurately processed and uploaded to System A. The one remaining sample valued at £73,000 for New Home Regeneration was a grant carried forward from the 2021/22 FY, where the reserve movement has not yet been actioned as it is dependent on the final outturn to determine how much of the reserve will be required, therefore, to avoid duplication of efforts such transfers are kept until year-end to action once the final position is known.

- As part of the budget reporting process, there should be a confirmation email containing the contingency value and approval distributed through the Senior Accounts Team. For our sample of five contingencies reported between April 2022 – January 2023, we found that the required email with approval was provided in four of the five instances. One of the five samples specifically required Executive Committee approval as the values exceeded £100k and is planned for review at the next meeting on 29 March 2023.

Management Information

- To confirm consistent budgetary reporting, we requested the Committee reports for all Executive meetings across 2022/23. We also reviewed three of the six PDS meeting reports to review the extent to which budget and financial reporting are present.

- Testing identified that the most recent Budget Report at the time of fieldwork was from 30 November 2022 and identified an overall net overspend of £9,568,000 within portfolio budgets and a £8,555,000 credit variation on investment income. This

budget gap could link to some of the concerns noted regarding the lack of a structured and universal approach to budget monitoring, undermining the robustness of budget monitoring.

- The Committees tested above displayed frequent and informative budget reporting to assist Members in understanding the financial landscape of the Council and making decisions.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report and an assessment of the risk associated with any control weaknesses identified are detailed in the Detailed Findings / Management Action Plan. Any management recommendations are prioritised in line with the criteria set within Appendix B.

1. New Budget Holder Training Records

Finding

We assessed whether all new budget holders have undergone training and had received the required documents as part of their training, including:

- Budget monitoring exercise;
- Estimate Exercise;
- Financial Awareness for Budget Holders; and
- System B Budget Holders Guidance.

We obtained a list of new budget holders for the 2022/23 FY from the Head of Finance, Children, Education and Families Finance. However, we were not provided with evidence that they have undergone training as required. In addition, we noted that there is no training framework to ensure that the completion records are maintained for those who have completed the training.

As part of our testing, we contacted ten new budget holders across various departments. We circulated a questionnaire regarding the training they had received, we received responses from five individuals. The results were as follows:

Sample	Received Budget Holder Guidance	Completed Financial Awareness	Completed Estimates Exercise	Completed Budget Monitoring Exercise
1	No	No	No	No
2	No	No	No	No
3	No	No	No	No
4	No	No	No	No
5	Yes	Yes	No	Yes

We were advised by the Head of Finance, Children, Education and Families Finance that training is typically performed on an ad-hoc basis, and it is the expectation that the core skills required to perform the role of a Budget Holder such as operating System A are already developed. Despite this, implementing a structured mandatory training regime would help ensure budget holders perform their duties in a standardised manner.

Risk

Budget holders may not be aware of the Council's expectations linked to their role, specifically when new budget holders are assigned. Staff may be unsure how they can fulfil their roles effectively and efficiently. Also, budget holders may not have the necessary knowledge and skills to monitor their budgets effectively. This could lead to overspending, underutilisation of funds or non-compliance with financial regulations.

Recommendation	**Rating**
New budget holders should receive a mandatory training session. The training should contain, at least, the following: • Budget monitoring exercise; • Estimate Exercise; • Financial Awareness for Budget Holders, and • System B Budget Holders Guidance. Furthermore, the Council should implement a training framework to ensure that training records are maintained for the budget holders who have undergone training. In addition, the framework should include clear steps for escalating action to be taken by Managers should training not take place. Management should also identify training needs for existent budget holders and provide ongoing training where needed. This will ensure budget holders are up to date through refresher courses to help them stay informed of best practices.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
Agreed. Managers should be receiving training on the basic fundamentals of budget monitoring. The department are looking at a new suite of training tools, both online interactive and in person training. The current set of training referenced above will be amended. This is already mandatory for new managers, but finance will work with HR in	December 2023

order to improve this process, so all managers are captured. There is also a separate System B training course now available for budget managers. Head of Finance – Children, Education and Families.	
2. Satisfactory Budget Tools	
Finding To evaluate if there were satisfactory budget management tools in place to facilitate effective budget monitoring, we met with a selection of new budget holders operating in the 2022-23 FY. Through discussion with the Head of Finance, Budget Holders and Senior Accountants, it was noted that whilst quarterly reports were being produced consistently by the budget holders for review by the Finance Team, there was no standardised approach implemented by all budget holders in formulating the reports. Three Budget Holders noted that they were left to their own approach/preferences to ensure funding and income were distributed and tracked appropriately. Through our testing, we also found that little extra guidance was provided between April 2022 – January 2023, with two out of three budget holders interviewed having liked more training through the last 12 months to facilitate the unavailability of the System B module. In one instance, we found that a budget holder has been employed for over nine months and was still unaware of their total budget, the budget holder advised us that this has led to feeling unprepared for the quarterly meetings with the Finance Team. **Risk** Without consistent and reliable tools, there may be inconsistencies and inaccuracies in budget tracking, leading to overspending or non-compliance with financial regulations. Moreover, budget holders may be unable to identify areas where cost savings or efficiencies can be made. The lack of standardisation can also make comparing budgets across different departments difficult, making it challenging for senior management to assess financial performance across the Council and make informed decisions.	
Recommendation All budget holders should be made aware of their budget and communication with the Finance Team should be more frequent than every quarter for those who need additional support. This will allow Managers to express concerns about budgetary position or request extra training. Management should consider implementing a standardised suite of budget reports for budget holders to monitor their position. Budget holders should use this set of monitoring reports and data from the Finance System to report	**Rating** **Priority 2**

spend and commitments, analyse variances and produce reliable forecasts of spend to minimise the risk of a budget under/overspending and provide Finance with the management information required to produce reliable budget spend and predicted outturn reports.	
Management Response and Accountable Manager Budget holders are made aware of their budgets, finance produce a budget book each year and their budgets are uploaded onto the system for them to view. In terms of frequency, this is already taking place. We report to Executive and PDS committees on a quarterly basis, but budget managers are in contact with finance on a regular basis as and when required. There is a standard set of monitoring reports on the new system that are available to budget holders to use which allow them to view all aspects of their finances. Finance also, depending on the complexity of the particular area, produce information above and beyond this to assist the budget managers where necessary.	**Agreed timescale** Done

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

CHIEF EXECUTIVE DEPARTMENT

SICKNESS MANAGEMENT

Issued to: Head of HR Business, Systems & Reward,
Director of HR and Customer Services,
Assistant Director, HR, Organisational Development,
Head of Finance ECS and Corporate (Final only)

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 22nd March 2023

Report No.: CEX/04/2022

REVIEW OF SICKNESS MANAGEMENT

INTRODUCTION

1. This report sets out the results of our audit of Sickness Management. The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management 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 purpose of the Managing Employee Ill Heath Procedure 'is to set out the framework within which the ill health of employees will be managed in a proactive manner, in order to minimise productive time lost to the Council as the employer and to protect the health and safety of each individual employee. It also aims to ensure a consistent and transparent process, balancing both the needs of the individual and those of the Council'.

3. This audit review concentrated on sickness absences of varying types across the Council and the associated processes and documentation. The audit included determining the level of awareness of the 'Managing Employee Ill Health Procedure' and attendance of those with line management responsibilities, at the mandatory Sickness Management training.

4. Thirty cases were selected over financial years 2021/22 and 2022/23. We could not test all samples due to line managers not being identified on the HR System or there being a change in line management. Efforts were made to contact all relevant line managers, but this was not possible in 3 cases.

5. The impact of sickness absence can be demonstrated from the table overleaf that relates to the 12 month period from November 2021 to November 2022:-

REVIEW OF SICKNESS MANAGEMENT

Department	Total Working Days Lost	Total Working Days Lost per FTE
Chief Executive's	999.15	6.14
People	7099.00	7.89
Place	2014.59	6.11
Total	**10112.74**	**7.26**

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

AUDIT SCOPE

7. The original scope of the audit was outlined in the Terms of Reference issued on 22nd June 2022.

8. We reviewed and tested the following key risks:

- High staff absence or turnover leading to operational difficulties with service delivery.
- Increased costs arise due to temporary staff cover together in addition to sickness pay.
- Non-compliance to legislation resulting in cases being taken to employment tribunals.
- Managers and staff are not aware of their responsibilities for sickness arrangements, leading to further employment tribunal cases.
- Return to work processes are not in place and consistently applied across the Council.
- Reporting of sickness absences may not be consistent in all areas resulting in inaccurate staff records and sickness absences.
- Accurate and up to date sickness management information is not available to effectively determine the current levels of sickness absence.

REVIEW OF SICKNESS MANAGEMENT

AUDIT OPINION

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

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

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

SUMMARY OF FINDINGS

10. We observed some areas of good practice and sound controls:

- Managers were confident in knowing who to contact, in the event that they needed help or guidance.
- The majority of managers contacted were aware of the Managing Employee Ill Health Procedure and the responsibilities for both them and the employee.
- Managers were confident to keep in touch with members of staff during of sickness absences by various methods.

REVIEW OF SICKNESS MANAGEMENT

- Recommendations made by Occupational Health were found to have been actioned by line managers and this was operating well.
- A sickness management update has recently been provided at a Managers Briefing.

11. Our review highlighted the following areas for further development:

- The 'Managing Employee Ill Health Procedure' is dated January 2020 with no planned review date; other relevant procedures are dated pre-pandemic and therefore require updating to ensure alignment with current desired practice.
- We found through testing that not all staff with line management responsibility had completed the mandatory sickness management training. Managers who have completed the training may need to attend refreshers to update their knowledge.
- Data held on the HR Management system in relation to line managers was not always complete and up to date.
- Current KPIs for sickness management had no target in place.
- Return to work forms had not been completed in a few cases and other cases could not be tested due no line manager being detailed or there being a change of manager.
- Contract monitoring documentation should have the agreed timescales for actions detailed.
- For the majority of our sample of sickness absences, the system entry had been made after the end date of absence however there is no complete audit trail available to determine whether prior entries had been made and then deleted, in order to establish the cause of the issue.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

12. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF SICKNESS MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Procedures, Policies & Guidance Documentation
Finding The following documents and procedures are all held on SharePoint with links from the Transform page, with the HR Policies & Procedures. Managing Employee Ill Health Procedure This procedure was last updated in January 2020.There is no planned review date detailed within the document. Although the sickness management process involves monitoring of trigger points, the policy itself does not refer to 'triggers'. The procedure itself does not mention the triggers of over 20 + days of sickness absence or 5 or more occasions of sickness absence. HR Consultancy advised that some sickness absences, such as Covid and maternity related absences do not result in triggers. However, these exceptions are not detailed in any procedures. The link to the Self Certification Form within the procedure did not work. One manager who was contacted as part of this review advised that they had been employed since 2015 and were not aware of this procedure and would not know how to locate it. Managers interviewed explained how they kept in touch with absent employees however it was not always clear how this contact was documented. Managing Ill Health Quick Guide This guide is dated March 2009 and there is no planned review date detailed within the document.

Return To Work Form & Guidance The Return To Work Form is dated September 2019 and the Return To Work Guidance for Managers is dated July 2017. It should be noted that the triggers are referred to in this guidance detailing the over 20+ days of sickness absence or 5 or more occasions of sickness absence. We found through sample testing, that return to work forms were not always completed and some managers were not aware that they had to be completed for all sickness absences. Some managers will upload the return to work forms onto the HR System or hold the forms within the service area. Self Certification Form This form details that it was last reviewed in August 2020. There is no planned review date detailed. **Risk** Some managers may not fully understand their responsibilities which may result in the correct process not being followed and an employee being treated unfairly such as not making reasonable adjustments.	
Recommendation The Managing Employee Ill Health Procedures and all associated forms and guidance should be reviewed and updated as detailed above. (i) The Managing Employee Ill Health Policy should refer specifically to the triggers and detail the agreed trigger points. (ii) Links to documents within the procedure should be updated for ease of access. Consideration should be made to all related documents and guidance to be appendices to this procedure at the next planned review.	**Rating** Priority 2

(iii) To assist managers, the procedure document should summarise the sickness management process by way of a flowchart detailing the key stages. (iv) All documents should include a planned review date.	
Management Response and Accountable Manager **Head of HR Business, Systems & Reward,** to review policy and forms and update where appropriate. There is now a HR Induction, introduced in 2022, for new employees and managers who join LBB which covers details such as where to find policies and procedures as well as giving an overview of the responsibilities of managers in managing sickness. HR Consultancy proactively contact managers where staff are close to or hitting sickness triggers to support them through the process. Covid is recorded as sickness for all purposes including the sickness management triggers but of course every case is considered/managed on the individual circumstances.	**Agreed timescale** June 30th 2023

2. Sickness Management Training
Finding HR Workforce Development organise Sickness Management Training for all managers. This course is mandatory and is run quarterly. HR Workforce Development will invite all new managers to attend this course at the next available date. All staff with line management responsibilities are expected to attend. During the audit, a list of those managers that were booked on the next sickness management training on 12/12/22 was requested and provided. However, some managers interviewed stated that they had not completed the mandatory training. Some managers could not recall whether they had attended this training, as it had been some time since completion. One manager also advised that they were not aware of this training or the Managing Employee Ill Health Procedure and also advised that they had previously had to take a case to an employment tribunal. **Risk** Managers do not meet their responsibilities, follow appropriate processes or make appropriate decisions. This could lead to an employee being treated unfairly, increasing the risk of employee relations issues.

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
HR should investigate how the best available information on relevant staff for the training can be sourced, for example through systems reports showing those with direct reports, structure charts or those on the 'Managers Briefing' distribution list. HR should investigate how attendance at mandatory training can be monitored, with exceptions followed up. This could be done through individual Departments, or completion of mandatory training could form part of appraisals and objective setting. HR should determine a policy on refresher periods for mandatory sickness management training. This could be completed when the policies and procedures in Recommendation 1 have been updated.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
HR are able to identify which posts manage employees and therefore can identify managers to cross reference those that have attended the Managing Ill Health course. **Assistant Director, Organisational Development.**	June 30th 2023

3. HR Management System
Finding Sample testing identified that information held on the HR system with regard to line managers was found to be incomplete or information not necessarily available to HR Consultancy. For cases reviewed for the 2021/22 financial year, there were 3 instances where no line manager was detailed on the system for that individual employee. There were also 2 cases where there had been a change in line manager. One of these members of staff remains as a current employee. For cases reviewed in the 2022/23 financial year, there were one case where no manager was identified and two cases where the incorrect line manager was detailed. HR advised that the reason for no manager being detailed 'is because the post to post hierarchy works on active posts so if an employee has been terminated they are no longer an active post holder and therefore there is no manager to show'. There also be a number of reasons for no manager being detailed, for example, long term sickness of the employee, the manager leaving or moving post or possibly utilising agency staff to cover a post. **Risk** HR Management information held is not robust, up to date and reliable, which may result in decisions being made on incorrect data.

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
Data held on the HR Management System should be regularly reviewed to ensure the correct information is held in respect of line managers to ensure that any data transfer to the HR system is accurate, up to date and robust. Managers should be reminded to advise HR Consultancy of any changes to line management responsibilities within their service. (This should be read in conjunction with Finding 2).	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
The HR database is regularly reviewed and updated when HR are advised of changes. Information is also readily available to managers to review in HR Self Service but HR will remind managers of their responsibility to inform of any establishment changes and other changes in a timely manner. Where a manager has left the organisation and the post has not yet been filled, the post will show as vacant but any information regarding teams can be viewed by the grandparent post. If a manager is on long term absence we can set up delegations so that information can be managed by another manager. **Head of HR Business, Systems & Reward**	June 30th 2023

4. Key Performance Indicators (KPIs)

Finding

The current KPIs in relation to sickness management are set out below:-

1) Average number of days absence per employee
2) Average days - less than 20
3) Average days - 20+
4) Cost of sickness

There are no targets for these KPIs which are reported quarterly to COE. This used to be provided to Committee, but a decision was made some years ago that a target for sickness was no longer required. Management advised that the KPI reporting is benchmarked against the public sector and local government, but evidence of this was not provided.

We requested information in respect of how the KPIs are calculated. HR advised that these are run from a standard report which is direct from the HR Management System.

The table below provides a summary of the KPIs detailed above reported to COE.

KPI's	Target	2020/21	2021/22	2022/23 to September
1) Average number of days absence per employee	Not Set	5.6 days	7.2 days	3.4 days
2) Average days less than 20	Not Set	1.7 days	2.1 days	1.16 days
3) Average days 20+	Not Set	3.6 days	7.7 days	2.34 days
4) Cost of sickness	Not Set	£934,000	£1,271,184	£394,000

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Risk	
Without meaningful targets in place, actual performance cannot be consistently measured.	
Recommendation HR should determine whether any meaningful targets can be put in place for the following KPIs for the next financial year (2023/24): 1) Average number of days absence per employee 2) Average days - less than 20 3) Average days - 20+ 4) Cost of sickness	**Rating** Priority 3
Management Response and Accountable Manager HR do complete regular benchmarking exercises with London Councils, including absence data, and that information can be used as part of ongoing comparisons. HR also keep up to date with data from CIPD etc to keep abreast of information relating to sickness absence levels across different industries. We will review and consider targets for the next financial year as set out in the recommendation. **Head of HR Business, Systems & Reward.**	**Agreed timescale** June 30th 2023

5. Contract Monitoring
Finding A contract is in place with Contractor A, the Council's Occupational Health Provider. The contract period is April 1st 2020 to March 31st 2024. The annual cost of the contract is £37,107 and the total cost for the contract period is £148,428. We requested copies of the scheduled dates for contract monitoring meetings and contract monitoring minutes. There was no schedule of dates for the planned meetings as it was confirmed by the Head of HR Business, Systems & Reward that at the meetings the next meeting date will be agreed. Contract monitoring minutes were provided over the last 12 months for the following dates:- 26/01/22 23/03/22 20/09/22 13/12/22 Actions contained within all the minutes had no timescales for completion. The meeting on 26/1/22 did not agree the previous minutes and confirm that all previous actions had been completed. **Risk** Contract monitoring may not be effective leading to unnecessary costs, referrals and delays in appointments.

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
The process of contract monitoring should be reviewed and updated. All actions should have an agreed timescale for completion.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**
Regular contract monitoring with Contractor A is undertaken but the **Head of HR Business, Systems & Reward** will review and update to make it clearer in minutes of meetings the actions and agreed timescales.	June 30th 2023

6. Return To Work Forms	
Finding For the sample tested, a return to work form had not been completed or was not available, in three cases in respect of the 2021/22 financial year and in five cases in the 2022/23 financial year. Guidance to managers is not fully clear as to where information should be stored and some gaps in information are likely to be due to changes in line manager, with documents not shared with subsequent line managers. Amongst the line managers interviewed, there was not a consistent approach in completing, submitting, retention and storage of these forms. **Risk** Return to work meetings do not take place which could result in a lack of understanding of the sickness absence. Assumptions may be made that the employee is fit to return to work, when they may need additional support or adjustments. This may result in further absences.	
Recommendation Managers should be reminded that return to work meetings should take place for all occasions of sickness absence and the return to work form should be completed and a copy passed to the employee. Guidance should be updated to detail the expectations on retention and storage to provide consistency. This will also assist future managers to be able to access these documents in the event that the line manager completing the form moves roles or leaves the organisation.	**Rating** Priority 2

REVIEW OF SICKNESS MANAGEMENT

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
The HR Induction as well as the Managing Ill Health training both address the need for Return to Work Interviews to take place. We will provide further clarity to managers regarding the expectations on them to complete these. **Head of HR Business, Systems & Reward**	June 30th 2023

7. Audit Trail	
Finding The audit trail of sickness entries for five selected employees appeared to show that sickness was rarely entered on the first date of absence. The time period for data entry was typically one to two weeks after the first day of sickness and, in 7/9 instances, after the end date of sickness. However, HR advised that 'if a sickness period has been deleted by the manager and re-entered, the system does not show the date the sickness was initially recorded'. Therefore we cannot confirm whether sickness was entered late or whether an original entry was deleted and re-entered. **Risk** If sickness absence entries are not entered timely on the system, this could result in incorrect pay and the absence not being managed appropriately. In the absence of a full audit trail, changes to employee records do not show all changes to personal data and which officer completed or initiated the change.	
Recommendation HR should establish whether an audit trail of changes and entries can be retained on the forthcoming HR system.	**Rating** Priority 2

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
The HR System is changing to a new system from April 2023 and information relating to entry of absences and the dates of entry will be reviewed to check on auditing functionality. **Head of HR Business, Systems & Reward**	June 30th 2023

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

8. Reason For Sickness Absence	
Finding Analysis of data for Q1 2022/23 and the 2021/22 financial year highlighted that • In Q1 2022/23, 10 out of 330 absences did not have a sickness reason entered • In 2021/22, 17/1245 absences did not have a sickness reason entered The gaps in this information are highlighted on reports produced by HR but had not been followed up. **Risk** Effective monitoring cannot be undertaken to determine whether the absences were also related to previous, or subsequent, absences.	
Recommendation HR should identify gaps in data submitted by managers from existing reports and raise the small number of exceptions with individual line managers. HR should investigate whether system controls for the forthcoming replacement system, can enforce sickness absence reason entries.	**Rating** Priority 3

REVIEW OF SICKNESS MANAGEMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
HR will make providing a sickness absence reason mandatory in the new system from April 2023. **Head of HR Business, Systems & Reward**	April 30th 2023.

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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REDACTED

FINAL INTERNAL AUDIT REPORT

PLACE DIRECTORATE

HMO LICENSING 2022/23

Issued to:	**Assistant Director (Public Protection)** **Head of Service for Community Safety, Licensing, Environmental and Domestic Regulation** **Environmental Protection & PRS Housing Manager** **Director of Environment and Public Protection**
Prepared by:	**Senior Internal Auditor (Mazars LLP)**
Reviewed by:	**Manager (Mazars LLP)** **Partner (Mazars LLP)**
Date of Issue:	**08 March 2023**
Report No.:	**PLA/10/2022**

INTRODUCTION

1. This report sets out the results of our audit of houses in multiple occupation (HMO) Licensing. The audit was carried out as part of the work specified in the 2022-23 Internal Audit Plan. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Council currently utilises the management information System A, to monitor Housing related case files, including those relating to HMO Licencing. A review of the system confirmed that the Council had received 167 applications for HMO Licencing between 1 January 2022 and 31 December 2022.
3. We would like to thank everyone contacted during this review for their help and cooperation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 9 January 2023.
5. We identified the following potential key risks:
   - Outdated processes can result in the Council being in breach of current legislative requirements or in breach of current policy decisions;
   - Where statutory requirements for license applications are not being met, there is a risk that licenses might be granted to unsuitable properties resulting in health and safety or safeguarding risks;
   - There is a risk of financial loss to the Council as the license holder may not pay after obtaining a license;
   - Where enforcement action is not being taken where necessary, there is a risk that illegal HMOs continue to run without a license; and
   - Where poor performance is not identified and/or addressed promptly, there is a risk that underperformance continues leading to poor customer service.
6. A review of System A management information system noted that the Housing Team had not received any complaints concerning a breach of HMO Licence conditions over the previous two calendar years from the point of audit (January 2023).

Therefore, we could not conduct testing in this area and obtain assurance regarding the control framework outlined in the Housing Enforcement Policy.

AUDIT OPINION

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

AUDIT OPINION	
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.

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

SUMMARY OF FINDINGS

8. Our audit identified areas of good practice and sound controls as set out below:

- The Council have in place a Housing Enforcement Policy, which outlines the requirements of the Housing Team concerning Housing Complaints raised by members of the public or other organisations, including procedures regarding HMO properties. The Policy contains a Version Control table noting the last review date as April 2021, with the following review dated April 2023.
- The Council currently identifies potential HMO properties through three different methods:
  - A complaint received by the Housing Team;

- The Planning Enforcement Team notifies the Housing Team of an application for a potential HMO renovation; and
- An application has been raised by an HMO property owner.

The Housing Team also advised that the Council undertook a proactive identification exercise in 2021 to identify HMO properties within the Borough. However, the Housing Team determined that the exercise was not cost-effective upon completion as no properties had been identified. It is not planned to complete this again in the future.

- A review of the Council's website noted that information relating to HMO Adopted Standards and applications for an HMO Licence are available to the public, with separate guidance for tenants and landlords. Guidance on specific fees and the payment of the HMO Application process are outlined before the individual completes the application.
- The Housing Team have introduced a new management system, System B, as of January 2022. Applications are received through the System B application on the Council's website. Once the application has been completed, and the first initial payment has been received, the application is processed through System A and saved as a PDF form.
- We identified 167 applications were received by the Council between the 1 January 2022 and 31 December 2022 period. Within these, there were 4 refused applications (100% of refused applications in the period) that were included in our sample testing. Testing of a sample of 14 applications taken from System A for the 2022 calendar year identified 10 applications resulting in a licence being issued and 4 resulting in refusal. In all cases, a completed application was received and retained on System A.
- The HMO Licence fee is split into two fees, one relating to the administration cost of processing the application and the second relating to the cost of an approved application. The Council should not issue the licence to the applicant until the second payment has been received. From the sample of ten approved HMO Licences between 01 January and 31 December 2022, we confirmed that the second HMO fee payment was received before the licence was issued in all cases.

9. Our audit review has, however, identified the following areas which we would like to bring to management's attention:

- Before an HMO Licence is issued for a successful application, a member of the Housing Management Team must review and sign the Licence to evidence approval. Currently, licences may be signed by the Housing Regulation Manager, the Head of Service for Community Safety, Licensing, Environmental and Domestic Regulation or the Assistant Director for Public Protection. Once signed, a copy of the Licence must be retained on the System A to evidence compliance. From our previously selected sample of ten licences issued by the Housing Management team between 01 January and 31 December 2022, we identified three cases where the Housing Team could not demonstrate a signed licence being retained on the System A.

- The Finance Team completes an annual reconciliation between the Council's Financial Management System and System A to highlight potential variances between systems on income received and issued to the Housing Team for review. However, the Housing Team noted that they currently do not have access to the Council's Financial Management System and thus cannot complete a regular reconciliation with System A.
- A review of System A, noted that for the four cases within our original sample of 14 applications submitted where a licence was refused, a secondary payment was initially received at the start of the process. On review of the system, it was noted that the payments were still recorded as being received. Discussions with the Housing Team confirmed that these refunds had not been processed.
- Before a decision regarding an HMO licence is issued to an applicant, a secondary independent check must be completed at two stages. One before issuing a proposal to licence and the second before issuing a decision regarding the licence. This should be completed by an Officer independent of the processing of the application and should be recorded on System A.
- A review of the System A noted that while the Officer's name is recorded with the date of the review noted, this is inputted by the validating Officer and not by the reviewing Officer. Furthermore, no evidence that the review has occurred is recorded on the system, such as email confirmation from the independent Officer.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

10. The findings of this report and an assessment of the risk associated with any control weaknesses identified are detailed in the Detailed Findings / Management Action Plan. Any management recommendations are prioritised in line with the criteria set within Appendix B

1. Approval of HMO Licences	
Finding Before an HMO Licence is issued for a successful application, a member of the Housing Management Team must review and sign the Licence to evidence approval. Currently, licences may be signed by the Housing Regulations Manager or the Assistant Director for Public Protection. Once signed, a copy of the Licence must be retained on System A to evidence compliance. Testing of a sample of ten licences issued by the Housing Management team between 1 January and 31 December 2022 identified three cases where the Housing Team could not demonstrate a signed licence being retained on System A. **Risk** Where a signed copy of the HMO Licence issued is not retained on System A, there is a risk that the Council have not complied with internal approval limits before issuing Licences. This may result in inappropriate or inaccurate Licences being issued to properties that do not meet the adopted Standards of the Council.	
Recommendation The Council should ensure that Licences are signed by an approved staff member before being issued. A copy of the signed Licence should then be retained on System A, to evidence compliance.	**Rating** Priority 2
Management Response and Accountable Manager The Team are aware of the signatory requirements and a Licence Holder is unlikely to accept a Licence that has not been signed as it would not be valid. The Team will be reminded of the requirement to scan and document the signed copy of the licence. This process will be digitised as part of the systems upgrade project where it should streamline document processing with the possibility of automating the process of saving final documents.	**Agreed timescale** Short Term – 1 month (end of April 2023). Long Term 6-12 months (between September 2023 and March 2024)

	– dependent on System C Project delivery
2. Regular Reconciliation between System A and Financial Management System	
Finding An annual reconciliation between the Council's Financial Management System and System A is completed by the Finance Team to highlight potential variances between income received and issued to the Housing Team for review. However, a discussion with the Housing Team noted that they currently do not have access to the Council's Financial Management System and thus cannot complete a more frequent reconciliation with the System A. **Risk** Where regular reconciliations between the Council's Financial Management System and System A are not completed, there is a risk that the Housing team are unaware of missing or inaccurate payments concerning HMO Licencing fees.	
Recommendation The Housing Team should contact the Finance Team within the Council regarding access to the Financial Management System or obtaining a monthly reconciliation. The Housing Regulations Manager should review and approve this, with any variances highlighted and investigated. The Housing Regulations Manager should sign and date these reconciliations to evidence compliance.	**Rating** Priority 2
Management Response and Accountable Manager The Finance Team will provide monthly transaction reports for budget code R58070. This will be reconciled by the Housing Enforcement Manager.	**Agreed timescale** 31 May 2023

3. Refund of Secondary Payment for Refused Licences

Finding

While the Finance and System A are not directly linked, System B allows the systems to be indirectly linked. A discussion with the Housing Team confirmed that since January 2022, payments had been received through System B, which occurs once an application has been processed. The first payment received by Council is automatically inputted into the application file. Email confirmation of the second payment is provided to a shared Housing Inbox, with the completing Officer inputting the payment date on System A. However, the system does not retain evidence of the email received in the shared box.

A review of System A noted that for the four applications submitted where a licence was refused, a secondary payment was initially received at the start of the process. On review of the system, it was noted that the payments were still recorded as being received. The Housing Team advised that these refunds had not been processed.

Risk

Where evidence of the second licence fee payment is not retained on System A, there is a risk that HMO Licences may be issued to applicants before the Council receiving full payment.

Where refunds are not issued to a public member once an application has been refused, there is a risk that the Council may be viewed as obtaining payment for services that have not been completed. This could result in reputational damage and legal actions taken against the Council.

Recommendation	Rating
The Housing Team should ensure that evidence of the second payment being received is recorded within the System A, such as the email received by the Shared Inbox being uploaded to a case file. Where a payment has been received in error by the Housing Team, such as when a second fee payment is received on the refusal of an application, the Housing Team should inform the applicant of the error and provide steps to recuperate the funds. The Housing Team should obtain evidence that a refund has been processed before closing an application file.	Priority 2

Management Response and Accountable Manager	Agreed timescale
Payment of the Part 2 fee is automated by System B. Officers will be reminded of recording requirements and will be referred to the Officer User Guide for inputting into System A. Where a payment has been incorrectly received a refund will be issued. Fulfilling Recommendation 2 will assist with identifying these cases. The System C project will consider the payment process and input into the System A to design out human error in this instance. The payment system should not allow a Part 2 payment unless the licence is to be granted.	**30th June 2023** Process involves 3rd parties so likely to take longer to finalise

4. Independent Secondary Checks

Finding

Before a decision regarding an HMO licence is issued to an applicant, a secondary independent check must be completed at two stages. One before issuing a proposal to licence and the second before issuing a decision regarding the licence. This should be completed by an Officer independent of the processing of the application and should be recorded on System A.

A review of System A noted that while the name of the Officer is recorded with the date of the review noted, this is inputted by the validating Officer and not by the reviewing Officer. Furthermore, no evidence that the review has occurred is recorded on the system, such as email confirmation from the independent Officer.

Testing of a sample of 14 applications received by the Housing Team between 01 January and 31 December 2022 identified the following:

- For five cases, the team were unable to evidence an independent secondary check for a proposal being completed; and
- For seven cases, the team could not find evidence of an independent secondary decision check being completed.

Risk

Where an independent Officer does not confirm they have reviewed an application file, nor where evidence of this review is retained on System A, there is a risk that secondary independent check procedures may be bypassed, resulting in HMO Licences being issued where errors or incomplete application processes have been undertaken.

Recommendation	**Rating**
The Council should ensure that evidence of a second independent check of the application process is retained on System A to evidence segregation of duties between the two Officers. This may be in the form of retaining email confirmation from the independent Officer within System A.	Priority 2
Management Response and Accountable Manager Confirmation of the independent check will be required via email and the document recorded on System C to the record.	**Agreed timescale** 31 May 2023

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.