PART 1

BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

THE LONDON BOROUGH
www.bromley.gov.uk

TELEPHONE: 020 8464 3333

CONTACT: Stephen Wood
stephen.wood@bromley.gov.uk

DIRECT LINE: 020 8313 4316

DATE: 21 March 2024

AUDIT AND RISK MANAGEMENT COMMITTEE: INFORMATION BRIEFING

Meeting to be held on Thursday 28 March 2024

This briefing will only be debated if a member of the Committee requests a discussion be held, in which case please inform the Clerk at least 24 hours in advance indicating the aspects of the information item you wish to discuss.

1 INTERNAL AUDIT REDACTED REPORTS (Pages 3 - 12)

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

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

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

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

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FINAL INTERNAL AUDIT REPORT

PARKING INCOME

PLA/11/2022

January 2024

Auditor	Assistant Manager
Reviewer	Manager
	Partner

Distribution list

Job Title
Head of Service Shared Parking Services
Assistant Director of Traffic and Parking
Director of Environment and Public Protection

Executive Summary

Audit Objective	The overall objective of the audit was to review the effectiveness of controls over the adequacy, identification, monitoring and accounting of Parking Income to confirm charges applied are in accordance with those approved by the Council, and monies due are promptly received and banked.

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.	-	1	2

Key Findings

We identified areas of good practice and sound controls as set out below:

1. We reviewed the report titled "The review of parking fees and charging processes" from the Director of Environment and Public Protection to the Portfolio Holder for Transport, Highways & Road Safety dated 22 November 2022. We confirmed that the parking charges were considered, scrutinised, and approved, as detailed in the ECS PDS meeting minutes.
2. We reviewed the Parking Orders document, including details such as the location of the parking place, number of spaces, special bays, machines, height barrier, our pay by phone provider, days and hours of operation, payment method and type, and tariff. Upon comparison of the above-mentioned report and the Parking Orders documents, we confirmed that the parking charges being applied are in accordance with those approved by the Committee.
3. We conducted a sample test of ten transactions (dated between January and April 2023) from the contractor's parking income listing to reconcile them to the Council's bank statements, we confirmed that the monies were banked completely (as per the income listings) and timely.
4. Our review of five months (January to May 2023) reconciliation reports (pay by phone provider, the Council's parking system, Multi Storey Car Park, and main accounting system) produced by the service provider against the income report from the Council's Finance system found no discrepancies. The reconciliations were carried out by the Performance Contracts Officer and ICT and Project Manager.
5. We selected a sample of ten PCNs from the cancelled/closed PCNs report (July 2022 to May 2023 period) to determine if the Notice Supervisor had checked a sample of cancelled PCNs and had adequate supporting evidence that justified the cancellation. We confirmed they were supported evidence, such as the cancellation letter, which provided its reasons. In addition, we obtained the case report as evidence that the Notice processing Supervisor regularly checked a random sample of cancelled PCNs, and we also obtained the screenshots from the system as evidence of authorisation for cancellations where applicable.

6. We sampled ten PCNs from the open PCN report (July 2022 to June 2023 period), and we noted that for nine out of ten, there was evidence that attempts were made to recover debt. In cases where debt remained outstanding, we confirmed these were handed over to third-party collection agencies, and payment was received in some cases. For some others, these were put on hold due to financial difficulties from the debtors. This was evidenced by reviewing the screenshots from the system.
7. For one PCN, we obtained a screenshot from the system. It was explained that this could not be chased due to the fact that the DVLA was unable to provide the name and address of the registered keeper of the vehicle. Therefore, no statutory documents have been sent for this case.
8. A signed contract agreement between the Council and the service provider is dated 31 March 2017. This is in respect of civil parking enforcement and associated services. The contract is valid for 10 years and covers key service delivery areas, such as financial arrangements, staff and complaints, contract management, and financial /contract monitoring.
9. The contract is accessible to relevant staff via the Council's shared site.
10. KPIs are in place in respect of the service provider as set out in the Bromley KPI Master table Appendix 10A of the contract. There are 92 KPIs which are monitored monthly through the Bromley Master KPI Table per the performance-related deductions expressed in monetary values, and supporting KPI sheets are produced for monitoring purposes. We reviewed the Bromley Master KPI Table spreadsheets for March, April, and May 2023. We confirmed that, in most instances, the KPIs were met. Where KPIs were not met, no action was taken because the performance-related reduction was below the defined threshold.
11. The Council holds monthly contract meetings with the Business Processing Unit (BPU) (the back-office administration office responsible for responding to customer emails, amongst others). Reviewing the March, April and May 2023 meeting minutes confirmed the relevant issue regarding the contract matters specific to the KPIs were discussed.
12. We obtained the above meeting minutes with the providers Operations Contract meeting for March, April, and May 2023. We confirmed that operational contract matters were discussed.
13. Parking Services produces a Contractor Performance Review – Redacted Parking, January 2023, submitted to the Portfolio Holder for Transport, Highways and Road Safety. The report's purpose is to update Members on the performance of the Parking Services Contract. We reviewed the report and confirmed that some of the areas reported upon were to update Members on the performance of the Parking Services Contract, PCNs issued via CCTV, Key Performance Indicators, and Cashless system.

We have identified the following areas for management attention:

14. **Monies due and reconciliations – Refunds** (Priority 2) We reviewed the reconciliations for cashless revenue for January to May 2023 and noted that refunds were made. However, we were not provided with evidence that an appropriate level of authority authorised all the refunds. We received approval emails confirming that the Parking Support Officers approved some refund amounts, but these refunds were not then independently checked or authorised by a senior manager. ***See Recommendation 1***

15. We also raised two 'Priority 3' recommendations regarding reviewing and updating the Notice Processing Policy and the independent review of monthly reconciliations.

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

Definitions of assurance opinions and priority ratings are in ***Appendix B****.*
The scope of the internal audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. Monies Due and Reconciliations – Refunds

Finding

We reviewed the reconciliations for cashless revenue for January to May 2023 and noted that refunds were made. However, we were not provided with evidence that an appropriate level of authority authorised all the refunds. We received approval emails confirming that the Parking Support Officers approved some of the breakdown refund amounts but there were no second checks or spot checks by a manager on the validity of the refunds. The total refunds processed for each month reviewed were as follows:

Month	Refund Amount
January 2023	£ 1,498.70
February 2023	£ 1,450.06
March 2023	£ 61.75
April 2023	£ 1,413.42
May 2023	£ 10.50

Risk

Where the Council cannot demonstrate that refunds are appropriately authorised, there is a risk that refunds are not appropriately authorised and are made for invalid transactions, leading to financial loss.

Recommendation	Rating
Implement second authorisations or management spot checks on the refunds that are authorised by Parking Officers. The Council should maintain evidence of approval with the relevant supporting document for all refunds.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**

Parking Services are able to start a monthly sign off for all pay by phone refunds that have been authorised by a Parking Support Officer for that month, this will be signed off by the Parking Supervisor.	Feb 2024

2. Policies and Procedures	
Finding We reviewed the 'Notice Processing Policy Consideration Guidance', which is for Council Officers to use, and it is a matrix detailing different circumstances where Notices could be either accepted or rejected. This document also links circumstances to other Policies such as bank holiday restrictions, blue badges and dropping off passengers. However, we found that this guidance was not dated or version-controlled. Therefore, we cannot confirm if it is up to date or subject to regular reviews when circumstances change. **Risk** Where procedural guidance is not dated with version control, there is a risk that the guidance does not align with current legislation, or inconsistent practices may exist where procedures do not reflect operations in practice. This could result in non-compliance with the legislative requirements or inefficient working practices.	
Recommendation Management should consider defining the process of periodic review schedule for the 'Notice Processing Policy Consideration Guidance' to ensure ongoing reviews take place for this document and any other relevant policies and procedures. Documents should be assessed to determine the frequency of review required. Subsequently, evidence of review should also be shown on the policies and procedures by updating the document version control and including the next review date.	**Rating** Priority 3
Management Response and Accountable Manager A version control will be added and a next review date.	**Agreed timescale** April 24

3. Monies Due and Reconciliations – Independent Checking of Reconciliations	
Finding We were informed by the Head of Service Shared Parking Services that monthly reconciliations between the reports produced by the service provider against the income report from the finance system are carried out by the Performance Contracts Officer and the Parking Projects and Information Communications Manager (ICT) Manager. We reviewed the reconciliations for the five months January to May 2023 and observed that these were completed in a timely fashion and balanced. However, the Head of Service Shared Parking Services advised independent checks were performed by the Finance team and the Head of Service Shared Parking Services. We were provided with the spreadsheets as evidence of independent checking; however, the spreadsheet did not specify who independently checked the reconciliations. **Risk** Where the reconciliations are not independently checked, there is a risk that errors, omissions, or misstatements may go unnoticed.	
Recommendation The Council should maintain a robust audit trail as evidence of independent checking of reconciliations.	**Rating** Priority 3
Management Response and Accountable Manager A monthly sign off can be completed and recorded. This will be signed and dated by the Head of Shared Parking Services	**Agreed timescale** April 2024

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 risk areas: • **Tariffs** - Robust process is in place to determine and approve car parking charges by Council, with sufficient scrutiny and challenge, and - Charges being applied for car parking are in accordance with those approved by the Council. • **Monies Due and Reconciliations** - All monies due to the Council in respect of car parking are promptly received and banked, and - There is an effective reconciliation process between monthly activity reports and payments received in respect of all car park activity. • **PCNs** - To confirm issued and cancelled on-street parking fines are supported with appropriate evidence, and - To confirm actions are taken to recover debt/outstanding PCNs. • **Contract Monitoring** - To confirm a signed contract is present between the two parties; - The Councils' contract with the provider enables the Council to issue rectification notices and default notices to the Contractor where service delivery falls short of expectations; - Where applicable, rectification/default notices had been issued appropriately; - The assigned Contract Manager attends monthly operational contract monitoring meetings with the contractor's representatives, and - Key performance indicators relating to Parking activity are in place and are reported to a relevant Committee.

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REDACTED

FINAL INTERNAL AUDIT REPORT

COMMUNITY SAFETY

PLA/01/2023

NOVEMBER 2023

Auditor	Principal Auditor
Reviewer	Head of Audit & Assurance

Distribution list

Job title
Assistant Director, Public Protection
Director of Environment & Public Protection
Head of Safer Communities

Executive Summary

Audit Objective	The overall objective of the audit was to review the adequacy and effectiveness of the Council's arrangements to discharge its duties under the Crime & Disorder Act 1998. This is achieved through the Safer Bromley Partnership and through working together on the priorities contained within the Safer Bromley Partnership Community Safety Strategy 2020-23. The approach of this audit was as a critical friend.

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	1

Key Findings

This audit was undertaken during a period of change. Some of the team were relatively new in post and there were vacant posts. The service is undergoing a number of improvements that have been put in place whilst the audit has been undertaken.

We identified areas of good practice and sound controls as set out below:

1. Partners of the Safer Bromley Partnership Board were supportive of the Chair and her team. Partners recognised the collaborative way of working, which was valued.
2. The team has put in place plans for the new Community Safety Strategy for 2024-27 and are consulting on the proposed priority areas. This has been highlighted during a workshop for all Safer Bromley Partnership Board (SBPB) partners, Councillors and officers.
3. Partners and officers highlighted the good levels of communication inside and outside the Board and also that actions of the Board were usually delivered by the next meeting.

We have identified the following areas for management attention:

4. **Safer Bromley Partnership Board** (Priority 2) – The Constitution and the Terms of Reference of the SBPB had not been reviewed recently and does not reflect current roles or structure, the status of published minutes and how the Board feeds into other meetings. ***See Recommendation 1***

5. **Community Safety Strategy Awareness** (Priority 2) – Performance measures have not been in place to assess delivery of the four priorities detailed within the Community Safety Strategy 2020-23 and there are gaps in information available to residents on the Bromley website. ***See Recommendation 2.***
6. **Procedures, documents & process maps** (Priority 2) – Procedures and other documents were found to be in need of reviewing and updating to reflect the current processes, structure and terminology. ***See Recommendation 3.***
7. **Anti-Social Behaviour & Safer Communities Team** (Priority 2) – There is a risk that Anti-Social Behaviour (ASB), Noise and Nuisance complaints could be incorrectly classified on initial triage and there are insufficient controls to detect and rectify this at later stages. ***See Recommendation 4.***
8. **Management Information System** (Priority 2) – There are data quality issues regarding the numbers of cases currently showing as 'open' on the case management system. ***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 ratings are in ***Appendix B****.*
The scope of our audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. Safer Bromley Partnership Board

Finding

The Safer Bromley Partnership Board (SBPB) was set up in line with the Crime and Disorder Act, 1998 to ensure that the public sector agencies, voluntary groups, and businesses work together with local communities to reduce crime and improve safety. The Crime & Disorder Act 1998 establishes partnerships between the local authority, police, probation, health, and fire services and these are the statutory partners. The SBPB currently meets quarterly.

This is in line with the 'Making Bromley Even Better' Ambition 4 'For residents to live responsibly and prosper in a safe, clean and green environment great for today and a sustainable future'.

We reviewed relevant documents pertaining to the Safer Bromley Partnership Board namely, the Constitution and the Terms of Reference.

Constitution

The Constitution document was last reviewed in February 2008. The document needs to be revisited to ensure responsibilities and the relevant roles are clearly identified for statutory and non-statutory partner organisations, both strategically and operationally.

The membership of the SBPB needs to be reviewed at the same time, to ensure that members in attendance are senior postholders (and nominated deputies) to ensure that the statutory and non-statutory partner organisations are sufficiently represented.

Terms of Reference

The Terms of Reference was last reviewed in March 2017 and also includes the Terms of Engagement. This document makes reference to the Bromley Community Engagement Forum, which ceased to exist in 2015. Clarity could be provided to partners within the Terms of Reference regarding the expectations and responsibilities as a Board Member, including attendance.

SBPB Organisation and Management

We reviewed the minutes of the meetings. In our view, these minutes are informative and provide a high level of information, which is publicly available. We noted that the minutes are published as draft copies and not final copies.

It was unclear from reviewing the minutes, that there was a forward plan for the SBPB to enable the partnership to be as effective as possible, fully meeting its objectives and to ensure that the Board is proactive rather than reactive.

The SBPB has been receiving a verbal update on crime data and to make this more relevant and informative, the way in which the data is presented will be changed from December 2023. There will be a presentation slide which will show crime levels by ward and by street level which will provide greater clarity and engagement of the data for partners.

It should be noted that there is no data analyst post available to undertake analysis on behalf of the Board.

Meetings, undertaken throughout the audit, with partners and officers, to gather their feedback, highlighted that there should be clarity around how the SBPB feeds into other meetings. They also highlighted a need for clarity of the role of each partner organisation and what they bring to the SBPB.

Redacted – Individual Partner & Officer Feedback

Risk

Without the agreed direction and functions of the SBPB clearly defined, the Board may not be able to be effective in the delivery of the Board's priorities, to impact levels of crime and disorder.

A lack of planned focus on the desired outcomes, may lead to reputational risk to the Authority and may also lead to worse outcomes for vulnerable residents.

Recommendation	**Rating**
The Constitution and Terms of Reference of the SBPB should be reviewed and updated. This should also include notifying Board Members of their obligations and responsibilities as a Board Member of the SBPB, including attendance.	Priority 2

The membership of the SBPB should also be reviewed, to ensure that there are sufficiently senior postholders in attendance (and nominated deputies), that the statutory and all non-statutory partner organisations are sufficiently identified and represented. A forward plan for the SBPB should be in place to enable the partnership to be as effective as possible and to ensure that the Board is proactive rather than reactive.	
Management Response and Accountable Manager	**Agreed timescale**
The Co-Chair will ensure the Constitution and Terms of Reference of the SBPB are reviewed in Q4 of 23/24 and implemented in April 24 with the commencement of the new Strategy.	30/04/24
The Head of Safer Communities will undertake a review of the SBP Members and circulate the updated Members list for discussion at the 29 February 2024 SBP meeting.	29/02/24
A draft Forward Plan was presented at the December 2023 for consideration by partners, items were added for the next meeting in February and partners were encouraged to proactively suggest agenda items for the Forward Plan.	6/12/23

2. Community Safety Strategy

Finding

The broad strategic themes of the SBPB have been identified as priorities within the Community Safety Strategy 2020-2023 (current strategy). This contains four priorities namely:

- Safer Neighbourhoods
- Violence against Women & Girls
- Keeping Young People Safe
- Stand together against hate crime and extremism.

Testing undertaken during the audit related to identifying how the progress and implementation against each priority is monitored and whether key performance indicators (KPIs) are utilised. We found that KPIs are not used as a performance measure, but instead regular narrative updates are provided to the SBPB meetings on progress made against each priority. Performance measures would have helped the service measure implementation of the four priority areas. However, this gap in performance measures has been acted upon and the updates against priorities provided against each of the four priority areas are now presented in a newly refreshed format with outcomes.

The Bromley Community Safety Strategic Assessment 2023 details the suggested priorities for inclusion for 2024-27.

The service has been proactive in organising and delivering workshops for partners, Councillors, and officers to attend, to gather feedback on proposals to further develop the service, most recently in November 2023. For those who were unable to attend, there is the opportunity to provide the feedback online.

The current Crime Prevention and Community Safety webpage on Bromley Council website does not detail the Community Safety Strategy for 2020-2023. The Strategy is difficult to locate unless searched for by name. The website for Community Safety does not provide relevant guidance and information for residents to access.

Redacted – Individual Partner & Officer Feedback

Risk Residents are unable to have access to useful guidance on community safety issues, that could be readily available, without having to contact the Council.	
Recommendation The Crime Prevention and Community Safety webpage should be updated to provide residents useful information, such as how to deal with neighbour disputes, noise and nuisance and anti-social behaviour and contact information for the service. The Community Safety Strategy should also be available on this webpage along with information about the Safer Bromley Partnership Board.	**Rating** Priority 2
Management Response and Accountable Manager The Public Protection Service currently have additional officer resource. They have been tasked to review the Community Safety Webpages and look at the options for developing a Safer Bromley Partnership website which can be jointly managed by the partner agencies, however, the delivery of this will be subject to available resources to fund the webpage development and provide a sustainable resource to ensure it remains up to date. The Council's webpage will be updated by the end of July 2024, to ensure it is consistent with the new Community Safety Strategy 2024/27.	**Agreed timescale** 31/07/24

3. Procedures, Documents & Process Maps

Finding

We reviewed procedures as part of the testing. These included the Out of Hours Service Operating Manual and the Nuisance and ASB Team Processes and Procedures for Case Management dated 24/11/21 and last reviewed on 1/5/22.

ASB staff have not been able to access the Manual as this had been password protected until recently. Supplementary procedures are dated 2009, and there are process charts additionally.

We noted that staff have not been able to access the manual for some time now due to the password protection. A member of the Community Safety team also confirmed that they were unaware of any procedures being in place.

There has been a recent change in the out of hours service and this will need to be reflected within the procedures.

Complaints come in via Customer Services and the Out of Hours service, who allocate the case to an officer, inputting the data directly onto System A. This should be accompanied by an email to the allocated officer to alert them so that they are aware of the input and allocation of the case to them; however, this process for the email to be sent has not been included within the procedures. The Contracts and Project Manager advised on 1/11/23 by email that 'All service requests which come in via CSC either by phone or webform, trigger an automated email to the relevant teams mailbox'. There were instances highlighted during the audit where this had not happened, but we were advised on 13/11/23 by email that this issue has since been resolved. The Contracts and Project Manager advised that 'the new system, System B, will reduce the number of these points of failure, as we will be able to manage new cases directly in the system rather than relying on the use of mailboxes'.

The Contracts and Projects Manager advised by email on 1/11/23 that 'It is the responsibility of officers to review and correct any information on the System A case which includes reviewing the complaint code allocated to the case. We also have instances whereby the initial complaint may be for example a noise issue but on further investigation by the officer this subsequently changes to a complaint of anti-social behaviour. Again, it would be the responsibility of the case officer to change any coding on the System A case'.

(See Recommendation 4 which relates in part to a review all reported complaints to determine classifications are correct. This process will need to be added to the procedural documentation).

The Prevent Strategy is dated September 2020. The document needs to be updated to reflect the current structure and reviewed to confirm that the content remains relevant.

The Information Sharing Agreement for the purpose of the Channel project is to be reviewed annually. A copy of the 2023 Agreement has not yet been provided to us.

The Prevent Case Management Declaration requires updating to reflect the current structure.

The LB Bromley Prevent Duty Risk Assessment is dated 2023 but does not reflect the current structure. The risk assessment is incomplete for 'Council owned venues' and the impact of failure requires further clarity. The current risk score has not been added. There is no date for the annual review of the current risks. If the risk score changes the appropriate review should be scheduled, within the appropriate timescale.

Risk

Staff may not be sufficiently prepared to deal with the challenges in this service area, leading to incorrect decisions being made.

Recommendation	**Rating**
All documents, procedures and process maps should be fully updated to reflect the current processes, structure, and terminology.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The Public Protection Service currently has an additional officer resource who has been tasked to review the current processes, including the Prevent Plan, Domestic Homicide Review Protocol, and the Information Sharing Protocol.	30/04/24
The review of the noise and nuisance offer has been completed and is now available on the Division's noise and nuisance webpages.	30/06/24
There is a review of the delivery of the ASB Service to determine the right structure for future delivery, all associated documentation will be updated and shared with officers as part of this process.	

4. Anti-Social Behaviour & Safer Communities Team	
Finding The Terms of Reference for the Anti-Social Behaviour Forum refers to the ASB Panel within the title of the document. Our discussions with relevant officers highlighted concerns that there was overlap of the ASB and noise cases and that staff that had not completed ASB training, may not be aware that cases fall under ASB and not Noise and vice versa. Staff taking the calls in customer services would also not be expected to know what would constitute a noise complaint or Anti-Social Behaviour per se. The Contracts and Projects Manager advised by email on 1/11/23 that 'It is the responsibility of officers to review and correct any information on the System A case which includes reviewing the complaint code allocated to the case. We also have instances whereby the initial complaint may be for example a noise issue but on further investigation by the officer this subsequently changes to a complaint of anti-social behaviour. Again, it would be the responsibility of the case officer to change any coding on the System A case'. (See Finding 3) Staff across both teams have recognised that they would like to undertake training or refresh their training and competences. **Risk** There is the potential for duplication of work whilst officers investigate to determine the classification of cases and that cases may not be dealt with according to statutory requirements. Staff may not have the necessary skills to be able to undertake the roles and responsibilities, and decisions may be made incorrectly.	
Recommendation The Terms of Reference for the ASB Panel/Forum should be updated. A process put in place to review all reported complaints to ensure that the classification of cases have been correctly determined both currently and in the future. Training should be undertaken to improve skills and competencies within the teams.	**Rating** Priority 2

Management Response and Accountable Manager	**Agreed timescale**
A review of ASB and nuisance services has started. This will determine the optimal structure for the future delivery of these services. This review will consider the role of a Panel or Forum and propose a new way of working to ensure appropriate involvement of internal and external partners in case management, for developing solutions to persistent issues, and to ensure that officers have appropriate information through different learning approaches, including training, mentoring, and learning reviews.	30/06/24

5. Management Information Systems	
Finding The Contracts and Projects Manager confirmed by email on 21/11/23 that the total number of open records on System A was 334 which represents all teams. Of these 334 cases, 132 records relate to the Community Safety and Nuisance & ASB teams. There are data quality issues regarding the numbers of cases currently showing as 'open' on the System A. **Risk** Data Quality within the new system B will be impacted on transfer of such data.	
Recommendation Open records on System A should be investigated and those that are no longer live cases, formally closed off in advance of the system B go live date in 2024.	**Rating** Priority 2
Management Response and Accountable Manager A data cleansing exercise is underway and will be completed ready for the System B launch in September 2024.	**Agreed timescale** 30/09/24

6. Funding for Project	
Finding Concerns were raised by the Head of Safer Communities regarding an amount of funding that was provided by the previous Strategic Lead for circa £10,000 to Organisation A. At the time of testing, there had been no confirmation of the purpose of the funding, supporting documentation, and outcomes/ deliverables, as a result of the funding being provided. **Risk** Inability to substantiate how grant monies have been utilised, which may lead to funding restrictions or reductions.	
Recommendation Confirmation should be provided to confirm the details of the funding, how the funding has been utilised and the resultant deliverables. All supporting documentation should be readily available.	**Rating** Priority 3
Management Response and Accountable Manager The Head of Safer Communities has provided a matrix of the grant funding that has been made available and provided the reports to Organisation B. New arrangements will be outlined in the documents for the 24/25 financial years, and all new agreements and grant allocations will be stored on the relevant Systems C, to ensure they are readily available in future.	**Agreed timescale** 30/03/24

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: ○ Governance arrangements may not be effective, resulting in a lack of consistency of approach across the service and partner agencies, and a lack of joined up working ○ Strategy awareness and communication activities are not effective, leading to awareness not being embedded. Priorities detailed within the strategy are not evaluated for implementation, leading to reputational risk to the Authority ○ Poor service delivery and performance, the Community Safety team does not meet the expectations or the needs of residents ○ Lessons learnt and the resultant changes to approach and policy are not taken forward. We did not include Domestic Abuse (Violence Against Women and Girls) as this was covered in our 2022 audit of Domestic Abuse. This review also did not include CCTV, Noise & Nuisance specifically. We did not review instances of community safety at case level. Anti-Social Behaviour complaints relating to locations, the work of the ASB Panel and the Community Trigger processes will be reviewed.

REDACTED

FINAL INTERNAL AUDIT REPORT

DISCHARGE TO ASSESS

PEO/10/22

1 December 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list
Director of Adult Services
Assistant Director of Integrated Commissioning ASC
Assistant Director ASC - Operations
Associate Director – Discharge Commissioning, Urgent Care and Transfer of Care Bureau (ToCB)
Operations Manager, Short Term Intervention
Assistant Director for Safeguarding, Practice and Provider Relations, ASC
Head of Finance ASC, Health and Housing

Executive Summary

Audit Objective	The objective of this audit was to review Discharge to Assess arrangements to ensure efficiency, best outcomes for the client and best use of Council Funds.

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

Key Findings

The D2A service starts with processes owned and delivered by the Local Care Partnership and we acknowledge the good practice evidenced by the Integrated Commissioning Service with regard to quality assurance and SPA discharge procedures. Our review of the D2A process has been completed from the point of referral to the Adult Social Care (ASC) Hospital Team through to the draft Support Plan referred to the Brokerage Team. The three main elements of our review were the assessment process, financial management and performance monitoring.

We have identified the following areas for management attention:-

Financial Management and Budget Monitoring (Priority 1) – There is no Operations Service budget monitoring of D2A expenditure, nominated budget holder or responsibility for actual spend. There is no process to identify, review and resolve high spend, long term D2A cases. There was no clarity or formality for the transfer of D2A cases that have exceeded the 6 week threshold. There was no priority set to refer Financial Assessment requests in a timely manner to achieve client contributions where applicable. ***See Recommendation 1.***

Operational Procedures (Priority 1) - The ACS Operating Procedures for D2A do not reflect actual service delivery. Key areas of the service are not included or are misrepresented. ***See Recommendation 2***

Performance Monitoring and CASE MANAGEMENT SYSTEM Reporting (Priority 1) – The current weekly reports for D2A do not include adequate information for the responsible ASC officers to make informed decisions regarding the service, identify log jams and pressure points or represent the service at the Strategic and Operational SPA Interface Boards. ***See Recommendation 3***

Consistency and Accuracy of CASE MANAGEMENT SYSTEM record keeping (Priority 2) – Audit testing on a sample of D2A cases over 6 weeks for both Domiciliary Care and Residential Placements identified inconsistencies, anomalies and omissions with data input, dates and record keeping. ***See Recommendation 4***

Our findings and recommendations are detailed in **Appendix A**. Management have agreed actions to all of our recommendations and the detailed Management Action Plan is set out in **Appendix B**.

Definitions of our assurance opinions and priority ratings are in **Appendix C**.

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

Appendix A - Recommendations

1. Financial Management and Budget Control
Finding The Assistant Director of Integrated Commissioning ASC and the Associate Director Discharge Commissioning, Urgent Care and ToCB control the funding available for D2A from the Better Care Fund and ICB funding streams. However there is no budget control or financial management evidenced in Adult Social Care Operations Service for the D2A expenditure at an operational level. It was not clear which officer has been nominated as the operational budget holder although the Team Leader Hospital Team was assigned to the 22/23 expenditure code. Although there is a designated D2A budget code in the Council's accounting system, all non chargeable D2A service lines are included in the normal Domiciliary Care and Residential Placements budget codes. These can however be identified separately from system reports so that the projected spend can be reported as required and for budget monitoring purposes. The 2022/23 Council budget for D2A was £725K and the actual spend at year end was £3,146K of which £2,780K was met by the Better Care Fund and funding from Health. The 2023/24 Council budget for D2A care packages is set at £956K (as per the budget book) which is partly funded from the Better Care Fund. The June 2023 budget monitoring sets a projected spend of £2,118K for Dom Care and £3,117K for Placements which would be an overspend of £4,279K. However there is Hospital Discharge Funding allocated to both LBB and the ICB for D2A in year of £1,341K which, if fully used, could reduce the projected overspend to £2, 938K. In-year savings could reduce this further as the service aims to reduce the time service users remain in the D2A service. The projected overspend will also fluctuate given the variable number of cases week by week as clients enter and leave the service. Finance produce weekly system reports for ASC expenditure but the suite of reports did not include D2A actuals. The Associate Director takes the weekly financial report to SPA Interface meetings but as they are not responsible for budget monitoring this role should be assigned to the Bromley ASC Operations Officer that attends the meeting. For the audit review Finance generated a bespoke report to identify weekly payments for D2A services over 6 weeks. As at 1.8.23 there were 20 open cases receiving Domiciliary Care with the duration ranging from 7 to 65 weeks, an average of 23 weeks. There were two domiciliary care packages costing more than £700 per week and one case at £661 that had been open for 53 weeks. As at 2.8.23 there were 41 open residential placements of which 28 were more than six weeks the range being between 43 and 253 days with an average of 115 days. These reports show actual expenditure at client level but will enable the service to identify high cost cases, cases approaching the 6 week threshold and long term cases.

There was no clarity regarding the 6 week threshold date for D2A services or process for cases to be transferred to a disputed line or chargeable service line. The weekly report "Temporary Services Following Hospital Discharge" clearly sets out the number of cases still on a non chargeable D2A service line. The current operational arrangement does not align to our D2A funding (which was based on 2 weeks for Domiciliary Care and 4 weeks for Residential Care with a 20% contingency, to allow for the cases up to a 6 week threshold), is contrary to senior management's understanding of current process and is adding financial burden to Public Funds as these services should be transferred to a chargeable service to allow client contribution to be collected where appropriate.

Risk

Overspent budget and/or efficient use of public money.

Non compliance to D2A funding guidelines which may result in reputational damage, poorer outcomes for clients or deterioration in joint working relationships.

Recommendation	**Rating**
ASC Operations Service must nominate a budget holder responsible for D2A expenditure. This officer will then represent financial management and projected spend for D2A expenditure. However for the nominated officer to be effective in this role there should be adequate financial reporting, development and training if required. Formalise the financial reports to monitor actual spend, identify high cost cases, monitor cases approaching threshold and focus resources accordingly. Review the procedure to process D2A cases that have exceeded the 6 week threshold. This will necessitate consultation with all interested parties but predominantly the Hospital Team, ASC Operations Manager and Brokerage. Refer the request for the Financial Assessment in a timely manner to ensure we collect client contribution at the earliest opportunity for chargeable service.	Priority 1
Management Response and Accountable Manager	**Agreed timescale**
Please see Appendix B – Management Action Plan.	

2. Operational Procedures

Finding

Appendix 12 of the ASC Operating Procedures sets out the practice guidance for D2A. These are high level principles for the service but are not step by step definitive procedures. The Operating Procedures do not reflect actual service delivery and are not a comprehensive document to clarify and assign roles and responsibilities.

Section 5.3 "Hospital Team" is a brief overview of the team but does not address any operational guidance or refer to assessments undertaken by the community social work teams.

During the course of the audit we identified several key areas that were not operating as senior management expected:-

- The D2A service line should be limited to 6 weeks, 2 weeks for domiciliary care and 4 weeks for residential placement after which the service should be moved to a disputed line. The number of D2A service lines exceeding 6 weeks is circulated weekly in the "Temporary Services Following Hospital Discharge" report. For week ending 22.7.23 there were 124 clients in receipt of D2A services of which 101 were over 6 weeks.
- From the same report 49 clients were assigned to the hospital team (40%), the remaining cases spread over 16 other teams. There was a lack of clarity during the audit on where cases should be allocated to in ASC. With effect from 31.7.23 the AD ACS – Operations has directed that all hospital discharges are to go through the Hospital Team.

Both examples are key elements of the D2A service and should be formally documented in D2A Operating Procedures available to all officers involved in the process.

There were anecdotal issues raised by the Hospital Team that information provided to the service user at the point of discharge does not reflect their future liability to pay for services and the duration of free support. Whilst there is no documentary evidence to support this, a review of the patient letter (there were several versions available from ToCB and ASC) did not clearly show possible duration of post discharge "free" care and a liability to pay for assessed services.

Risk

Social work practice and / or case management is not as desired, leading to inconsistencies, actions that are not in the best interests of the service user or the Council and increased likelihood of complaints or challenge.

Recommendation	**Rating**
Standard Operating Procedures need to be reviewed, revised and reissued for the D2A process from the point that the case has been referred to ASC, which takes place in the SPA. The procedures need to include the roles and responsibilities of all teams	Priority 1

involved in the D2A process, expected input and output with target times and an expected level of data entry to deliver consistency, completeness and accuracy and ensure management information reflects actual service delivery, identifies pressure points and an improved service for users. The procedures should also include communication (with colleagues in Health, Central Placement Team and Exchequer contractor), updating the case management system and access to management reports generated from the system. The procedures should also include adequate checks to manage social care fraud risks specifically overstatement of need. As a priority the service need to resolve the 6 weeks D2A service line to ensure compliance to agreed D2A funding, transfer to a chargeable service line and applying financial assessments to collect client contribution where appropriate. The service should confirm information distributed at the point of discharge, clarifying key points such as variable duration of care dependent on assessed need in the community and liability to fund. Service user expectations need to be effectively managed and these can be confirmed or reinforced by the Hospital Team Seniors during the first contact call post discharge.	
Management Response and Accountable Manager Please see Appendix B – Management Action Plan.	**Agreed timescale**

3. Performance Monitoring and Case Management Reporting
Finding The ASC Performance Team provide weekly reports to enable managers to monitor their service. For D2A the primary document should be the "Temporary Services Following Hospital Discharge" which has a distribution of 49 officers including senior management. The report shows all open D2A service lines, allocated across ACS and the duration of service. As at 23.7.23 there were 174 service lines of which 101 were over 6 weeks. These numbers will fluctuate given the unpredictability of the service. As at 21.8.23 there were 191 service lines of which 87 were over 6 weeks. These reports should enable the service to identify "log jams" and to focus on pressure points in the process. The issues arising from our review of the case management system reports and performance monitoring are:-

- There was no clear ownership of the information distributed, although we acknowledge that the cases are discussed at the fortnightly Performance Review meetings and the Operations Manager (Short Term Interventions) directs update enquires to the allocated Social Worker.
- Initial interviews with the Associate Director Discharge Commissioning, Urgent Care and ToCB and the ASC Performance Team had a view that the current CASE MANAGEMENT SYSTEM processes present a "log jam" with the hospital or allocated team as the D2A service remains open to this team until moved to a permanent care package or residency. The system report does not include the completed assessment dates and/or support plan date that would confirm when the Hospital Team have completed their work and the case has passed to Brokerage.
- We reviewed the accuracy of data input to the case management system during our sample testing. We found ambiguity of dates, inconsistency of information uploaded and non compliance to procedures. Given the data is the basis of all case management reports and subsequent service decisions, the quality of that data is paramount.
- There is no "tracker" on an individual service user as the case is progressed through the case management system. There is no evident reconciliation between the system reports and outstanding tasks report to reconcile numbers and give assurance that we can account for all service users on a D2A service line.
- There are regular planned meetings for both Strategic and Operational issues, chaired, minuted and with action points. In the current report format the ASC Operations officers do not have the data available and in a format to lead and effectively represent the actual position within their service. This includes ASC case and financial information.
- As discussed in Finding 1 above, there is no operational budget monitoring. There is a weekly Dom Care and Residential Placements financial report generated from the case management finance system by the Finance Team but this had not been filtered to show D2A only and distributed to ASC management. There is no summary report that brings together D2A service at client level and client expenditure to identify high cost and long term service users on D2A.
- It is not clear if the Quality Assurance work completed by the Integrated Commissioning Service and reported to the SPA Interface Meeting is then used by ASC Operations to follow up and investigate any issues at a local level.

Risk

The management information does not represent actual service delivery or allow considered business decisions relating to service pressure points.

Clients are lost in the system incurring additional expenditure for the Authority and a poor outcome for the service user.

Recommendation	**Rating**
Clarify the roles and responsibilities with regard to owning the D2A weekly report, taking action, escalation and compliance to agreed procedures with regard to the 6 week threshold. Develop the system performance reports to include the FCAA completion date to clearly identify the end of the hospital team's responsibility and transfer to Brokerage. Liaise with the ASC Performance Team to develop a suite of reports that will support the ASC representation at the Operational and Strategic SPA Interface Boards. These reports should be in a simplified format, represent the key information required and allow that data to be analysed to support decisions and allocate actions.	**Priority 1**

Liaise with Finance to develop and formalise regular expenditure reports to identify high costs and long term D2A service user to focus review and resolution. Develop a methodology to reconcile all clients held in the case management system and at each stage of the process to limit D2A service, minimise costs and improve service users care and support.	
Management Response and Accountable Manager Please see Appendix B – Management Action Plan.	**Agreed timescale**

4. Consistency and Accuracy of Case Management Record Keeping
Finding We sampled 5 cases that had been on a D2A service for over six weeks from the "Temporary Services Following Hospital Discharge" Report for week ending 22.7.23 and were assigned to the Hospital Team. We found that: • There is no temporary suspension or brokerage work tray to show that the Hospital Team's active role has been completed, when the FCAA has been completed, the support plan drafted and the case transferred to Brokerage. • For our testing and the source of system performance reports, the date fields were used to calculate duration. However the discharge date, allocation to the hospital team, social worker assignment and completion of the FCAA were not easily identifiable or consistent. We had to source dates from a variety of screens and for some clients refer to Case Notes to establish a chronology. We therefore have limited confidence as to the accuracy of dates. • For 4/5 cases checked the FCAA was started within the suggested threshold for Dom Care and Residential Placements, 2 and 4 weeks respectively and completed within the 28 day threshold. The delay on these cases was either prior to the assignment to the Social Worker or once transferred to Brokerage. The sample cases have been shared with the AD ASC Operations for information and investigation where necessary. • There was no evidence that a financial assessment had been completed for 3/5 cases although the FCAA records that the service user had been advised that a Financial Assessment would be required. • The Discharge Passports differed in format and length but neither version showed the actual discharge date. For 1/5 the estimated discharge date was 4 weeks prior to actual and for 1/5 there was no estimate. The Assistant Director of Integrated Commissioning ASC confirmed that "*the Passports are designed by each hospital whose guidance says they have to give an estimated discharge date at the point of admission. This date should have no consequence to the discharges that we manage".* • There is no authorisation of the draft Support Plan. Brokerage use the draft support plan and the FCAA authorisation to initiate procurement of services. Formal authorisation of the support plan is after the services have been commissioned and agreed. • The Care Pathway overview did not consistently show the most recent care plan or status.

We understand that there is a concurrent Quality Assurance review of the Hospital Team which will give management an opinion on social worker practice, care packages and client experience.

Risk

Agreed time thresholds and performance are not met resulting in additional expenditure to the Authority and poor customer outcomes.

Recommendation	**Rating**
Review the assignment of D2A cases between teams to accurately reflect workflow, manage log jams and identify pressure points. Review and agree input of key dates to allow accurate and consistent reporting of performance. Review and agree when the financial assessment request should be referred to the Exchequer contractor to ensure transfer to a chargeable service can then be met by client contribution, if appropriate, timely. It is acknowledged that charges can be backdated but this will represent poor customer service and likely issues regarding collection of debt. As part of the review of Operating Procedures, ACS will need to look at consistency of information held on the case management system, authorisation of Support Plans and Discharge Passports (to liaise with ICB as this is their document).	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
Please see Appendix B – Management Action Plan.	

Appendix B – Management Action Plan (as at finalisation of report 01.12.2023)

Action No.	Date	Priority	Key Finding	Recommendation	Action	Action Owner	Comments	Update	Evidence/Statement	Due Date	Status
1		1	1. Financial Management and Budget Control	**1.1** ASC Operations Service must nominate a budget holder responsible for D2A expenditure. This officer will then represent financial management and projected spend for D2A expenditure. However for the nominated officer to be effective in this role there should be adequate financial reporting, development and training if required.	Budget holder to be nominated within ASC Operations Service for responsible for D2A expenditure	NG	Completed		The named holder is NG	31/10/2023	Closed
2					To develop and a budget reporting template to show D2A actuals (Dom care &Placements)	PF	NG met with PF 19/10/23 06/10/23 and agreed future fortnightly reporting arrangements. The budget is to be refined to show D2A actuals for Dom and Placement costs	NG met with PF and shared a report, final amendments required. This will be produced fortnightly at the budget meeting.	Template included	31/10/2023	Closed
3					Start monthly Operational D2A budget meetings, to be attended by NG, CB, MT, SR, SE,	NG	To monitor high cost packages, timeliness of assessments, identify blocks, and monitor financial assessments have been triggered, troubleshoot and agree actions to progress cases.	Meetings are currently scheduled	Invitations sent for scheduled meetings	31/10/2023	Closed
4					Confirmation required of total D2A budget	JJ	Create a single D2A Budget report including all ICB and LBB funding streams	NG has sent further email to request update Currently ongoing		31/10/2023	Open
5				**1.2** Formalise the ContrOCC reports to monitor actual spend, identify high cost cases, monitor cases approaching threshold and focus resources accordingly.	Weekly finance system reports to be developed to include D2A actuals.	NG, JJ, CB, PF, SR, JA	Possibly remove as included in first action with PF above?		Template included	31/10/2023	Closed
6					Finance to share the reports with the AD for Operations and Head of Service for Hospitals	PF	This has been confirmed, PF will share with NG fortnightly for the D2A budget monitoring meeting	Fortnightly reporting is agreed and first report received	Template included	31/10/2023	Closed

7					AD for Finance and Head of Service for Hospitals to take the reports to the SPA interface meeting as the responsible budget Managers for Operations.	JJ		In progress Confirmation required if this is still needed for purposes of D2A Audit		31/10/2023	**Open**
8					ToR for the SPA interface meeting to be reviewed and updated to reflect this.	NG, SR	Clear roles and responsibilities required	ToR shared by SR	Document produced on 31/10	31/10/2023	**Closed**
9				**1.3** Review the procedure to process D2A cases that have exceeded the 6 week threshold. This will necessitate consultation with all interested parties but predominantly Hospital Team, ASC Operations Manager and Brokerage.	Operational Teams responsible for Discharge to Assess to continue to adhere to set timescales for completion of the Care Act assessment post discharge of 2 weeks for Domiciliary Care Services and Enhanced Care and 4 weeks for Placements.	CB, SE	This is built in to our performance reports	NG is currently exploring funding an independent agency to respond to Dom Care pressure		31/10/2023	**Open**
10					Performance will continue to be monitored through the review of the weekly 'Temporary Services Following Hospital Discharge' report at the Operational Performance meeting fortnightly every Thursday. As well as the SPA Interface meeting, where this will be monitored. As well as the new D2A budget monitoring meeting	NG	This is updated in the SPA Interface meeting terms of reference	NG has confirmed that this is currently taking place through the weekly performance meeting.	Report produced 31/10	31/10/2023	**Closed**
11				**1.4** Refer the request for the Financial Assessment in a timely manner to ensure we collect client contribution at the earliest opportunity for chargeable service.	This will now be monitored at the weekly operations performance meeting and the D2A budget monthly monitoring meeting	NG	This will be a new meeting with NG, MT	Brokerage will also be closing D2A service lines at the point that they receive service lines for D2A service, this will automatically triggered a financial assessment as reassurance.	D2A performance report	31/12/2023	**Closed**

12		1	2. Operational Procedures	**2.1** Standard Operating Procedures need to be reviewed, revised and reissued for the D2A process from the point that the case has been referred to ASC, which takes place in the SPA. The procedures need to include the roles and responsibilities of all teams involved in the D2A process, expected input and output with target times and an expected level of data entry to deliver consistency, completeness and accuracy and ensure management information reflects actual service delivery, identifies pressure points and an improved service for users.	A working group to be established to review and revise the Discharge to Assess pathway from the point that the case has been referred to ASC.	CB & AS	The Policy Development Officer is working with the Head of Service to update the policy from the point that the case is referred to ASC	Draft of updated Operational Guidance with NG for review and will be presented to the Editorial Board on 27th November. Updated policy will then be presented at the SPA Interface meeting 22nd December, before publishing.		31/12/2023	**Open**
13					Roles and responsibilities of all internal teams involved to be outlined in the D2A process.	CB & AS		As above		31/12/2023	**Open**
14					Target timescales for allocation, Assessment, support planning and triggering financial assessment to be confirmed	CB & AS		As above		31/12/2023	**Open**
15					Central Placement Team Process to be confirmed, including timescales for sourcing services and clear guidelines and adherence to the choice policy. This will include confirmation of whose responsibility it is to liaise with families regarding provision.	MT & AS		As above		31/12/2023	**Open**
16					Procedures required to set out the local authority's interface with Health post discharge. I.e. the SPA interface meeting.	CB & AS		As above		31/12/2023	**Open**
17					Interface with Liberata (Financial Assessment processes) to be included.	AS & SR		As above		31/12/2023	**Open**
18				**2.2** The procedures should also include communication (with colleagues in Health, Central Placement Team and Liberata), updating system and access to management reports generated from system. The procedures should also include adequate checks to manage social care fraud risks specifically overstatement of need.	The procedures should also include communication (with colleagues in Health, Central Placement Team and Exchequer contractor)	AS &CB		As above		31/10/2023	**Open**
19					The procedures should also include adequate checks to manage social care fraud risks specifically overstatement of need.	CB		As above		31/10/2023	**Open**

20				**2.3** As a priority the service need to resolve the 6 weeks D2A service line to ensure compliance to agreed D2A funding, transfer to a chargeable service line and applying financial assessments to collect client contribution where appropriate.	Colleagues in Central Placement Team to end service lines for D2A cases at 6 weeks, on receipt of the Care Act assessment. This triggers a financial assessment and in theory, should be within 6 weeks.	MT		As above		31/11/2023	**Open**
21					Social workers within the Hospital Discharge Team to ensure that cases are assessed and financial assessments are triggered within the 6 week timeframe.	CB &SE	This will be reviewed in the monthly budget meeting and weekly performance meeting.	As above		31/11/2023	**Open**
22				**2.4** The service should confirm information distributed at the point of discharge, clarifying key points such as variable duration of care dependent on assessed need in the community and liability to fund. Service user expectations need to be effectively managed and these can be confirmed or reinforced by the Hospital Team Seniors during the first contact call post discharge.	A letter to be developed for people discharging from hospital with care and support to be sent by the Hospital Discharge Team Administrator on allocation of cases to the Hospital Discharge Team.	CB, KS, MT	The letter will set out the requirement of the local authority to complete a formal Care Act Assessment within 6 weeks of discharge to determine ongoing services and provide information on the charging policy and links to the online financial assessment	As above		31/10/2023	**Open**
23		**1**	**3. Performance Monitoring and LAS Reporting**	**3.1** Clarify the roles and responsibilities with regard to owning the D2A weekly report, taking action, escalation and compliance to agreed procedures with regard to the 6-week threshold.	As reflected in Audit recommendation	NG & EA	The performance reports are developed by Performance and Strategy are own by ASC Operations and shared at the weekly performance meeting and monthly budget meeting. Reports to include: - Dates of allocation to the hospital social work team - Completed assessment/support plan dates - Date of authorisation - Date case assigned to Brokerage - Completion of financial assessment date. This will enable officers to better identify where the blocks are in the process.	This is monitored through the SPA Interface meeting. Escalation will be actioned to appropriate team, following discussion at this meeting	SPA Interface meeting established and defined to cover	31/11/2023	**Closed**
24				**3.2** Develop the LAS performance reports to include the FCAA completion date to clearly identify the end of the hospital teams responsibility and transfer to Brokerage.	As reflected in Audit recommendation	NG & EA		System doesn't currently produce financial information. Mitigation in place against this		31/11/2023	**Open**

25				**3.3** Liaise with the ASC Performance Team to develop a suite of reports that will support the ASC representation at the Operational and Strategic SPA Interface Boards. These reports should be in a simplified format, represent the key information required and allow that data to be analysed to support decisions and allocate actions.	As reflected in Audit recommendation	EA		I have devised some KPIs on the second tab to measure the following:- 1. Number D2A Clients 2. Number D2A CPLIs 3. Number of Non D2A cases assigned to the Hospital Team. 4. Duration of D2A service 5. Type of D2A services 6. Team D2A Clients are assigned to 7. Care Act Assessment completed since D2A commenced 8. D2A cases with completed assessment and length of D2A Service 9. Of Cases Assessed, time taken from start of D2A service to assessment completion 10. Cases yet to be assessed and length of D2A service	D2A performance report	31/11/2023	**Closed**
26				**3.4** Liaise with Finance to develop and formalise regular expenditure reports to identify high costs and long term D2A service user to focus review and resolution.	**Covered in 1.1 & 1.2**	NG & PF	Completed within 1.1			31/11/2023	**Closed**
27				**3.5** Develop a methodology to reconcile all clients held in system and at each stage of the process to limit D2A service, minimise costs and improve service users care and support.	**Covered in 1.1 & 1.2**	NG	Methodology established			31/11/2023	**Closed**
28		**2**	**4. Consistency and Accuracy of LAS Record Keeping**	**4.1** Review the assignment of D2A cases between teams to accurately reflect work flow, manage log jams and identify pressure points.	As reflected in Audit recommendation	CB		Currently in progress. Process is currently under review.		31/11/2023	**Open**
29				**4.2** Review and agree input of key dates to allow accurate and consistent reporting of performance.	As reflected in Audit recommendation	NG				31/10/2023	**Closed**

30				**4.3** Review and agree when the financial assessment request should be referred to FA contractor to ensure transfer to a chargeable service can then be met by client contribution, if appropriate, timely. It is acknowledged that charges can be backdated but this will represent poor customer service and likely issues regarding collection of debt.	Review current process to ensure that assessments are triggered and completed within timescales, as backdating capability is limited	CB	Currently exploring an earlier assessment timeframe, however this is dependent on the OFA. This will completed by Liberata once trigger raised.	Ongoing, awaiting enforce of financial year		31/03/2024	**Open**
31				**4.4** As part of the review of Operating Procedures, ACS will need to look at consistency of information held on system, authorisation of Support Plans and Discharge Passports (to liaise with ICB as this is their document).	As reflected in Audit recommendation	CB & MB	To be reviewed at future SPA Interface meeting	Currently in progress. Process is currently under review.		31/11/2023	**Open**

Appendix C – 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 D – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Overspent budget and /or inefficient use of public money • Poor decision making resulting in poor outcomes for the client • Delays in assessment and accessing permanent care plan Our scope included:- • Procedures for the D2A process, including time targets, authorisation and compliance with the Care Act 2014 and associated regulations. • Workflow and communication between teams including the Discharge Coordinators, SPA, Hospital Team, Central Placements, Exchequer contractor (Financial Assessments) and Locality Teams. This will also include key decision points and timely information shared with the client and family to measure expectations and ensure positive outcomes. • Completeness and accuracy of the information uploaded to the case management system including mandatory fields, templates, confirmation of the clients address and documentation to support D2A decisions. • Measures in place to reconcile between systems to ensure all D2A clients are accounted for. • Management reports available from the case management system to monitor performance, account for all discharges and identify any delays in the process. • D2A expenditure, funding and budget monitoring • Sample testing from all hospital discharges since 1st October 2022 to check to case management system records and against agreed processes. • Controls in place to manage social care fraud risks, specifically overstatement of need, and the Council's obligation to assess and support.

REDACTED

FINAL INTERNAL AUDIT REPORT

HEALTH AND SAFETY FRAMEWORK – ENVIRONMENT AND PUBLIC PROTECTION

PLA/02/2023

31 January 2024

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of Environment and Public Protection
Head of Performance Management and Business Support
Assistant Director of Public Protection
Assistant Director of Environment (Carbon & Greenspace)
Assistant Director of Environment
Assistant Director, Traffic and Parking
Assistant Director, Highways

Executive Summary

Audit Objective	The objective of this audit was to review the assurance framework in place to ensure Health and Safety (H&S) risks are managed and mitigated.

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	1	4

Key Findings

To evaluate the effectiveness of the H&S assurance framework in Environmental Services and Public Protection (PP) we looked at the departmental H&S Board, risk registers and selected the Waste contract (Lot 1-3) and the CCTV Monitoring contract as examples of H&S performance monitoring and reporting.

We identified the following areas of good practice and sound controls:

1) The quarterly H&S Board is well chaired, minuted and allowed a forum to cascade H&S issues across the department and to/from Corporate H&S.
2) The two departmental risk registers included a specific H&S risk with adequate mitigating controls and methodology of work required to deliver those controls.
3) The monitoring and management of the H&S elements of the Waste Contract evidenced a comprehensive approach to performance monitoring, liaison with the contractor, clarity of roles and responsibilities and reporting. This approach is both acceptable and expected given the risks associated with the delivery of a Waste service. In comparison the H&S element of the CCTV Monitoring contract monitoring is proportional to the risk associated with this contract.

We have identified the following area for management attention:-

4) **Collection, collation and distribution of H&S data** (Priority 2) – The online contractor inspection form, primarily used by Neighbourhood Management Officers, is a generic template which would benefit from revision and update. Our review of the H&S Board minutes highlighted that Highways were also using their service specific system to collate H&S inspections. It was not clear if this data was being collected, collated and reported and therefore we did not have assurance that H&S inspection data for the Department (ECS and PP) was complete. Similarly the Board minutes showed a lack of clarity regarding the use and reporting of AR3 forms to Corporate H&S. We could not reconcile the accident / incident report for Place generated from Corporate H&S. ***See Recommendation 1.***

We have made four additional Priority 3 recommendation for good practice only.

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

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

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

Appendix A - Management Action Plan

1. Collection, Collation and Distribution of H&S Data	
Finding The online contractor inspection forms are primarily utilised by the Neighbourhood Management (NM) team. Data is collated and reported to show the number of inspections and failures. For quarter 2, 2023/24, 251 inspections were completed of which 189 (75%) were for Waste and Streets (Neighbourhood Management Officers). The remaining inspections were split over Highways, Parks, Parks Security and Transport Operations. Of the 11 failures noted in this period, 7 related to Waste. The online form is a generic template which has not been reviewed or updated and does not meet the needs of the NM team. The NM Team have set a target of 50 inspections per month but this has not been formally adopted, neither has a split between ad hoc and planned inspections been set. The H&S Board minutes (23/10/23) showed that a cross divisional discussion had highlighted that Highways were also using a site specific form in their system for H&S inspections. It was not clear if this data was being collected, collated and reported and therefore we did not have assurance that H&S inspection data for the Department (ECS and PP) was complete. The same Board minutes showed a lack of clarity regarding the use and reporting of AR3 Forms to Corporate H&S and we acknowledge that officers have been tasked to seek resolution. We requested a service specific report from Corporate H&S to reconcile accident/incidents reported at the H&S Board and Service Operations Board (SOB). We were unable to complete the reconciliation given the format of data and timelines. The ECS procedures to complete and monitor were comprehensive documents and included links to supporting documents. The completion of the online forms has not been reviewed since 2018 and although it is acknowledged that the procedure has not changed there should be a review date shown. **Risk** Inaccurate and incomplete reporting of H&S incidents, meaning that trends and emerging risks may not be identified and resolved, and a breach of H&S statutory requirements.	
Recommendation The Department should confirm that all H&S inspections completed across each Division are collected, collated and reported to the H&S Board. Develop the online inspection form to meet the needs of the NM Team and/or ensure that the generic template meets the needs of all users.	**Rating** Priority 2

Any changes in process or record keeping should be updated on the H&S Monitoring Procedures, the revised date and next revision date noted for version control. Clarify the completion and reporting of AR3 forms and reconcile the information reported by Corporate H&S to locally held H&S reports to ensure completeness.	
Management Response and Accountable Manager Head of Performance Management Response: Online Form: The guidance document has been completed and has been updated with a new review date. This has now been reviewed as of January 2024 and the date has been added to the new version on the shared site. The online form itself is still relevant and discussions with the Head of Neighbourhood Management took place and it was decided the form will remain the same for the time being and the questions are still relevant and no action to change the form. This is complete. The Head of Performance Management will ensure a review takes place at least once a year to assure the online form is accurate and if it needs amending this will be actioned. This will be completed at the same annual review time of Departmental Risk Assessments. Inspection Reporting: At the Departmental Board Meeting under the agenda item 'Data and Discussion' the Highways team will now provide commentary by exception of their system recorded H&S inspections' the Highways Officer complete. This will provide assurance for the H&S work they complete if the online form does not allow them to provide a full response for their service area. This is relevant for all divisional areas and if the online form does not capture all their H&S information the delegate at the board is responsible for raising this at the 'Data and Discussion' agenda point. The Head of Performance Management will ensure a review takes place at least once a year to assure the Highways system H&S form is accurate and if it needs amending this will be actioned. This will be completed at the same annual review time of Departmental Risk Assessments. Discussions regarding this took place at DMT on 11th January , where colleagues were informed of the findings in the first draft report. This has been discussed at the Environment Governance meetings with ADs from the department. A separate meeting with the AD of Highways and Head of Performance took place to provide a response for the Highways divisional Discussions at Departmental H&S board on 24th January 2024 regarding divisions reporting H&S issues, if teams have separate spreadsheets or systems to report H&S issues they need to present this at the board. If they do not have a system in place for their division they can use the departmental online form or an AR3 (depending on the severity of the issue/incident). Head of Neighbourhood Management Response: Target for NM Team:	**Agreed timescale** Version of the guidance – Completed. Agenda added 'Highways H&S Data' - Completed Head of Performance Management to complete an annual review of online and system data inspection forms. Neighbourhood Management -

NM did have an indicative target from February 2022 following the realignment of teams and this was confirmed to NOs in a meeting on 25th October 2023 and now embedded into the NM H&S framework. The NM H&S Framework document which was provided as part of the fieldwork for this audit shows the indicative volume of unplanned inspections as being 40 and the indicative volume of planned (joint) inspections being 10. This has been adopted by the NM team. In addition to this, the Senior Performance Officer and Senior Neighbourhood Officer (NO) for Waste will produce a mid-monthly (on or around the 15th of the month) report, in addition the monthly report and this will highlight the Senior NO if Neighbourhood Officers are in line to meet their target and this will show at the mid-monthly report. Highways Representative Response: The Highways team have a target for the two Highways Inspectors to complete at least one (1) online form a week, depending on when they carry out inspections. One Highways Inspector completes daily inspections on the Highways system and these are mainly to keep track of the works on site and there are H&S related elements. Highways & Street Lighting Manager will present the number of inspections at the board meeting and comment by exception.	Target Completed. Neighbourhood Management and Performance Management – Mid Monthly Report – take place from January 2023.

2. H&S Training Logs – Neighbourhood Management (NM)
Finding We selected the NM team as the sample division within ECS and PP to look at H&S training; identification of need, access to training and record keeping. There was evidence of a training programme, access to the contractor's training and discussion at the H&S Board. The 1:1 template used by NM has H&S issues as a standing item and allows any training needs to be identified at this point. NM management evidenced a spreadsheet as their control document for all NM officers and training available however this had not been completed.

Mandatory H&S training for officers is now managed on the HR system platform but we were advised by Learning and Development that this has only been available since September 2023. Mandatory induction H&S training would need to have been recorded and compliance verified at department level before this date. **Risk** Increased likelihood of health and safety incidents if training needs are not met.	
Recommendation NM should utilise the training spreadsheet they have already developed to capture all training needs determined by job specifications, emerging requests for training, the contractor specific training and the mandatory induction H&S course. The Department should ensure that a similar training log is maintained for all officers across the divisions.	**Rating** Priority 3
Management Response and Accountable Manager Head of Performance Management Response: The Performance Management team have their own team individual Training Needs Analysis. Head of Neighbourhood Management Response: The NM yearly training programme control sheet, tab 'staff details' has now been completed with dates of when service specific training was carried out. This also shows the dates of when PPE, first aid kits were supplied and LBB driving assessments by transport operations undertaken. The NM yearly training programme was provided as part of the fieldwork for this audit. ALL: The LBB Learning and Development team discussed at COE, CLT and Managers Briefing a new system will be in place to capture all mandatory staff training. The HR team will be implementing this new system for all staff in 2024. This will be captured in a corporate review of the system to help all managers and all officers. This system will supersede the need for managers to coordinate their own training needs analysis, as the system will identify training gaps and assist the department to ensure all staff are attending training sessions. Prior to this change from the corporate team, at DMT meetings ADs were asked to complete the Corporate Development Plan for each service area and send to HR. The NM team completed this in 25/05/22 and this document was provided as part of the fieldwork for this audit. Divisions within the department did complete this to highlighting all training for their areas.	**Agreed timescale** Completed Completed Awaiting HR to action corporate system.

3. E&PP Quarterly H&S Board

Finding

The Terms of Reference for the E&PP H&S Board covers a satisfactory range of activities, sets out the responsibility of the Board and specifies representation from all the main E&P service areas. We reviewed the minutes for the four Board meetings held in 2023 and noted satisfactory attendance, standard agenda items, cascaded information to and from Corporate H&S and an update from each division. We attended the July 2023 meeting and noted that the meeting was well chaired and facilitated exchange of information and debate. We have made the following observations:-

- The representative from PP is the Business Support Officer whilst the ECS representatives are either Heads of Service, service leads or contract owners. During the audit we spoke to the two contract owners who at management grade may be better placed to make decisions on behalf of the service.
- The Corporate H&S Officer was not at the July meeting and the substitute representative had not been provided with an update for the specific agenda item. The Head of Performance Management and Business Support was able to provide an update given this officer also sits on the Corporate H&S Board.

The Board minutes are a comprehensive representation of the meeting, distributed timely and available on the shared site. The action log is addressed at each meeting and actions assigned to nominated officers. We reviewed the action log as at 13.12.23 and noted that 5 open actions had exceeded their target date and were still shown as green on the RAG rating.

Risk

Incomplete or inaccurate information distributed between Corporate and Departmental H&S forums meaning that decisions may be flawed or necessary actions may not be identified.
If Board representation is not sufficiently senior, the profile of Health and Safety may be reduced, responsibilities may be diluted or important decisions may not be made quickly or appropriately.

Recommendation	**Rating**
PP to consider their representation on the H&S Board and nominate an officer with an oversight of divisional and contractual H&S objectives and at an appropriate grade to make decisions on behalf of the service rather than being a nominated officer to be a conduit for information. The action log is a live document on the shared site but should be updated to show actions as they are completed and utilise the RAG system to correctly show overdue actions.	**Priority 3**

Management Response and Accountable Manager	**Agreed timescale**
Head of Performance Management Response: Action Log: This has been completed. The Performance Management Team have amended the RAG status and deadline dates on the action log and this will be reviewed in line with the quarterly meetings and the deadline dates reflecting this. The Senior Performance Officer has completed this and this will be actioned at each board. Meeting Attendance: The Business Support team have forwarded on the calendar invite to the Head of Service to attend the quarterly board meeting or to send another manager in their place. The Public Protection Business Support Officer will still attend the meeting, however a manager needs to be present an invite has been sent to be representative. Head of Service – Public Protection Response: The Head of Service (Safer Communities) will attend the quarterly board meeting or send another manager in his place	Action Log – Completed. Action Log – Completed.

4. Indemnity Clause and Supporting Documentation
Finding We selected two contracts to review H&S performance indicators; the contractual documentation to support these indicators and the reporting process to monitor the indicators. The Waste contract (Lots 1-3) was selected as there are 13 H&S indicators in the contract and it is a service with a higher exposure to H&S risk. The H&S performance was well managed and monitored through Performance Monitoring Framework (PMF) data and contractor monthly reporting. A review of 3 months (PMF) data showed no issues arising and this agreed to the corresponding SOB minutes. The CCTV Monitoring contract was also selected as the only contract in PP with a H&S indicator. Similarly the H&S indicator is managed and monitored via the PMF and for the sample months no H&S issues were arising. The monitoring and reporting of the PP contract H&S indicator is proportional to the nature of the service. We checked and verified the indemnity clause in each sampled contract to ensure that the Authority was adequately covered for insurance purposes. Both clauses were satisfactory however the Public Liability and Professional Negligence policy documents for the CCTV Monitoring contractor had not been checked annually and could not therefore be evidenced as current. **Risk**

Due to the potential financial amount of any claim, the Authority may not be able to recover full costs from the contractor in the event of a claim if the contractor does not hold a current Public Liability and/or Professional Negligence insurance policy.	
Recommendation The CCTV Monitoring contract owner should check the contractor's Public Liability and Professional Negligence policy documents annually and note in the appropriate Service Review meeting minutes.	**Rating** Priority 3
Management Response and Accountable Manager Head of Performance Response: An ongoing action will be added to the departmental H&S board to ensure all divisional representatives will remind contract owners for each division to ensure the Public Liability ensure is reviewed annually for each contractor and contractor owner to check this. For Environmental Contracts (Lots 1-5) the lead business support officer for each contract ensures this is completed as this is an indicator on the PMF. There is no resource for the business support to complete this for each contract, however the team will assist with this with a reminder on the departmental H&S board for each representative to raise with the AD for each division. The Head of Performance will send an annual reminder to all Departmental Contract managers to ensure their Service Providers have Public Liability Insurance (this is already completed for the Environmental Contracts), this will be for Parking contractor, Highways contractor, CCTV Monitoring, CCTV Maintenance and the Stray Dogs contract. This email will be saved to the H&S section on the shared site. The responsibility will sit with contract owners once the email has been sent from Performance Management. Head of Service Public Protection Response: The CCTV Monitoring contract owner will review the contractor's Public Liability and Professional Negligence policy documents in April of each year (next date April 2024) and record a note in the contract meeting minutes.	**Agreed timescale** Complete – Added as ongoing action To be completed at financial year end. April 2024

5. Ownership and Delivery of H&S Executive Findings

Finding

The H&S Executive completed an unannounced site visit to the Central Depot on the 28.4.23. There is no final report of this visit however the service have provided an e-mail trail with the H&S Executive inspector which shows that the visit was satisfactory apart from an issue with the asbestos management survey and asbestos management plan.

This action is owned by Strategic Property. An e-mail from the then Head of Facilities Management in May 2023 confirms that remedial work was planned to be undertaken but colleagues at the Depot could not confirm if this action had been completed. The current Head of Facilities Management has advised us that as at 8.1.24 the asbestos survey was completed but the asbestos management action plan is outstanding and will now be a priority.

The July H&S Board minutes note that *"redacted was pleased to report the outcome of the inspection was positive in terms of site compliance with no issues being raised. There will be a follow-up in terms of providing some evidence of inspections/surveys from both LBB (asbestos surveys of buildings) …… however this was for administration purposes only. Redacted will be a point of liaison with Bromley officers as part of the follow-up by the HSE."* There is no evidence through e-mail or Board minutes that ECS officers maintained oversight of this open finding. We acknowledge that the H&S Executive finding was assigned to and is the responsibility of Strategic Property colleagues, however ECS colleagues should have maintained oversight that remedial action was completed at the Central Depot.

Risk

Findings from an external inspection are not assigned and completed, leaving the Authority at continued and unacceptable exposure to risk.

Recommendation	**Rating**
The Department should liaise with colleagues in Property to ensure that the action specific to the asbestos management plan at the Central Depot is completed. The H&S Board action log could be used to monitor progress. Future H&S findings and recommendations from external agencies that impact on the Department should be tracked via the H&S Board to ensure compliance and action.	**Priority 3**
Management Response and Accountable Manager	**Agreed timescale**
Head of Performance Management Response: • Departmental H&S Board Meeting: The Department H&S Board will now have a standing sub-agenda item under the 'Central Depot' agenda item called 'Asbestos Management Plan (AMP)'. This will allow for the Transport Operations team and Neighbourhood Management plan to discuss the property owned Asbestos Management plan for the	Action Complete- Added to the Departmental H&S Agenda

Depot and feed this into the quarterly board. This should also be discussed at the Depot User Group Meeting and the Service Provider Collaboration Board. • Service Provider Collaboration Contract Meeting: This is chaired by the Assistant Director of Environment. The Asbestos Management Plan has been added as a sub agenda items over 'Other Matters Arising from Operation of Sites'. • Depot User Group Meeting: This is chaired by the Transport Operations Team and Asbestos Management Plan will now be a standing agenda item. The TOM team confirmed they will update on AMP at the Departmental H&S Board meeting too. Departmental H&S Board (24/01/24): Discussions regarding the Asbestos Management Plan were discussed at the board meeting. The Corporate Asbestos Policy confirms that the responsibility is owned by Facilities Management. Therefore, ownership and responsibility remains with the Property division.	Action Complete - Added to the Service Provider Collaboration Board Agenda Action Complete- Added to the Depot User Group Meeting Agenda

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: • Ineffective management, processes and systems within the department (as stated on the departmental risk registers) • Personal injury sustained by an officer of the Council, a contractor's operative or a resident. This audit has been included in the 2023/24 plan to review the H&S assurance framework to minimise the likelihood of accidents, incidents and other H&S issues for residents, officers and contractor's operatives. We will review the management of H&S processes within ECS divisions and Public Protection looking at H&S reporting, distribution of guidance and remedial action. The time frame for our review is the previous 12 months, 1 September 2022 to 31 August 2023. Our scope included:- • Review of the procedures for H&S management and monitoring, including completion of online contractor inspection forms, AR3 forms to Corporate H&S, collation of data and dissemination of results and/or lessons learnt. • Review the Terms of Reference, divisional representation, minutes and action log for the quarterly H&S Board. • Review the H&S performance indicators in a sample of ECS/PPE contracts, monitoring arrangements and reporting at the monthly Service Operations Boards. The inclusion of an indemnity clause in a sample of ECS/PPE contracts to protect the Council in the event of a Personal Injury claim. • Identify responsibility for completing inspections in a sample of ECS/PPE services and compare to legislative or contractual targets. • Use of all information available to the Department to identify potential H&S issues above the inspections, online public reporting or complaints/claims. . • Verify the controls identified on the ECS/PPE risk registers and evaluate how management evidence assurance that these controls are in place, are effective and are complete. • Verify the "work required" identified on the ECS/PPE risk register and evaluate how and if management have delivered. • Document the information flow between Corporate H&S and Departmental H&S both reporting of H&S issues and the cascade of information, guidance and lessons learnt. • Controls in place to manage fraud risks, specifically misrepresentation or false H&S claims. Our audit included interviews with the Assistant Directors, Heads of Service, the Head of Performance Management and Business Support and the Contract Managers for the selected contracts. We will be liaising with the Corporate H&S Officer but only in the context of ECS H&S.

REDACTED

FINAL INTERNAL AUDIT REPORT

HOMES FOR UKRAINE

PLA/04/2023

15 December 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Director of Housing, Planning, Property and Regeneration
Head of Compliance & Strategy / Asylum Lead
Homes for Ukraine Operational Manager
Homes for Ukraine Project Co-Ordinator
Assistant Director, Exchequer Services

Executive Summary

Audit Objective	The objective of this audit was to review the effectiveness of the controls over the Council's approach to the Homes for Ukraine scheme and the mitigation of associated risks.

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	4	0

Key Findings

We identified areas of good practice and sound controls as set out below:

1. The Homes For Ukraine (HFU) scheme is included on the Corporate Risk Register, with existing controls to mitigate the risk and further action required. Updates on the Homes for Ukraine scheme are provided to the Executive each quarter and the Chief Executive each month.
2. The HFU team have set up a 'Ukraine Support Hub' which operates from the Civic Centre every Thursday. It enables Ukrainians and residents hosting them to visit and receive advice and support, from Bromley Council representatives and other agencies, on a range of matters including housing, employment and school placements. We visited the Hub during our audit and evidenced the significant contribution which it makes.
3. For each of the cases in our sample, the welcome visit had taken place following the guest's arrival at the host property. The questions asked on the welcome form followed the suggested HFU welfare checks guidance on the gov.uk website. The result of the visit was documented and recorded correctly on the Housing system. For each of our cases sampled no concerns had been raised. In each case all members of the sponsor household over the age of 16 had been identified and the required level of DBS check had been carried out.
4. For each of the cases in our sample, the home assessment check had been carried out before the guest had moved into the property.
5. There is separation of responsibilities between the HFU team and the Exchequer contractor for the payment process and a signed agreement with the Exchequer contractor setting out respective roles and responsibilities. There is an appropriate level of authorisation for the monthly payment batch. For each case in our sample of 10 we confirmed that the payment to the sponsor and level of payment (£350 or £500 - if the guest had arrived in the UK over 12 months previously) in July 2023 was correct. A self-declaration form had been completed by all of the sponsors in our sample, prior to payment.
6. Considerable assistance is provided by the HFU team to help re-match or re-house a guest who has to vacate a property. Numerous options are explored and assessed. Advice and help is given to try to ensure that the best outcome for the guest is achieved.

We have identified the following areas for management attention:

7. **Length of time between the home assessment and guest moving into the property and the timescale for a welcome visit** (Priority 2). In 6 cases out of the 10 in our sample the guest had moved into the accommodation over 100 days after the home assessment had been carried out. There is no guidance as to whether or not a further home assessment should have been carried out, given the length of time in days since the original assessment and any changes or developments which may have occurred. There is no timescale for carrying out a welcome visit after a guest has moved into a property. Four visits out of our sample of 10 had been made over nine working days after the team had become aware that the guest had moved into the property. ***See Recommendation 1.***
8. **Home assessment form – scope and completeness** (Priority 2) – In each case a home assessment had been undertaken prior to the guest moving in. Analysing the answers on the home assessment check form, some of them were unclear on specific matters such as gas and electricity safety and home insurance. Other questions had not been answered. ***See Recommendation 2.***
9. **Follow up welfare and safeguarding visits** (Priority 2). In two cases we were informed by the HFU team that a follow up visit was pending, with arrangements being made to arrange a mutually convenient time for the follow up visit. From a quick examination of answers on all the completed forms, not only those in our sample, we could see that there were questions on the form which had not been answered. We noted that in one case the guest was not present and so only the sponsor's view and details of the apparent disagreement were obtained by the visiting officer. ***See Recommendation 3.***
10. **Incomplete information obtained from home assessment and welcome visits** (Priority 2). We noted that on the home assessment and welcome visit forms completed for our sample, no answers had been provided to some of the questions. ***See Recommendation 4.***

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

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

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

Appendix A - Management Action Plan

1. Length of time between the home assessment and guest moving into the property, and the timescale for a welcome visit.	
Finding In each case in our sample a home assessment had been undertaken prior to the guest moving in. In 6 cases out of the 10 in our sample the guest had moved into the accommodation over 100 days after the home assessment had been carried out. The longest gap was 197 days after the assessment. There is no guidance as to whether or not a further home assessment should have been carried out, given the length of time in days since the original assessment and any changes or developments which may have occurred. We recognise that it is not easy due to the matching process to know the exact date in the future when a guest will move in, but a tolerance level should be established, after which time a re-assessment of the property takes place. There is no timescale for carrying out a welcome visit after a guest has moved into a property. The welcome visit is important because it includes a welfare/safeguarding check and may be the first face to face meeting with a member of the Homes for Ukraine team. Four visits out of our sample of 10 had been made over nine working days after the guest had moved into the property. The number of days in these cases were 10, 18, 20 and 24 working days. **Risk** Structural or internal changes to the property, or deterioration to it, may have taken place since the original home assessment, leading to an increased risk of injury for a guest, or the property being deemed unsuitable as living accommodation. If the welcome visit is delayed, guests may not receive essential information and any issues may not be promptly identified and addressed.	
Recommendation Establish a tolerance level and procedure for carrying out a re-assessment of a property prior to a guest moving in, if the original home assessment took place over a given number of days previously. Set a timescale for a welcome visit to be made after becoming aware that a guest has moved into a property and put in place arrangements to meet this.	**Rating** Priority 2

Management Response and Accountable Manager	**Agreed timescale**
This is an area for improvement that we had already identified. We have already implemented a new procedure to mitigate against this: When a new Accommodation Request is received, we review what information we hold to see if we have previously completed a Home Assessment to the accommodation. If we completed a Home Assessment more than 6 months ago, a new Home Assessment will be arranged. If a Home Assessment was completed within the previous 6 months, we review what information we collected at the visit - if the guests arrived, if they have subsequently moved out - and if, based on the information recorded, the accommodation is suitable for the new group. If it doesn't look to be suitable, a new Home Assessment will be completed. If the property looks to be suitable, the Response Officer will review the suitability of the accommodation at the Welcome Visit. When there is a new arrival, the sponsor is sent an e-mail with the link to the Welcome Visit booking system. If they have not booked within 5 days, they will be contacted by phone. If we are unable to make contact or they still do not book a visit within 5 days, the guest is e-mailed in Ukrainian to ask if they have arrived, if they are staying at the accommodation and making them aware of how to contact our team and details of the Hub. If they respond that they are living in the sponsor accommodation, we ask them to prompt their sponsor to book a Welcome Visit. If this line of communication is still unsuccessful within 5 days, the Response Officer will e-mail a date and time that they will visit the accommodation and two members of staff will then attempt to visit at that time. We have put these procedures in place but unfortunately it is still dependent on the sponsor engaging with us, which sometimes they do not. Accountable manager: Homes for Ukraine Project Co-Ordinator	29 February 2024

2. Home assessment form – scope and completeness

Finding

We compared, for completeness and any apparent gaps in coverage, the content of the home assessment form used by the Council against the form used by four other Councils, examples of which were provided on the gov.uk website. We noted that:

Other Councils are more specific on safety issues. For example, Bromley's form says 'Is there a carbon monoxide alarm?' whereas another Council's form asks for the date tested and has a 'Safe / Unsafe' option box to be completed.

That Council's form also has questions about medicines being locked away, fuel servicing appliances serviced within the past year and the date tested, and chemicals and alcohol being safely stored. Another Council's form also includes a question about if there are firearms in the home and if they are secured, with an appropriate licence held.

Bromley's form has a question 'Do all rooms have windows that can be opened/closed?' whereas other Councils' forms ask about restrictors on all windows above ground level. Other risks not covered in Bromley's form, but addressed by questions in other Councils' forms include blind cords, safety gates at the bottom of stairs (where appropriate), specific kitchen and bathroom risks and outside risks such as hazardous garden chemicals, garden equipment and garden play equipment. Other Councils' home assessment forms are more comprehensive, both in areas of risk covered and information and evidence obtained to help assess and mitigate those risks. It is not clear on Bromley's form what the criteria and expectations are regarding gas safety and other checks. On one form we saw that there were no smoke alarms at the time of the visit, but the owner said he has them and would install them. There was however no evidence of this being followed up to ensure they had been fitted.

Risk

Guests may be housed in accommodation which is unsafe, leading to injury or loss of life. Relevant areas of risk may not be covered and addressed. Sufficient evidence to mitigate risks may not be obtained so that the Council has a defensible position in the event of an incident.

Recommendation

A review of Bromley's home assessment form in comparison with other Council's forms should be carried out by the HFU team. The review should focus on the scope of questions asked and evidence required and any training which may be required for those completing home assessments in future.

Rating

Priority 2

Management Response and Accountable Manager	**Agreed timescale**
The Home Assessment form will be reviewed in line with the examples on the gov.uk website. This has been assigned to the Project Co-ordinator & Response Officer to action. We have already implemented a mechanism for following up on any issues to be addressed which come out of the Home Assessment. Accountable manager: Homes for Ukraine Project Co-Ordinator	29 February 2024

3. Follow up welfare and safeguarding visits.

Finding

We took a sample of 10 cases out of 42 where the guest had moved in between 1 Oct 2022 and 31 March 2023. In two cases we could see that the follow up visit had taken place and an update position on the host and guest(s) had been recorded, including any issues which they were concerned about. In two cases we were informed by the HFU team that a follow up visit was pending, with arrangements being made to arrange a mutually convenient time for the follow up visit.

In five cases analysis showed that the sponsorship ended before a follow up visit could take place. In one case the sponsorship had not been approved originally as the accommodation was not considered suitable, due to overcrowding.

From a quick examination of answers on all the completed forms, not only those in our sample, we could see that there were some questions on the form which had not been answered e.g. 'Have there been any issues that the sponsor/s and guest/s have had to resolve between them and how are they finding ways to communicate any issues that arise?' and 'What is the plan for the future of the placement?'

Regarding the above, there was one case where we could see that those questions had not been answered but later in the form under 'Is there any advice they would give to future sponsors and guests about sharing accommodation?' the written answer was 'The guest was not present. The host does not wish to extend beyond 6 months - serious differences of opinion.' It then sets out what those differences of opinion were. The visiting officer's observations were 'Host advised to give guest notice to leave in 2 weeks' time as this is not working out. Safeguarding team will be notified. Housing options team will be notified.' We noted that in this case the guest was not present and so only the sponsor's view and details of the disagreement were obtained by the visiting officer.

On the gov.uk website, for the initial welfare check visit, under 'During the visit, it says that Councils 'should also ensure all guests and sponsor household listed on the application are correct and present.'

Further down on the website, under 'Follow-up visits' it says:-

'The scheme expects a single visit at the outset, and it is good practice for councils to check how the sponsor-guest relationship is going, and whether support is needed or if any concerns have emerged. We recommend councils conduct at least one in-person check at the 6-month mark, primarily from a fraud perspective, to check the guest is still living in the accommodation, though this is not mandatory and is up to their discretion. Councils must choose when and how often any follow-up visits should be made, based on their assessment of need and appropriateness, in line with existing statutory responsibilities for children and adults.' **Risk** Welfare concerns and any support required may not be identified if follow up visits do not take place. There is an increased risk of payment fraud or error.	
Recommendation Review the existing follow up arrangements to ensure that follow up visits for sponsors and guests take place periodically and that the form includes: (i) a question for visiting officers to answer, confirming that the guest was seen and is still living in the accommodation, and (ii) a question asking if anything has changed since the original assessment and if the accommodation continues to be suitable.	**Rating** Priority 2
Management Response and Accountable Manager We are aware that we are behind with follow up visits which has been due to the increased work in chasing for home assessments and welcome visits. The team are currently working through the list of those who are due a follow up visit and contacting them to book them in. Accountable manager: Homes for Ukraine Project Co-Ordinator	**Agreed timescale** 29 February 2024

4. Completeness and quality of information obtained from home assessment and welcome visits.

Finding

We noted that, analysing the answers to the questions on the home assessment and welcome visit forms completed for our sample, no answers had been provided to some of the questions.

For example, on the home assessment form, for the question e.g. 'How many bedrooms are available for the guests?' it had not been answered for any of the 10 cases in our sample. On that form the question has a red asterisk implying that it has to be answered before proceeding to the remaining questions. Another question was 'Is there an unaccompanied minor in the household?' and that had not been answered for three cases in our sample.

On the welcome visit form, for three of the questions e.g. 'Have there been any changes to the household composition since the Home Assessment?' no answers were apparent. That question also has a red asterisk implying that it has to be answered before proceeding to the remaining questions. In one instance the question 'Have you provided the Lead Guest with their payment card? was answered 'No' but no explanation was then provided as to why.

We noted that some of the answers recorded on the forms were subjective and were in effect the opinion of the person carrying out the visit, with comments on the accommodation and what had been seen, rather than keeping the responses factual and objective.

We noted that the home assessment form, welcome visit form and follow up visit form do not have a link to the Council's privacy notice for the Homes for Ukraine scheme. These forms are however completed by the visiting officer and there is no confirmation that the sponsor has been made aware of the privacy notice and processing of their personal data. The self-declaration form completed by sponsors includes the statement 'I understand and agree that you may use my data to undertake further checks for the prevention and detection of fraud, prior to payment being made to me.'

Risk

The Council may not have obtained complete and relevant information. This may lead to issues not being identified before placing a guest with a sponsor. Sponsors may be unaware how their personal data collected may be used by the Council.

Recommendation	**Rating**
In future, remind visiting officers to be mindful when recording information to ensure that it is always factual and objective, and review each completed home assessment and welcome visit form to ensure that all necessary information has been obtained. Ensure that sponsors are made aware of the Council's Homes for Ukraine privacy notice and the reasons for processing their personal data.	Prioritv 2

Management Response and Accountable Manager The mandatory questions which do not have an answer have been added since the time those visits took place, or the branching in the form does not lead the respondent to that question as it isn't relevant. We had already added the question "Why have you not provided a payment card?" to the Welcome Visit form. Many officers from across the Council conducted visits prior to having a team in place due to the emergency response required. As such, there are variations in the way the forms have been completed. Visiting officers in the current team will receive further training to ensure there is consistency across the team and that responses are factual. We will add information related to the privacy policy to the forms, including a question confirming the sponsor and (where relevant) the guest/s consent to their information being collected and processed. Accountable manager: Homes for Ukraine Project Co-Ordinator	**Agreed timescale** 29 February 2024

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: • Failure to fulfil statutory obligations, including the risk of legal challenge as a result of providing unsuitable accommodation, • Risk of incorrect payments to sponsors, • Failure to identify and address welfare and safeguarding concerns, • Risk of homelessness due to the ending of sponsor accommodation, with no alternatives readily available, other than temporary accommodation or foster care. Our scope included the following: • Checks on accommodation, welfare and safeguarding, including DBS checks. • Setting up and monitoring payments to sponsors for accommodation provided. • Recording of sponsor and guest data to the Council's housing case management system. • The Council's arrangements for re-matching guests if a sponsor's accommodation ends. Scope exclusion: We did not compare the recording of sponsor and guest data to the Council's housing case management system to records held on the case management system put in place by the Department for Levelling Up, Housing and Communities (DLUHC). This was partly due to time constraints but also because we focussed as a priority on the accuracy, completeness and timeliness of the data collected from sponsors and guests and recorded on the Council's housing case management system.

Redacted

FINAL INTERNAL AUDIT REPORT

PROPERTY SERVICES – FACILITIES MANAGEMENT - CONTRACT MANAGEMENT

PLA/06/2023

8 March 2024

Auditor	Senior Auditor (Mazars LLP)
Reviewer	Assistant Manager (Mazars LLP)
	Manager (Mazars LLP)
	Manager (Mazars LLP)
	Partner (Mazars LLP)

Distribution list

Job Title
Assistant Director Strategic Property (Interim)
Head of Facilities Management (Interim)
Director – Housing, Planning and Regeneration
Head of Finance

Executive Summary

Audit Objective	The overall objective of the audit was to assess the adequacy and effectiveness of internal controls regarding contract management practices within the Facilities Management team, which form part of Property Services.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	-	6	-

Key Findings

1. The Council has 16 active contracts in place concerning facilities management. The testing completed in this audit focused on a sample of five contractors, four of which represent those with the highest value and one low-value contract.
2. We reviewed the contracts and service agreements for each and confirmed these outlined the Council's and contractors' roles and responsibilities. Contract details, such as commencement and expiration dates, as well as total contract value, had been outlined correctly within the Council's contract register.
3. We confirmed that contract specifications had been documented for the sample of five contractors, which outlined the specific services to be delivered – including details on the specific locations for services to be provided and frequency of service provision. The service specifications also provided details on the precise methodology for completing work. They outlined the Council's expectations regarding service standards and the completed work quality.

We have identified the following areas for management attention:

4. **Performance Monitoring Arrangements** (Priority 2) Our testing confirmed that the performance monitoring arrangements and key performance indicators (KPIs) to be monitored for each of the five contractors within our sample had been outlined within the contractual agreements. However, our testing noted that the KPIs outlined within the contracts had not been reported for four of these contracts. ***See Recommendation 1.***
5. **Budget Monitoring Arrangements** (Priority 2) The Council monitors expenditure for its primary repairs and maintenance contractors via an Excel spreadsheet that compares the monthly and cumulative expenditure against budgeted amounts. However, the Council does not maintain oversight over the expenditure for all other facilities management contractors and does not produce detailed management information to maintain effective oversight over budgetary performance per contractor or to justify budgetary over/under spends. ***See Recommendation 2.***
6. **Oversight Over Quality of Service Delivery** (Priority 2) As part of an effective control framework related to contractor management, the Council should maintain sufficient oversight over the quality of works and services delivered by its contractors to ensure that instances of sub-standard service delivery

are promptly identified and resolved. Our testing highlighted that the Council does not have a post-inspection process whereby the quality of work is regularly reviewed and scrutinised. ***See Recommendation 3.***

7. **Understanding Issues Related to Existing Facilities Management Contracts** (Priority 2) **and Incomplete and Inaccurate Asset Register** (Priority 2) Without a detailed asset list outlining all equipment under the Facilities Management remit and their respective servicing/inspection dates, we sought to confirm whether the Council has an effective strategy to overcome any challenges faced as a result of this and whether an exercise has been completed to identify the issues experienced by its current contractors before retendering the facilities management contracts. The Interim Head of Facilities Management advised us that the Council is in the preliminary stages of appointing a contractor to create a comprehensive asset register. However, a formal exercise to identify the challenges faced by its existing contractors has not yet been completed. ***See Recommendations 4 and 5****.*
8. **Payments not Aligned with Contract Terms** (Priority 2) To ensure that payments to contractors were made following the contract payment terms and for the services delivered, we reviewed the three most recent invoices for the sample of five contractors. Our testing confirmed that for three contractors, invoices were paid in line with the contract payment terms, and we were able to confirm the invoices, with the related application for payments. However, our testing identified instances related to two contractors where payments were inconsistent with the contractual payment terms. ***See Recommendation 6****.*

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

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

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

Appendix A - Management Action Plan

1. Performance Monitoring Arrangements	
Finding Our review of the contractual agreements and specifications confirmed that performance monitoring arrangements, such as frequency of meetings and key performance indicators (KPIs) to be reported, had been clearly outlined for the sample of five contractors. We requested the three most recent performance monitoring reports and meeting minutes for each of the five contractors to confirm that agreed performance monitoring arrangements were adhered to. For one contractor, we confirmed monthly performance information was provided to the Council by review of June, July and August 2023 performance reports. These included detail on the progress of the planned maintenance programme, issues arising, health and safety incidents and findings from site audits. However, monthly performance information/KPIs, for the remaining four contractors within our sample was not provided. The Interim Head of Facilities Management advised that monthly informal meetings are held between the Council and three contractors. However, we were advised that the contractors did not report/monitor KPIs, as agreed within the contract specifications. For the final contractor, we were advised the Council does not hold regular meetings or receive performance reports due to the relatively low contract value; though we noted that the respective contract stipulated that KPIs would be reported to the Council monthly. **Risk** The Council does not maintain effective oversight over the performance of its contractors. It cannot identify and scrutinise sub-standard contractor performance, thus continuing to utilise ineffective contractors and leading to adverse value for money performance and reputational damage.	
Recommendation The Council should ensure that performance monitoring arrangements, as outlined within contractual agreements, are followed and sufficient performance information is received from the contractors to allow the Council to evaluate service performance appropriately. This should include maintaining regular, documented meetings with contractors once information is received to ensure performance is discussed and actions are taken when poor performance is identified. Regular meetings should then revisit discussions and actions assigned to ensure these are followed up and completed.	**Rating** Priority 2

Management Response and Accountable Manager	**Agreed timescale**
The management and accountable manger note the recommendations of the report. Urgent management attention will be given to ensuring the following: • That performance monitoring arrangements, as outlined within contractual agreements are followed and sufficient performance information is provided by the contractors to allow the Council to evaluate service performance appropriately. • It is noted that this should include maintaining regular, documented meetings with contractors. • Once information is received from Contractors to ensure performance is discussed and actions are taken when poor performance is identified. • That regular meetings should revisit discussions and actions assigned to contractors ensure these are followed up and completed. Assistant Director – Strategic Property / Head of Facilities Management	28 February 2025

2. Budget Monitoring Arrangements
Finding We assessed whether the Council has budget monitoring arrangements to effectively review and scrutinise monetary performance and ensure that any budgetary overspends are promptly identified and addressed. The Facilities Management Team maintains a spreadsheet which records the total expenditure for its primary repairs and maintenance contractors. The spreadsheet outlines a comparison of the monthly and cumulative expenditures against the contract budget. However, the spreadsheet does not provide detailed information or commentary to explain the expenditure incurred or variances against the budgeted amounts. For example, as of October 2023, the budget monitoring spreadsheet outlined an overspend of £74,456 for one contractor when comparing cumulative expenditure to the total contract value, however, commentary to justify or explain the overspend had not been documented. The Council did not produce similar budget monitoring information for the other contractors in our sample, as we were advised by the Interim Head of Facilities Management that they were fixed monthly contract costs, so expenditure was not monitored. The Council's Finance Team produces monitoring reports for repairs and maintenance costs, where actual expenditure is compared against the budget. Our review of the September 2023 spreadsheet noted that the actual expenditure for major and reactive repairs, property refurbishment, asbestos works, water services maintenance, and fire safety works had been collated and compared against budgets. However, the spreadsheet did not outline a breakdown of the

expenditure related to the facilities management function or total expenditure per contractor; the spreadsheet outlined that the budgeted expenditure for 2023/24 was £2,519,560 and we noted that as of September 2023, total expenditure was £1,510,690.

The Operations Manager advised that the Facilities team schedules monthly meetings with the Finance team to review financial performance. We requested the three most recent monthly meeting reports or minutes from the discussions. However, we were advised that the meetings had been cancelled due to limited staff capacity and no evidence was provided.

Risk

Due to insufficient financial performance information available, the Council does not maintain effective oversight over budgetary commitments and is unable to effectively review and scrutinise financial performance for the facilities management function and budgetary performance of its contractors.

Recommendation	**Rating**
Facilities Management should liaise with Finance to ensure that they have access to sufficient granular financial information, including a breakdown of expenditure per contractor, to enable them to accurately monitor spend and identify potential variances or overspends. This financial information should be regularly monitored within the team and discussed. Variances should be investigated and explained, with actions identified and followed up as appropriate. Facilities Management and Finance should agree the frequency of meetings required on a risk basis and jointly ensure that these are maintained and documented.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The management and accountable manger note the recommendations of the report. Urgent management attention will be given to ensuring the following: • Liaison with Finance and FM to ensure that there is sufficient access to granular financial information, including breakdown of expenditure per contractor to enable accurate monitoring of spend and identify potential variances/overspends. • That the relevant financial information should be regularly monitored and discussed within the team. • Variances should be investigated and explained, with actions identified and followed up as appropriate. • Finance and FM should agree the frequency of meetings required on a risk basis and jointly ensure that these meetings are maintained and documented. Assistant Director – Strategic Property / Head of Facilities Management	28 February 2025

3. **Oversight Over Quality of Service Delivery**	
Finding We considered whether the Council has controls to review the adequacy of completed contractor works to identify and rectify instances of sub-standard or non-delivered services. The Interim Head of Facilities Management advised that the Council does not complete post-inspections of completed works and has no other alternative controls or processes in place to evaluate completed works or ensure that agreed services have been effectively delivered. We were advised by management that before 2015, the Council used to complete post-inspections of completed works, whereby ten percent of completed works were reviewed monthly to review the quality and adequacy of completed services/works. However, the Council no longer completes post-inspections due to limited staffing resources and availability within the Facilities Management Team as advised by management. **Risk** The Council fails to identify and remediate incomplete or sub-standard contractor performance appropriately and continues to utilise ineffective contractors, thus leading to adverse value-for-money performance and reputational damage.	
Recommendation The Council should complete periodic post inspections for a sample of services delivered by its facilities management contractors, whereby the quality and adequacy of completed works are reviewed and where any identified issues are discussed and resolved directly with the contractors. This could be done on a risk-based approach.	**Rating** Priority 2
Management Response and Accountable Manager The management and accountable manger note the recommendations of the report. Urgent management attention will be given to ensuring the following: • The Council should complete periodic post inspections from a sample of services delivered by its FM contractors, to assess the quality and adequacy of completed works and where any issues are identified that they are discussed and resolved directly with the contractors on a risk-based approach. Assistant Director – Strategic Property / Head of Facilities Management	**Agreed timescale** 28 February 2025

4. Understanding Issues Related to Existing Facilities Management Contracts	
Finding Existing facilities management contracts are due to expire in September 2024. We assessed whether there was a clear and effective understanding of any issues experienced on the existing contracts, and if an exercise has been completed whereby any issues have been identified. Via discussion with the Interim Head of Facilities Management, we noted that the Council was aware of some issues. However the Council had not documented an exercise to determine the lessons learned and improvements to be made to the new contracts. Linked to other findings in this report, there is also a lack of KPI monitoring and reporting, formal documented performance and budget monitoring meetings. **Risk** The Council is unaware of the shortcomings and issues experienced with its current contracts and fails to implement the necessary changes when retendering contracts, thus failing to rectify underperforming service delivery areas and not achieving value for money.	
Recommendation The Council should identify all contracts due to be retendered and complete a lessons learned exercise, whereby the issues experienced during the duration of the contracts are identified, alongside the improvements and changes to be made when retendering the contracts. As discussed within Issue 1 of the Management Action Plan, the Council should ensure that sufficiently detailed performance monitoring reports and KPIs are being reported for all contractors, to ensure that an effective evaluation of the quality of contractor performance can be completed.	**Rating** Priority 2
Management Response and Accountable Manager The management and accountable manager note the recommendations of the report and confirm the following • A review on individual existing contracts to be undertaken to ascertain any contents that may need to be changed, or additional added, to increase robustness for new contracts due for procurement. • Instigate a review on KPI levels across the contracts and ensure they fall in line with a single standard that can be measured to identity performance across all contracts. • Undertake regular documented contract meetings with each individual supplier to review KPI's. Head of Facilities Management	**Agreed timescale** 28 February 2025

5. Incomplete and Inaccurate Asset Register	
Finding The Interim Head of Facilities Management advised that the Council does not have a complete and accurate asset register which records all assets within the Council's operational buildings. Management advised us that the Council has not implemented a strategy or alternative arrangements to overcome the absence of an accurate asset register, as the existing contractors have been utilised for multiple years and, thus, have an appropriate understanding and knowledge of all relevant assets. Management advised that the Council has contacted an external consultant to provide a quote for the proposed asset register development. We requested evidence of any correspondence or information related to the prospective appointment. However, we were not provided with the requested information. **Risk** The Council has an ineffective understanding of all assets within its operational buildings, which leads to assets not being included in the servicing and maintenance programmes, thus compromising the safety of the equipment and occupants.	
Recommendation The Council should continue its procurement exercise to appoint a contractor to develop and document a comprehensive asset register. After a detailed record of Council assets is created, the register should be shared with existing (or prospective contractors) to form the basis of the planned maintenance/servicing programme and future procurement exercises.	**Rating** Priority 2
Management Response and Accountable Manager The management and accountable manager note the recommendations of the report and confirm the following • The Council is currently in the process of undertaking a procurement process through an identified Framework to undertake a full asset register across all operational buildings. • Once completed this will be issued as part of any new procurement process for future contracts, applicable to the discipline, for maintenance and servicing to plant and equipment across the estate. Head of Facilities Management	**Agreed timescale** 28 February 2025

6. Payments not Aligned With Contract Terms

Finding

We reviewed the three most recent invoices (April, May and June 2023) alongside related supporting evidence to confirm that payments were made in line with the terms of the contracts and for actual services delivered. Our testing confirmed that the three most recent payments for three contractors were made in line with the amounts outlined within the contracts. This was confirmed via review of the invoices with the related application for payments, which provided a breakdown of all jobs related to the invoices. However, our testing noted issues with the two remaining contractors as follows:

Contractor A

Although we requested the three most recent invoices, we were only provided with the March 2023 invoice related to the services provided for April, May and June 2023. We noted that the contract stated that the disposal services were to be invoiced in arrears monthly. However, the March 2023 invoice was paid before the services to be provided within the following quarter. We queried this with the Interim Head of Facilities Management, who was unaware of the reasons behind the services being invoiced differently from the contract payment terms. Financial Regulations stipulate that 'Payments in advance should only be made where there is no practical alternative, and the reasons should be recorded. Payments should not be made in advance of goods or services being delivered'.

Also, we noted that the March 2023 invoice amount was £2,314, which exceeded the £1,352 cost calculated when using the contract's annual value. Management advised us that the additional expenditure related to further services requested by the Council to assist staff in preparing to relocate office workspaces from Civic Centre to Churchill Court. However, management did not provide evidence or correspondence to confirm that additional services had been requested and the costs agreed in advance.

Contractor B

Our review of the April, May and June 2023 invoices noted that the Council paid a monthly amount of £27,784.50, rather than the £26,052.47 agreed with Contractor B before the commencement of the 2023/24 financial year. We queried this with management and were advised that the Council requested additional services; however, management did not provide any evidence or correspondence to confirm that additional services had been requested and the costs agreed in advance.

Risk

The Council processes inappropriate payments for services not delivered by its contractors, leading to adverse value for money performance and financial loss.

Recommendation	**Rating**
	Priority 2

The Council should ensure that all payments made to its contractors are paid following the contract payment terms and that an appropriate audit trail is maintained to justify any additional expenditure incurred from where extra services are requested.	
Management Response and Accountable Manager The management and accountable manager note the recommendations of the report and confirm the following • Review the current practise to approval of supplier payments and put in place, as necessary, measures to ensure payments are made in line with contract payment terms. • Where you have a supplier with a repetitive contract with a set monthly payment, on occasions additional work may be required, this additional work should be instructed in accordance with such variations to the contract as outlined within the contract documents and recorded on the contract data base. Head of Facilities Management	**Agreed timescale** 28 February 2025

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 risk areas: • **Contracts** – Contractual arrangements clearly set out the roles and responsibilities of the relevant parties. – The contracts contain clear and measurable requirements against which contractor performance can be monitored. • **Schedule of Works** – There is a clear schedule of works which sets out the requirements and standards the Council expects from the contract. • **Asset Management** – A strategy to overcome the lack of a comprehensive asset list has been developed, and a procurement exercise is due to commence to appoint a comprehensive asset register across the Council's estate. – There is also a proposed strategy for retendering the Facilities Management contracts once the asset register has been undertaken. The challenges that exist at present have been identified and reported to Members through the formal channels. • **Quality Control, Rectification and Default** – Sub-standard, incorrect, incomplete and non-delivered services are identified, and subsequent management corrective action taken. – Where there are clear arrangements in place for the deduction of penalties or non-payment of incentivised bonuses in the event of substandard, incorrect, incomplete and non-delivered services is followed. • **Payments** – Payments made to the contractor are in accordance with the contracts and for services delivered. • **Performance Monitoring** – There is a robust process of performance monitoring in place that ensures that the quality of services is in accordance with Council requirements. • **Budgetary Control** – Budgets are effectively monitored and under/overspends are promptly identified and addressed.

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FINAL INTERNAL AUDIT REPORT

STREET ENVIRONMENT CONTRACT

AUDIT REFERENCE: PLA/03/2023

8 November 2023

Auditor	Principal Auditor
Reviewer	Assistant Director Head of Audit and Assurance

Distribution list

Assistant Director of Environment
Neighbourhood Manager
Head of Neighbourhood Management
Head of Performance Management and Business Support
Director – Environment and Public Protection

Executive Summary

Audit Objective	The objective of this audit was to review the effectiveness of the controls in place to govern and monitor the Street Environment Contract to ensure the service is delivered to expected standard and at the agreed cost.

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

Key Findings

It is positive to report that we found the controls over the Street Environment Contract were robust in design and working effectively. This is reflected by no findings being raised in this report. Our review found that the following controls are in place and working well:

- There is an up to date signed contract which includes a clear governance structure, performance monitoring arrangements and KPIs.
- Monitoring of performance against the delivery targets set within the contract is carried out. On a monthly basis the contractor provides a performance report using the performance management framework (PMF) template. The PMF includes the performance against KPIs in categories of Performance, Operational Delivery, Operational Reporting, Strategic Plans & Operational Programmes, Financial Performance & Administration, and Health & Safety and Personnel. A score is populated against each KPI based on supporting documentation, this is checked by the Business Support Officers to ensure it is accurate when the report is received from the contractor. A sign off email is sent to the Neighbourhood Manager to confirm the data has been checked and the Service Operations Board (SOB) meet monthly and discuss the performance on an exceptions basis.
- There is a process for managing non-compliance within the contract and issues of supplier failure. For example, where a performance measure has not been met a Performance Adjusted Value is calculated using the PMF and deducted from payments made to the contractor. When a threshold has been reached, a corrective action plan is initiated. It was noted that no corrective action plans had been initiated for the contractor's performance in Street Environment and low performance measures were rectified quickly. In the event that this changes, the contract also includes a clear disputes resolution procedure.

- Contract costs are monitored in detail and any variance is identified and investigated. On a quarterly basis the Senior Accountant meets with the Neighbourhood Manager to discuss the budget forecast and any accruals. There are no issues with the 2023/24 budget and 2022/23 came c.£7k over budget (the budget was £6.7 million).

- Invoices are supported by evidence and appropriately approved. Variable invoices are checked by the Business Support Team for accuracy and approved by the Neighbourhood Manager, reviewed at the SOB and payments are subsequently signed off by the Assistant Director of Environment and the Director of Environment and Public Protection. We tested a sample of 12 invoices and found that they complied with this process.

- Inflation pressures are effectively managed to minimise impact on the Council's budget and MTFS as far as possible. Uplifts are calculated each year per the contractual mechanism and then agreement is finalised via the respective SOB meeting.

- Business continuity procedures are in place and a different scenario is tested by the contractor annually. The results from the tests are shared with the Council, and we were provided with evidence to support that the 2023 test had been completed. Overall, the outcome was positive with one action raised which has been addressed.

Definitions of our assurance opinions and priority ratings are in ***Appendix A****.*
The scope of our audit is set out in ***Appendix B****.*

Appendix A - 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 B – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • The contract is not well governed and as such there is a risk of poor service which could lead to reputational and financial damage to the Council. • Payments are made for services that have not been received, or that have not been received to a satisfactory standard. The review focussed on the following elements: • The contract includes details on performance monitoring arrangements and KPIs. • Monitoring of performance against the delivery targets set within the contract is carried out. • Processes are in place to identify, manage and escalate concerns. • There is a process for managing non-compliance with the contract and issues of supplier failure. • Lessons learned and areas for improvement are considered. • Contract costs are monitored in detail and any variance is identified and investigated. • Invoices are supported by evidence and appropriately approved. • Inflation pressures are effectively managed to minimise impact on the Council's budget and MTFS as far as possible. • Business continuity procedures are in place. Our audit included interviews with key officers who help manage the contract, a review of relevant reports and documentation as well as sample testing of related procedures and processes.

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