Report No.
FSD 18083

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**AUDIT SUB-COMMITTEE**
Date:	**Wednesday 14 November 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**INTERNAL AUDIT PROGRESS REPORT**
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Chief Officer:	Director of Finance
Ward:	(All Wards);

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1. Reason for report

This report informs Members of recent audit activity across the Council and provides updates on matters arising from the last Audit Sub-Committee. It covers:-

3.2 Risk Management
3.3 Annual Governance Statement 2017/18
3.4 Audit Activity (Key Findings)
3.24 Audit Activity (Priority 1 Commentary)
3.30 Audit Activity (Other work)
3.33 Waivers
3.34 Publication of Internal Audit Reports
3.35 Letter of Representation
3.36 Code of Transparency
3.37 Annual Audit Letter
3.38 Objection to the Accounts

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2. RECOMMENDATION(S)

a) Note the Progress Report and comment on matters arising

b) Note the actions taken in respect of the Risk Management process, the departmental risk registers and approve the revised Corporate Risk Register

c) Note the list of Internal Audit Reports published on the council's website

d) Note the list of waivers sought since May 2018

e) Note the letter of representation

f) Note the Annual Audit Letter from KPMG

g) Note the Code of Transparency – reporting of fraud

h) Note the latest position on the objection to the Accounts

Impact on Vulnerable Adults and Children

1. Summary of Impact: Some of the audit findings could have an impact on Adults and Children's Services

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Corporate Policy

1. Policy Status: Not Applicable:

2. BBB Priority: Excellent Council:

Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Budget head/performance centre: Internal Audit

4. Total current budget for this head: £560k including £165k Fraud Partnership Costs

5. Source of funding: General Fund/Legal Cost recoveries

Personnel

1. Number of staff (current and additional): 6.5 FTE (1 post currently vacant)

2. If from existing staff resources, number of staff hours: 2018/19 – 900 days are proposed to be spent on the audit plan, fraud and investigations – excludes RB Greenwich investigators time.

Legal

1. Legal Requirement: Statutory Requirement:

2. Call-in: Not Applicable:

Procurement

1. Summary of Procurement Implications: Some audit recommendations will have procurement implications

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Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Approximately 100 including Chief Officers, Heads of Service, Head Teachers and Governors

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3. COMMENTARY

3.1 Internal Audit Progress

3.1.1 The Accounts and Audit Regulations require the Council to undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account the Public Sector Internal Auditing Standards (PSIAS) or guidance. Internal audit is a key component of corporate governance within the Council. The three lines of defence model, provides a simple framework for understanding the role of internal audit in the overall risk management and internal control processes of an organisation:

- First line – operational management controls
- Second line – monitoring controls
- Third line – independent assurance (Internal Audit forms the Council's third line of defence)

3.1.2 In simple terms this assurance will assess whether risks are being appropriately managed. This will help the organisation to; avoid surprises, establish whether activities are being delivered as expected and ensure opportunities are delivered in an efficient way. This provides accountability to our stakeholders and establishes priorities for managers where further action is required.

3.2 Risk Management

3.2.1 It was agreed by the Committee that Risk Registers would be reviewed at least 6 monthly, updated and reported first to Audit Sub-Committee and then to the respective PDS Committees. Internal Audit has discussed the registers with DLT's and CLT. They have also been discussed at a meeting of the Corporate Risk Management Group (CRMG). The updated Risk registers are shown in Appendix A.

3.2.2 As part of the Council's Insurance Contract with Zurich there is a "notional budget" to use the services of their Strategic Risk Management Consultants and their expertise and knowledge to further strengthen risk management and control arrangements within the Council.

3.2.3 Members will be aware that the Corporate Risk Management Group (CRMG) has commissioned Zurich, our insurers, to undertake the following work streams to inform and strengthen risk management.

- Risk Register Refresh, Check and Challenge
  A series of Check and Challenge sessions to review and refresh the Risk Registers resulting in an updated set of Directorate Risk Registers reflecting the current risk profile of the organisation.

- Information Governance Health Check
  A desktop review of the existing policies and procedures, supported by a series of interviews with key stakeholders, resulting in recommendations for improvement and an Information Risk Maturity grading, including a sector comparison.

- Business Continuity Planning
  Provision of guidance and reassurance on best practice and approach supplemented by testing, through suitable scenarios, of the Business Continuity Plans of each Directorate to provide greater awareness of the individual service needs and responses to others and vice versa.

3.2.4 At the Executive, Resources and Contracts PDS meeting of 5th September, it was requested that the risks marked as 'Red' (High) should be presented to each meeting of the relevant PDS committee and that the 'further action required' column of each Risk Register was to be kept under review. This requirement has been disseminated to all Risk Register owners and the process commenced with the presentation of the Chief Executive's, Commissioning and Finance Risk Registers to the Executive, Resources and Contracts PDS meeting on 11th October. The Human Resources Risk Register does not currently contain any Red (High) risks and therefore was not included in the paper.

3.3 Annual Governance Statement 2017/18

3.3.1 The Annual Governance Statement (AGS) for 2017/18 received final approval from the Authority's External Auditors (KPMG) who reported, in their External Audit Report of 25th July 2018 and presented to the General Purposes and Licensing Committee meeting of the same date, that the AGS 'complies with Delivering Good Governance guidance issued by CIPFA/SOLACE in April 2016'.

3.3.2 The Annual Governance Statement for 2017/18 identified the following five areas as requiring further work during 2018/19:-

a) Finance (capacity to make further budget savings)

b) Contract Management (need for strengthened control and management oversight)

c) Performance Management (robust quality assurance arrangements)

d) Code of Corporate Governance (update to reflect 2016 CIPFA/Solace guidance)

e) GDPR (significant changes required to ensure compliance)

3.3.3 All of the above, with the exception of d) Code of Corporate Governance, are embedded through existing work streams and reporting arrangements. The Code of Corporate Governance is in the process of being reviewed and progress against all five areas will be reported in the 2018/19 Annual Governance Statement.

3.4 Audit Activity (Key Findings)

3.4.1 The latest list of outstanding Priority 1 recommendations is shown in Appendix B. There have been some additions since the last meeting of this Committee and these are detailed below. There has also been some movement in Priority 1 recommendations brought forward that are also detailed below.

3.4.2 A summary of key findings from Audits completed to date follow:

3.5 Contract Management of Adult Mental Health

Objective

3.5.1 Review the contract management and monitoring of the Section 31 agreement with Oxleas to provide Mental Health Services.

Audit opinion – Limited

3.5.2 For the Section 31 agreement with Oxleas, controls noted to be in place included a signed agreement, stipulation that the provider complies to statutory regulations, the functions of both parties are stated, confidentiality and compliance to the Data Protection Act was stated, the

financial arrangements of the pooled budget are documented as was the procedure to action over and under spends.

3.5.3 However examination of the Section 31 Agreement and interviews with responsible officers indicated issues arising with the contract management and monitoring of this agreement. Five Priority 1 recommendations were raised which are summarised below:-

Variation to contract

3.5.4 The agreement had been in place for 14 years without any evidence of review or variation to ensure it is relevant and fit for purpose. There was no evidence of any change control documents issued for the agreement

Performance Measures and Monitoring

3.5.5 Performance measures stated in the agreement were obsolete and out of date and no defined monitoring arrangements were in place. No Mental Health Board was in place and no formal reviews undertaken or reports as stated in the agreement

Roles and Responsibilities

3.5.6 LBB operational lead was not defined or evidenced during the course of the audit review. The Business Support Officer (BSO) is key as the link between Oxleas and LBB, RIO system and CareFirst. This was a temporary post and the agency officer left 31/3/18 with no funding to replace. The BSO had no defined reporting lines and worked in isolation.

Service Agreement Reviews

3.5.7 Reviews should be completed every 3 to 6 months, as stated in the Panel decision for each case. A summary spreadsheet evidenced to audit showed that as at the beginning of March 2018 53% of clients had an outstanding review (this value excludes the priority cases where the care package exceed £900 pw). The Department engaged 2 temporary care managers to review all cases with a view to achieve savings.

Management Reporting

3.5.8 Quarterly performance reports have not been received from Oxleas.

3.6 Contract Management – Adult Mental Health – Follow up

3.6.1 The audit report was finalised in May 2018 just after the previous Audit Sub Committee. The 5 Priority 1 recommendations are reported in the paragraphs above as being new to the Priority 1 list. Given 5 months has elapsed and the target date for all recommendations passed, it was timely to carry out the follow up and report progress to implement.

Variation to contract

3.6.2 The Director of Programmes and the allocated Strategic Commissioner have referred the agreement to the Authority's Legal Team for consultation and guidance. The initial issue to resolve is whether this is a section 75 or section 31 agreement. The agreement will either be terminated and a formalised partnership agreement will be issued or the existing agreement will continue with Change Control Notices to support the variations to contract.

3.6.3 Bromley officers have identified the changes to the agreement required to operate the Mental Health service for service users. Oxleas have similarly been requested to highlight any changes to the agreement and respond to the Authority by the 22/10/18. The Strategic Commissioner confirmed that there was a data sharing agreement with Oxleas for client information but there would need to be an agreement for data relating to seconded staff and this was work in progress. The recommendation will remain open.

Performance Measures and Monitoring

3.6.4 The Director of Programming is currently reviewing the structure of the division. With the Contract and Commissioning Team transferring back to the Department the monitoring of this agreement can be assigned accordingly.

3.6.5 As discussed above the agreement will be updated and reflect the service delivery required by the Authority and agreed with the provider. Key performance indicators may therefore be changed but as an interim measure the Strategic Commissioner has developed a draft performance management schedule. The final list of indicators has not yet been agreed by both parties. Oxleas need to respond with their assessment of the feasibility and timescales for collecting the data and reporting on the proposed indicators. Information will be available in report format generated from RIO, the case management system used by Oxleas. Bromley officers anticipate that the first test run to monitor and qualify submitted data will be November 2018.

3.6.6 The CCG Monitoring Board meet monthly, the Section 31 agreement has now been added as a standing item on the agenda. A dedicated monitoring meeting led by Bromley and chaired by the Director of Adult Social Care has been scheduled to start in November 2018. The recommendation will remain open.

Roles and Responsibilities

3.6.7 The Director of Adult Social Care has been formally nominated as the Council's Authorised Officer and is also the Lead officer with operational responsibility. Resources have now been secured to fund the BSO as an established post and will be part of the brokerage team with clear reporting lines and designated authorising officer. Two officers are currently completing the BSO role in terms of panel administration, liaising with Oxleas, uploading service agreements to CareFirst and monitoring reviews. The recommendation is therefore closed.

Service Agreement Reviews

3.6.8 The service has confirmed that the reviews are now being completed on time and the outstanding reviews cleared. The HoS P&B confirmed that the approach to reviews has now changed. Previously Oxleas completed a review and notified Bromley to duly update CareFirst, the team have now set up a desktop alert for all reviews due for this client group and Oxleas are instructed to carry out the reviews. There is also now a link between Practice Review Group (PRG) minutes and requests to Oxleas to complete specified reviews, evidenced by e-mail to the provider. The outcome of all reviews is reported back to the weekly PRG meetings.

3.6.9 Since June 2018 the department have made a concerted effort to clear the back log of reviews for Adult Social Care clients. When the project started in June, 355 adult clients had an overdue review; 174 clients were less than 3 months, 60 clients were 3-6 months, 80 clients were 6-12 months and 41 over 12 months. The Performance Team reported on the 5/10/18 that the total of number of overdue reviews was now 112, of which 69% were less than 3 months overdue and no clients were more than 12 months overdue. Of the 112 identified 77 were new clients so only 35 of the original 355 clients were still outstanding at the time of testing. The Director of Adult Social Care has now confirmed that as at 26/10/18 all of the 355 reviews have been completed.

3.6.10 The original audit review finalised in May 2018 identified 177 Mental Health clients with an outstanding review of more 3 months, 95 of these cases were overdue for more than 12 months. The October Dashboard report evidenced that 8 cases were overdue for the Mental Health clients, 7 are less than 3 months and 1 3 to 6 months. However the agreed review period for new clients to the Mental Health service is within 6 months. The current performance data generated from CareFirst and reported to management does not identify new starters and measure against the 6 month guideline. This issue has been discussed with the Director of

Adult Social Care and the Performance Team and will be resolved.

3.6.11 The recommendation is partially implemented and will be progressed to implemented once the performance data can evidence that Oxleas are achieving service agreement reviews within 6 months for new starters. Initial investigation suggests that there may be 7 clients that are overdue and the Director has confirmed that these reviews will be scheduled as a priority.

Management Reporting

3.6.12 As discussed above the Strategic Commissioner and Director of Programmes have, in consultation with Oxleas, reviewed the current agreement including the information to be submitted as quarterly management reports.

3.6.13 The Department have made significant progress to implement the Priority 1 recommendations, specifically ownership of the agreement, assignment to a strategic commissioner and undertaking a complete review and revision of the agreement to ensure it supports the service delivery required by the Authority to meet the statutory functions for Mental Health. The Director of Programmes stated that "Whilst the Authority has the responsibility for the management and governance of the S31 agreement, negotiating new terms and conditions and adopting a new performance framework do require the cooperation and input of Oxleas which impacts on the time taken to complete the Priority 1's." The Department have set a target date on December 2018 to issue the new agreement, formally adopt the monitoring framework for performance management and schedule the receipt of quarterly and annual management reports. As such the three Priority 1 recommendations will remain open. The recommendation relating to service agreement reviews is partially implemented and will be fully implemented when the Performance Team separate the new starters and evidence that the reviews for these cases are completed within the first 6 months. The recommendation relating to roles and responsibilities has been satisfactorily implemented and will be closed.

3.7 Adults Safeguarding

Objective

3.7.1 Review of the system to monitor the budget, assessments and controls to ensure that all cases are effectively managed within agreed timescales and according to safeguarding procedures.

Audit opinion – Substantial

3.7.2 Controls were in place and working well in the areas of policies and procedures; staff completed regular training related to Adult Safeguarding, timely receipt and recording of referrals on CareFirst; strategy discussions and enquiries were completed and recorded on CareFirst in a complete manner; case conferences and review meetings were completed and where required a protection plan developed; regular meetings to monitor Adult Safeguarding cases; safeguarding process closed and appropriately approved when the safeguarding concern had been removed and management information was produced and reviewed on a weekly basis.

3.7.3 Two Priority 2 recommendations were raised with regard to the timeliness of the strategy discussion, the plan and review meetings and secondly the timeliness of closing the case.

3.7.4 In accordance with the PAN London procedures and Bromley local procedures, a strategy discussion should be completed within five working days of receiving the referral. Audit testing identified that 4 of the 10 cases sampled exceeded this target the longest delay being 49 days. The plan and review meeting/case conference should be completed within 20 days of the enquiry report, according to the PAN London Procedures and the Bromley Local Procedures.

For 2 of the 10 cases tested this target was not met.

3.7.5 In accordance with the PAN London procedures, it is suggested that closure of Safeguarding cases should be undertaken immediately following the removal of risks. This has been adapted by Bromley, with the local procedures detailing that the review and closure should be within 30 days of any final actions. For the sample of 10 cases tested, 5 had not been closed within the 30 days target.

3.7.6 A Priority 3 recommendation was raised in respect of the upload of information to CareFirst and the need for officers to use consistent document names and save information to consistent locations.

3.8 Continuing Healthcare Funding

Objective

3.8.1 Review of the systems to assess and monitor clients moving from social care to health care funding. Evaluate value for money issues regarding end of life funding and ensure that all available funding streams are utilised.

Audit opinion – Substantial

3.8.2 Controls were in place and working well in the areas of formal reporting lines identified, the panels meet on a monthly basis, checklists and Decision Support Tools (DST) are completed and uploaded to CareFirst where possible and joint funded cases are reviewed regularly.

3.8.3 Seven Priority 2 recommendations were raised with regard to the need to develop policies and procedures; maintain a training log to ensure all relevant staff have adequate training to carry out their duties; confirmation that assessments have been completed; retaining supporting documentation on CareFirst (care plans and Individual Service Agreements) with start and end dates to ensure all appropriate costs are recovered; completion of a panel decision sheet for all joint funded cases to confirm the agreed split and the need to invoice the CCG in a timely manner to recover costs with senior managers receiving monthly reports to monitor the financial status of joint funded cases.

3.8.4 Two Priority 3 recommendations were raised; checklists to be passed over to the CCG in a timely manner and recorded on CareFirst and secondly that the terms of reference for the CHC and Joint Funded Panels be finalised.

3.9 Council Tax

Objective

3.9.1 The overall objective of the audit was to review the key controls around council tax, including collection and recovery methods and provision for bankruptcy. We also reviewed controls over council tax support payments and discounts and compliance with the Service Level Agreement currently in place.

Audit opinion – Substantial

3.9.2 Controls were in place and working well in the areas of monthly monitoring arrangements with the Exchequer contractor, documentation for support payments and the collection rate for Council tax, including recovery where bailiffs were engaged.

3.9.3 We made seven Priority 2 recommendations where management action will improve controls. These include the documenting of supporting evidence for discretionary payments made,

refunds requested and discounts provided. The way Council tax complaints were dealt with also showed a lack of evidence retained. We found that the Discretionary Council Tax Support claim form was not Data Protection Act 2018 compliant.

3.10 IT Project Management

Objective

3.10.1 The overall objective of the audit was to review the key controls around IT project management.

Audit opinion – Substantial

3.10.2 Controls were in place and working well in the areas of the Change Control Notice process for projects and availability of information for staff applying for projects to be carried out. Weekly meetings were held to discuss on-going projects and their progress and purchase orders raised for projects matched the agreed costings.

3.10.3 We made six Priority 2 recommendations and one Priority 3 recommendation where management action will improve controls. These include the completeness of information provided on the Change Control Notices and the lack of information provided to the Partnership Board on the performance of IT projects. Furthermore, there were no terms of reference for the Governance Portfolio meetings and the Partnership Board.

3.10.4 Our sample testing identified payments which had not been authorised for payment at the correct level of financial authority and the invoices received did not specify in detail the goods/services provided. A lessons learned' review had not been carried out for two of the projects in our sample.

3.11 Creditors

Objective

3.11.1 The overall objective of the audit was to review the key controls around payments to creditors.

Audit opinion – Limited

3.11.2 Controls were in place and working well for the regular reconciliation of the ledger control account to the creditors' control account, monitoring of duplicate payments and evidence of checks carried out on goods and services received prior to payment. We found that payments are correctly coded in the accounting records and VAT payments are correctly identified.

3.11.3 There is one Priority 1 recommendation. A set-up/amendment form is required for all new set-ups/amendments to the Creditors' Masterfile. Whilst section 1 of the form is completed by an officer in the business service area which requires the supplier to be set-up/amended, the form is not checked or signed off by the budget holder or other designated manager within that business service area.

3.11.4 We also made three Priority 2 recommendations to further improve controls. These relate to the monitoring arrangements to identify purchase orders raised retrospectively and the need to change periodically the code to the safe where blank cheques are stored. We also identified that a payment of £230,832 had been authorised by an officer with insufficient delegated financial authority.

3.12 Home Tuition

Objective

3.12.1 To review the system for referral and payment to providers.

Audit opinion – Limited

3.12.2 The Home and Hospital Tuition Team has three distinct areas of service; the hospital team at the PRUH, Electively Home Educated children, and the Home Tuition service for children not able to attend school for physical, medical or mental health reasons. Children with an Education, Health and Care Plan (EHCP) may also receive Home Tuition for a limited period funded from the SEN budget.

3.12.3 This review considered the Home Tuition service only, no testing was completed for the Hospital Team or Elective Home Education. A sample of 20 cases was selected from the Home Tuition database for audit examination. The sample was used to test referral documentation, reviews, allocation of hours, timesheets, attendance records and the use of the proprietary purchasing system. From the audit testing and interviews with the Home Tuition Team there were 11 findings; 5 were considered to be Priority 1 as follows:-

Core Panel Decisions

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

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

Database

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

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

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

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

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

Payments to Agency Tutors

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

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

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

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

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

Attendance Registers

3.12.13 All tutors, Bromley and agency, are required to complete the weekly attendance sheet for each child and this should be returned at the end of each half term. The spring term attendance records were checked to the timesheets for both the Bromley (February 2018) and agency (w/e 23/2/18) tutors. The main issues arising for agency staff were that:-

- For 5 of the nine tutors tested attendance records could not be found and for 2 of the tutors. The team confirmed in an e-mail that neither had submitted attendance records and that this had been an ongoing problem.
- For one tutor at the Link, the attendance sheet cannot be used to support hours claimed as 14 children are recorded over the week and tuition is not 1:1
- The attendance sheet did not agree to the hours/days claimed on the timesheets for two of the tutors.

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

- For 1 of the 5 tutors sampled no attendance record could be found

- For 3 of the tutors the hours claimed were above the hours declared on the attendance records.

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

Procurement and the use of one supplier (supplier A)

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

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

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

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

3.12.20 The review of budget monitoring identified that:-

- the expenditure code set up in the procurement system for SEN pupils was incorrect. Home Tuition will procure tutors for SEN cases, temporarily assigned to Home Tuition but the cost remains with SEN. The Service accountant was alerted and worked with the Lead Teacher to identify the miscodings and correct. Procurement confirmed that the codes were entered when the system was set up but could be changed for each requirement.
- the engagement of 2 tutors from supplier A working at the Link, is not subject to competitive tendering as the requirement on the procurement system is set to “manual” rather than “tender”. This effectively means that the engagement of both tutors is not subject to competitive tendering. The annual cost for one of the tutors is £77,220 based on a confirmed hourly rate of £66, 30 hours per week and 39 weeks per year.
- the cumulative spend report identifies £8,750 to supplier A in 2017/18 and £20,000 in 2018/19 but the summary spreadsheet maintained by accountancy of the weekly invoices show £471,366 to them for 2017/18. Accountancy explained that as the payments are made from a holding account and recharged rather than individual expenditure codes, the value is not captured on cumulative spend.

3.12.21 The audit test to check the sample of agency tutors and allocated pupils to ensure that the engagement was supported by a requirement, a contract and that the rates, hours and start dates agreed to the weekly payment was not completed. The Home Tuition Team were not able to access the procurement system website to provide the information required for

testing. This indicates a training issue that can be addressed as the procedure to check and verify engagements for tutors is developed and the necessary controls put in place.

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

- Of the 13 contracts declared 5 started in the academic year 2017/18, 2 16/17, 2 15/16, 2 14/15 and 1 in 13/14.
- None of the requirements state an end date, a start date only is specified.
- The Lead Teacher confirmed that there are open engagements on the system no longer used but cannot be closed on the system.
- For a sample of two requirements the Senior Procurement Officer evidenced that 11 and 8 providers were invited to bid for a requirement set up by Home Tuition but all cancelled except supplier A. The owners of the proprietary purchasing system have not done any review work to suggest why providers do not bid for Home Tuition work but the Senior Procurement Officer suggested that it is the short period of time between the close time and review time.
- There are service agreements for more hours than are allocated.
- A check on one requirement evidenced a bid of £48 per hour for 10 hours but the weekly payment summary for this agreement showed that the value regularly exceeded this amount. This should be a basic check undertaken by the Team but is not currently considered.
- The Lead Teacher confirmed that no checks are made on the rates charged; the team do not have access to the weekly spreadsheet that is attached to the invoice. The invoices for February 2018 and July 2018 were checked for the Home Tuition engagements; rates had both increased and decreased but the LT HT/H was not aware of any change and had not received any uplift or change of rate notification.

3.12.23 The 6 Priority 2 recommendations related to the medical evidence available to support the referral to the service; the need to formally record the weekly reviews by the team; the submission and checking of monthly timesheets for LBB tutors; the need for mandatory training for the Home Tuition team; development of operational procedure notes to support the work of the team and the need to securely store historical data.

3.12.24 The audit findings were discussed with the Team during the course of the audit and progress to implement for some recommendations commenced before the report was finalised to allow new practices with improved control to be rolled out for the start of the Autumn Term.

3.13 Direct Payments

Objective

3.13.1 To review the system in place for assessment and review of clients for direct payments. To include the contract monitoring for the direct payment support and payroll service and follow up the recommendations identified in the 2016-17 investigation report.

Audit opinion – Limited

3.13.2 Ten recommendations were made within this audit, four were priority one recommendations and the remaining six recommendations were priority two recommendations.

3.13.3 There are four significant findings relating to DP5 documentation, direct payment terms and conditions and payments and ownership of documents for update & review including appointed person form.

DP5 Documentation

3.13.4 The DP5 is the legal agreement between the service user and the Authority, whereby the both parties sign to confirm that the direct payment will be used in accordance with the terms of and conditions of the DP5 agreement.

3.13.5 Unlike other DP forms, which are embedded within Carefirst the DP5 is issued by the contractor and a scanned copy of the signed form should be held on Carestore for each service user. Audit testing showed that the DP5 could not be located within Carestore for 20 of the thirty cases reviewed at the time of testing.

Direct Payment Terms and Conditions not met

3.13.6 It was found that issues arose with 3 cases whereby terms and conditions of the direct payment were found not to have been complied with.

3.13.7 In two cases (siblings) both received a one off amount of £4,000 for the year to enable respite provision. It was found that no monitoring information has been provided since 2015 and it has not been confirmed whether the client contributions have been paid into the account and whether the monies have been used for respite services. The Exchequer contractor advised the Auditor that 'Email from sent to Senior Accountant on 26/10/2017 advising that receipts for respite not received. Letter was sent 21/3/2018 regarding both clients to parent this is scanned onto Care Store under Finance Direct Payments. Email was sent to three officers on 17/4/2018 no response received.

3.13.8 For the third case statements from the contractor showed that individuals with the same surname were potentially providing the service user with care and the approval for this was not seen at the time of testing.

Payments

3.13.9 Payments in place at the time of testing were cross referenced to supporting documentation. Issues arose in 2 cases.

3.13.10 In the first case, it was found that this service user had 4 direct payment service agreements on Carefirst all commencing on 5/5/14 and totalled £4,358.20 per week. The service agreement selected for testing was the night wake service which stated that it should be 8 hours (1 person) x £13.28 per hour = £106.24. This equates to £743.63 per week, however, £804.16 has been paid per week instead. Enquiries have been made with the Interim Group Manager for LD and the Senior Care Manager.

3.13.11 It was confirmed by the Interim Team Manager, that the service agreement should be 8 hours x £13.28 x 7 days a week. This should have been at a weekly cost of £743.68. This has resulted in an overpayment of circa £12,500 from May 2014 to May 2018.The service agreements have since been closed off as at 2/4/18 as the service user is now within a supported living placement. It should be noted that for this service user the DP5 could not be located at the time of testing. The DP7 was completed on 22/5/18.

3.13.12 The second case had a current direct payment that commenced on 27/10/14 for 21 hours per week @ £11.78 per hour = £247.38 but £264.39 has been paid weekly to date. This is an overpayment of £17.01 per week and circa £3,000 in total to the end of March 2018.The DP1 (start-up form) dated 30/10/14 confirms the rate should be £247.38.

Ownership of Documents For Update & Review Including Appointed Person Form

3.13.13 During the audit enquiries were made in relation to the location of the Direct Payment documentation.

3.13.14 It could not be determined which officer was responsible for the review and update of the direct payment documentation and also where the latest copy resided such as the DP5, which is the legal document that is signed by all parties.

3.13.15 A contact at contractor provided the latest copy of the DP5 to the Auditor. Enquiries have been made to determine what happens once the DP has been signed by all parties as a number of the completed DP5 documents could not be located.

3.13.16 In relation to the Nominated / Appointed Person form, it could not be determined where these forms are located. This form was discussed at the contract monitoring meeting on 23/10/17. The minutes state in relation to the Authorised Person Form "It was agreed that this would be used instead of the DP5 and that there needs to be clear instruction in the referral stating who needs to sign the form during the DP set up visit".

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

3.13.18 There were also six priority 2 recommendations made within this report that related to related to the following areas:-

- Reviews
- Support plans & Statement of Needs
- Balances held on the direct Payment Accounts – these are being reviewed.
- Contract Performances Measures
- Direct Payment Monitoring Information – procedures are being reviewed jointly by Care Management and Finance to include the role of Care Management and the exchequer contract responsibilities.
- Direct Payment user groups.

3.14 Edgebury Primary School

Objective

3.14.1 Adequacy and effectiveness of the system of controls surrounding the financial administration of the school, as required by the 1998 School Standards and Framework Act Section 48, paragraph 2(d) and the Authority's Scheme for Financing Schools.

Audit Opinion - Substantial

3.14.2 Internal Audit visited the school on the 1st May 2018. Controls were in place and working well in the areas of financial management, governance arrangements, safeguarding assets and for primary accounting, bank reconciliation, DBS checks, income, petty cash and credit cards.

3.14.3 There were 3 Priority 2 recommendations relating to a review of the expenditure process to improve the procedures to authorise; evidencing the completion of the HMRC online questionnaires for payments to individuals; and extend the information shown on the

contracts register to report the annual cost and the whole life value of all contracts and agreements.

3.14.4 There were 2 Priority 3 recommendations relating to the availability of the signed pecuniary interest forms for Governors and to record the presentation of the certified audited accounts for the voluntary fund to Governors.

3.14.5 All findings were discussed and agreed with the Head Teacher and Finance Officer at the end of audit meeting on the 1st May. The management comments incorporated in the report finalised on the 19th June indicate that the school have implemented all recommendations by July 2018.

3.15 Family Placements

Objective

3.15.1 Review of the system for the assessment of service and payments. The review will include connected persons and adoption, kinship allowances, special guardianship (SGO) and child arrangement orders.

Audit opinion – Limited

3.15.2 One Priority 1 recommendation and five Priority 2 recommendations have been raised.

3.15.3 The Priority 1 recommendation related to the payment of weekly allowances for Child Arrangement Orders (CAO) and Connected Person (CP) allowances. A sample of 20 children was tested and in all but 1 case the weekly payment did not agree with the 2017/18 DfE rates that have been provided by the Team but were later confirmed to be the 2016/17 rates.

3.15.4 Further investigation by Internal Audit and interviews with Finance and the Head of Service Placement & Brokerage (HoS P&B) highlighted several issues with regard to the payment of allowances:-

- Before September 2016 all foster carers, SGO's, CP and CAO had been paid according to locally agreed Bromley rates which were higher than the DfE rates.
- A report to Executive in May 2016 resolved to transfer all foster carers to the DfE rates with immediate effect for new carers and 1st September 2016 for existing foster carers and pertinent to this audit:-
  "The Department for Education maintenance allowances be used as the core allowance in the calculation for connected person, special guardianship, adoption and child arrangement financial assessments from 1st July 2016 for all new carers"
- The Service Accountant evidenced the 2014/15 Bromley rates that had been taken to Committee. The HoS P&B evidenced the same report template but for 2016/17 and these are the DfE rates that are currently being paid.
- The source of the 2016/17 allowances template evidenced by the HoS P&B could not be confirmed but thought to be the previous Head of Service who left the Authority in February 2017.
- There is no evidence that following the May 2016 Executive report LBB rates have been reviewed and uplifted to pay allowances to existing carers at the July 2016 cut-off date.
- The cases selected for audit testing agreed to the 2016/17 DfE rates in 19/20 cases. It should be noted that the 10 CAO cases all predated the July 2016 cut off and should therefore, according to the May 2016 Executive report, be paid at local rates rather than the DfE allowances.
- No uplift had been applied to the foster carer, Connected Person or Child Arrangement Order for 2017/18 or 2018/19.

- The DfE thresholds are a minimum to be paid, Bromley are currently paying carers below that minimum for maintenance.
- The Finance Officer (FPT) arranged to meet with the HoS P&B and the CareFirst Support Officer on the 6th June 2018 to discuss the uplift and to potentially back date to December 17 for the 2017-18 rates however at this time there was no evidence that this decision had any authorisation or management consideration.
- There is a further complication given the DfE rates have an additional banding of 0-2 years old whereas Bromley have 0-4. Carers for 0-2 children in Bromley are currently being paid at the higher rate. To implement the same bandings as the DfE rate, **0-2, 2-4**, 5-10,11-12,13-15 and 16+ will take significant work on CareFirst to cancel all service agreements, amend the set up and then re-enter all cases.
- The end of audit meeting held on the 7th June with the Head of Service confirmed that the uplift for 2018/19 should have been actioned as it had been discussed at budget monitoring in December 2017. The Head of Service was not aware that the 2018/19 uplift was still outstanding or that the current rates were the 2016/17 rates and therefore the 2017/18 uplift had also, not been actioned.

3.15.5 At a meeting with the Director of Children's Social Care on the 3rd July 2018 it was confirmed that The Fostering Network had written to the Authority in December 2017 highlighting that data collated in a recent survey identified that the Bromley rates were lower than the current DfE rates. In an exchange of e-mails between the 8th and the 11th December 2017 the Director of Children's Social Care agreed that the rates should be moved up as identified by The Fostering Network and the Head of Service instructed the Finance Officer to action this effective from week beginning the 18th December 2017 if possible.

3.15.6 The reason for the delay or oversight would be considered by management. However going forward any training needs or skill gaps should be assessed and facilitate access to Finance colleagues and peers for the Finance Officer (FPT). The Priority was to address the underpayment, assess the financial impact for 2017-18 and 2018-19 and execute the uplift with the 2018/19 DfE rates. The financial impact and sensitivity of the service area would warrant careful consideration and authorisation at the appropriate level.

3.15.7 Management provided a chronology of communication exchange with the CareFirst Help Team from December 2017 to evidence that the team had attempted to uplift the rates. The e-mail exchanges indicate that the original work request was put on hold in February 2018, awaiting confirmation from the service that they would undertake the additional work required to change the banding. At a meeting in June 2018 between the Finance Officer (Fostering and Adoption), HoS (P&B) and the CareFirst Help Desk it was agreed to retain the current banding. A second work request was submitted and the rates uplifted in two stages; 2017/18 rates backdated to December 2017 and paid to carers on the 20/7/18; the 2018/19 rates backdated to April 2018 and paid to carers on the 3/8/18.

3.15.8 There were five Priority 2 recommendations relating to:-

- Financial Regulations training had not been undertaken by all officers in the Fostering and Adoption Team with financial responsibility;
- Family Placement Officers were storing information in different locations on CareFirst/CareStore. Children's Team were not notifying the Central Placement Team when the placement classification or legal status of the child changed so that the information held on CareFirst and used by Finance did not agree to the actual case numbers monitored by the Family Placements Team;
- The means test reviews for 2/10 adopters sampled exceeded 12 months and for 4/10 cases the value paid did not equate to the means test completed;
- For 2/10 SGO assessments the Group Manager had not dated the review when authorising the document and for 1/10 the reviewer had not signed as authorised;

- For 3/10 SGO cases the annual means test review was not evidenced on CareFirst

3.16 Leaving Care

Objective

3.16.1 Review and evaluation of the system for the payment and monitoring of financial assistance to clients.

Audit opinion – Limited

There are six Priority 1 findings made within this report that related to :-

- Documentation to support payments to service users
- Pathway Plans
- Individual Service User Finance Records
- Grant Sheet (Central Log)
- Reconciliation to Oracle (T accounts)
- Staying Put Allowances

Documentation to support payments to Service Users

3.16.2 Issues arose in six cases concerning the supporting documentation and substantiating the payments currently being paid:-

- For Sample 1 no documentation could be located to verify the amount of £1,337 per week.
- For Sample 2 – A Living Together agreement was located for this service user at the weekly rate of £155.75. The current service agreement is £255.75 from 24/8/16. The Group Manager advised that the rate that should actually be paid is the staying put rate of £376.45 per week.
- For Sample 6 – A service agreement from 5/3/18 to 25/11/18. This service user turned 18 on 23/11/18 but it is unclear why the payment was not ended on 23/11/18.An overpayment of £16.54 has arisen.
- For Sample 13 a service agreement commenced on 21/12/17 to 19/5/18 for £100 per week. This was a staying put retainer payment for term time only while the service user attended education. It was found that the period related to term time and non-term time, so the incorrect rates had been paid.
- For Sample 16 a service agreement commenced on 8/7/16 for £1,800 per week and remains current. No agreement has been located to support this placement. The Finance & Monitoring Officer confirmed that the service agreement should have been closed as the service user is no longer there and the service agreement ended on 15/12/16 retrospectively.
- For Sample 19 a service agreement commenced on 4/4/18 and ended on 4/4/18 for £699.01for the carer whilst the service user returned home for 13 days. This was a one of payment. The rate is not correct.

Pathway Plans

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

Individual Service User Finance Record

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

Grant Sheet (Central Log)

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

Reconciliation to Oracle – T accounts

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

Staying Put Allowances

3.16.7 Staying Put allowances are included within the agreed Fostering Allowances. In May 2016, a report went to the Executive Committee to approve a change whereby rates were to be brought in line with the DFE rates. It was confirmed by officers that this was to be from December 2017. The Auditor was informed that the Staying Put Rates were linked to the Fostering rates.

3.16.8 It was found that the Staying Put rates had not been subject to any uplift for 2017/18 and 2018/19.

3.16.9 This should be read in conjunction with the Family Placements Audit for 2017-18.

3.17 Temporary Accommodation and Rent Accounts

Objective

3.17.1 Review the system for placement of B&B, young people and families with no recourse to public funds. Review of ANITE, accuracy and completeness of information, management reports and compliance to agreed procedures. Verify the procedures for procurement and budget monitoring.

Audit opinion – Substantial

3.17.2 Controls were in place and working well in the following areas; the sign up packs and checklists; the introduction of two new visiting officers; contracts with landlords; accurate information shown on the system regarding payments required and confirmed rent payments; eviction referrals sent through to Housing and monthly performance reports generated to show arrears, debts and collection statistics.

3.17.3 Six priority two recommendations were raised. The responsibility to implement assigned to either Housing, Liberata Housing Accommodation Charges (HAC), Finance or Leaving Care Team as follows:-

- There were two findings for Housing to address; retained evidence of a landlord being notified of a placement not seen for 3/20 cases sampled and notification to the landlord of an eviction not actioned in a timely manner.
- The two findings for HAC related to, compliance to agreed arrears collection procedures for current and former clients and completion of the write off procedure for former clients.

- One finding assigned to Finance related to the issues log maintained and discussed regularly between Finance and Liberata but the date the issue was raised was not recorded to monitor progress.
- The Leaving Care Team (LCT) update HAC of changes in placements by a movement sheet. Incomplete information issued resulted in an error on the rent account. The recommendation was for LCT to remind case workers to update the Finance Officer in a timely manner and explore how the ANITE system could be used to generate exception reports to identify errors before any impact on the rent account.

3.18 Housing Benefit 2017-18 – Follow Up

Objective

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

Outcome

3.18.2 We carried out sample testing and analysis of relevant documentation to confirm the extent to which the recommendations made in our original report had been implemented. We found that out of the 5 original recommendations 2 had been implemented and 3 remained outstanding, 2 Priority 2 recommendations and 1 Priority 3 recommendation.

3.18.3 The three outstanding recommendations related to:-

1) A process for part time and self-employed claims being put in place to ensure that are reviewed on a regular basis. Management advised that a process was adopted to review self-employed claims but there were technical issues experienced. This has since been rectified.

2) In order to achieve the objective of maximising recovery an annual target was to be set. Management commented that the target has not been re-set as agreed by PDS. There are significant functional implications if the target was re-set.

3) Appeals approaching the target date, action should be taken to ensure that these are reviewed within 3 months target as suggested by the DWP. Management commented that significant improvements have been made to the process during Quarter 1 of 2018/19 which has had positive effect on the percentage of claims reviewed in line with DWP suggested timescales. This is being monitored.

3.19 Penalty Charge Notices Audit

Objective

3.19.1 Review of the new parking enforcement contract with APCOA. The audit included a review of the contract monitoring arrangements and their adequacy to monitor the performance of the contractor. The audit also included a follow-up of previous audit recommendations.

Audit opinion – Substantial

3.19.2 Controls were reviewed by way of checking supporting documents and sample testing. The supporting information was reviewed to ensure that monitoring information is provided by the contractor in a timely manner, the information is reviewed by management, discussed at contract monitoring meeting and penalties are applied if applicable. The sample testing highlighted some minor contract monitoring issues.

3.19.3 The sample testing to ensure that the PCNs are progressed in a timely manner and appeals are managed as per the procedure was found to be satisfactory for the sampled PCNs.

3.19.4 The contractor is responsible for collection and banking of the income. The reconciliation of the PCN income for the financial year 2017-18 has been delayed due to difficulties in reconciling daily, weekly and monthly amounts for different payment types and for different categories. At the time of writing this report, Parking were awaiting further information from the contractor detailing the outcomes of PCN exceptions that needed to be cleared for the end of financial year 2017-18.

3.19.5 An updated process for reconciliation has been put in place from April 2018 to address the above issues. Now all PCN payments are collated into 1 monthly spreadsheet, divided by day. Each daily amount for each stream can be tracked on the sheet, and checked against Oracle to ensure it had been received in our accounts. Refunds are accounted for on the same document, and monthly totals are verified. Any discrepancies are more easily flagged, since the contractor is responsible for the attribution of payments to the revenue sources.

3.19.6 Five recommendations made within the 2016-17 report were followed up as part of this audit. 4/5 recommendations have been implemented and 1 recommendation relating to keeping policies and procedures updated has been re-recommended.

3.20 Vehicle Crossovers

Objective

3.20.1 To review controls within the process for applying, commissioning and payment for Vehicle Crossovers.

Audit opinion – Substantial

3.20.2 Controls were in place and generally working well. Five Priority 2 recommendations were raised with regard to ensuring that administration costs are correctly applied and recouped in full as authorised by the Policy; reviewing the data flows and processes within the workstream with the up to date procedure documented and made available to all appropriate staff; ensuring that each element of the Minor Works contract is included within the sample checked to verify that work has been carried out as specified; ensuring that all income is accounted for through a periodic reconciliation of the income recorded on Confirm (Highways case management system) and the Financial system; applying uplifts payable to the Contractor in a timely manner.

3.20.3 Two Priority 3 recommendations were raised with regard to the feasibility of scanning paper documents and uploading them to an agreed location in one system to ensure that there is a full audit trail; reviewing the internal application and administration fees introduced in 2012 to consider if any changes should be made to reflect increases in costs.

3.21 Winter Maintenance Service

Objective

3.21.1 To review Winter Service plans and procedures (gritting/salting) and the inspection regime, reviewing effectiveness in mitigating risks of higher maintenance costs and insurance claims.

Audit opinion – Substantial

3.21.2 Controls were in place and generally working well. Two Priority 2 recommendations were raised with regard to ensuring that the Winter Service Policy and Plan is up to date in terms of schools listed; E mail addresses monitored; performance reporting undertaken and that Public Liability Insurance Certificates should be obtained for farmers undertaking snow clearance support.

3.22 Reablement – Full Report and Priority 1 Follow Up

3.22.1 The Reablement Services help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement Services may be offered to someone who has recently come out of hospital. Reablement should be provided free of charge by the local authority for up to six weeks. Reablement is one of Council's main tools in managing the costs of an ageing population and is important as Authorities face cuts in government funding. Since the Care Act 2014, there is more of a responsibility for prevention and to enable people to remain independent.

3.22.2 In March 2017 we reported on the service with the findings split between the Reablement Team and the Reablement Assessment Team. Internal Audit brought the following to management's attention:-

Reablement Team

- A definitive number of clients could not be accurately identified at the time.
- Concerns relating to the accuracy and robustness of performance management data.
- An asset register was not maintained and signed off by a senior manager.
- Reablement Policies and Procedures had not been updated since May 2016, despite a change in processes.
- Insurance certificates to confirm that staff are insured for business use were found in have expired in some cases.

Reablement Assessment Team

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

3.22.3 In June 2017 we reported this in Part 2 at the request of management due to an ongoing tender exercise at the time of the audit. There were two priority one recommendations in respect of Performance Management Data and use of the Outcome Measurement Tool.

3.22.4 In November 2017, we reported that this remained within Part 2 at the request of management. The transfer of the service to the provider was awarded in June 2017 with the transfer delayed to 1st February 2018. This transfer related to the service delivery element specifically and not care management.

3.22.5 In June 2018, a full follow up report was undertaken in respect of the original report dated 9/3/17. Of the previous 10 agreed recommendations, 1 has been fully implemented, 2 are being progressed for completion, and 7 have not been implemented. The recommendations not being implemented relate to; detailing current reablement users, performance data, asset register, procedures in both teams, outcome measurement tool, support plans, service agreements and reablement reviews.

3.22.6 The recommendation relating to the outcome measurement tool was previously reported as no longer applicable due to the service transferring out. However, the service is now to be retained in house and the finding was re-tested. This related to the Outcome Measurement Tool and issues arose in 4 out of five cases. Therefore, this has been re-recommended.

3.22.7 In October 2018, the two priority one recommendations were followed up and both were found to be outstanding. Both the original report from March 2017 and the Follow up Report dated June 2018 are now published with the Committee papers for this meeting.

3.23 For definitions of audit opinions see below:

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

- Substantial Assurance- While there is a basically sound system and procedures in place, there are weaknesses, which put some of these objectives at risk. It is possible to give substantial assurance even in circumstances where there may be a Priority 1 recommendation that is not considered to be a fundamental control system weakness. Fundamental control systems are considered to be crucial to the overall integrity of the system under review. Examples would include no regular bank reconciliation, non-compliance with legislation, substantial lack of documentation to support expenditure, inaccurate and untimely reporting to management, material income losses and material inaccurate data collection or recording.

- Limited Assurance- Weaknesses in the system of controls and procedures are such as to put the objectives at risk. This opinion is given in circumstances where there are Priority 1 recommendations considered to be fundamental control system weaknesses and/or several Priority 2 recommendations relating to control and procedural weaknesses.

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

3.24 Commentary on Priority 1 recommendations

St Olave's School – Priority 1 Follow Up

3.24.1 The Priority 1 recommendation related to the tendering of the IT contract and the need to comply with EU regulations.

3.24.2 At the beginning of May the School Business Manager (SBM) met with Bromley officers from the Information Services Division and Procurement to discuss the priority 1 recommendation and consider how the Authority could support the school going forward with the IT contract and procurement generally. At the initial meeting it was agreed that the SBM would present an options paper to the Governing Body to determine the level of support to be commissioned from the Authority for procurement and BT, Bromley's contracted IT provider with regard to the IT contract. It was agreed at this meeting that given the current contract expired in August 2019 and not withstanding termination penalties, to complete the term with the incumbent provider and schedule the re tendering exercise to start in October.

3.24.3 At the end of June the school confirmed their intention to commission BT to scope the ICT System/Service support requirements to assist with the planned tender exercise. BT have now completed the first site visit to document current provision and noted that the school had

recently upgraded the system by installing two new servers. BT will now draw up the technical specification for the school to use for the tender exercise.

3.24.4 The SBM confirmed by e-mail that as at October 2018 the school had conducted an options appraisal to determine ICT management going forward. The decision is still outstanding as the school want to compare costs with an option to bring the service in house.

3.24.5 Given that the decision on how to proceed is still under discussion the priority 1 will remain outstanding until the tender process or alternative is underway.

3.24.6 The planned audit at St Olave's has been booked for the 3rd and 4th December at which point this project and other procurement activity will be tested and reviewed to assess progress to implement the Priority 1 recommendation.

3.25 Document Storage – Priority 1 Follow Up

3.25.1 The original Priority 1 reported in November 2016 related to cumulative expenditure and the requirement to undertake a comprehensive review of documents in storage. This recommendation has been updated and reported at successive committee meetings and progress to implement linked to the Accommodation Strategy. However at the previous meeting in May this year Members were informed that with the rollout of GDPR at the end of May 2018 there was a greater urgency to review our archived data and for managers to assure compliance. It was also noted that there was a project to review and update the retention of documents policy.

3.25.2 It was agreed that Internal Audit would carry out more testing in this area to update the original audit findings and consider the GDPR and retention of records work undertaken by colleagues in the Information Systems Department. Nominated Information Asset Owners would be contacted to confirm the accuracy of information presented by TNT for the records held off site. Initial investigation in July identified that:

- There was no current policy or procedures for managers to archive at Restore PLC (formerly TNT) or retrieve stored data.

- The November 2016 spreadsheet provided by TNT following the 2016 audit report was the latest available. This spreadsheet is a comprehensive list of all boxes and the contents details held by the contractor. Restore PLC was asked to provide the current inventory list to be used as the basis for the planned review.

- The contact details held by the Project Support Officer (PSO) were out of date as staff have moved teams or left the organisation. The PSO had attempted to reassign responsibility with limited success. It was agreed that the nominated Information Asset Owner in each team would be the contact and Chief Officers would be asked to ensure that these officers assumed responsibility.

- There was a need to clarify the procedure to destroy. Officers have returned the spreadsheet issued to all responsible officers in March 2017 indicating a destroy date and assumed that as this has passed the boxes have been destroyed. Managers were not aware that TNT would need an authorisation to destroy certificate signed before any boxes would be destroyed.

- A random sample of managers were selected to pilot test the review process before it was rolled out across the whole Authority and identified varying standards of locally held lists to support the offsite storage.

- The monthly invoice is recharged to each team by Finance using historic cost centres. A review of 2018/19 charges indicated miscodings that have been referred to Finance to rectify.

- As at 19.6.18 ISD confirmed that 4 information asset owners out of 94 have declared off site storage. It may be that the task to complete the asset information asset inventory is incomplete or managers have failed to include TNT stored data.

3.25.3 At the beginning of August all Chief Officers were e-mailed requesting support for the review of archived data. The Asset Management Team Manager had written procedure notes for sending and retrieving documents to Restore PLC which were attached as were the comprehensive inventory list as at July 2018 held by Restore. Managers were asked to:

- review the records kept off site to ensure that they still need to be retained.
- confirm that an Information Asset Owner (IAO) has been appointed
- confirm that an up-to-date Document Retention Schedule is in place for the department
- confirm that the Information Asset Register (IAR) has been completed and includes records held off-site

3.25.4 IAO's were asked to initiate a check of the contents of the boxes and to ensure that the locally held records matched the Restore PLC list provided. The review would identify:-

- boxes whose contents needed to be reviewed – the boxes to be brought back to the civic centre site or staff to go to the off-site storage facility in Thurrock. IAO's would need to consider the best option and this would largely depend on volume
- boxes whose contents needed to be destroyed following the procedure detailed in the guidance note
- boxes that require no further action at that time
- inaccurate records

3.25.5 IAO's must ensure that all records (locally held, IAR and on the Restore database) were up-dated to reflect any changes made to the offsite storage of data.

3.25.6 The PSO is coordinating the responses from IAO's, monitoring requests to destroy and updating the central record of boxes assigned to each service area to be matched to the monthly invoices. It was requested that the review be completed by the end of October 2018; as at 11/10/18 the response can be summarised as follows:-

- Managers commented that the procedure guidance notes were useful and clearly set out the process to follow.
- Of the 41 service areas and IAO's identified 16 have not responded and will be referred to the respective Chief Officer to support completion of the review. These 16 service areas account for 4,913 boxes. There are 4 other areas which are either conducting their own reviews in conjunction with ISD colleagues (accounting for 4,083 boxes) or had already completed a comprehensive review and visit to the offsite storage at Thurrock (125 boxes).
- The review has been completed for 11 service areas that started with 2,566 boxes and have identified and authorised for 1,064 boxes to be destroyed.
- Ten IAO's have responded to the PSO and are actively engaged to retrieve and review boxes. These service areas account for 1,550 boxes; although work in progress 38 boxes have been identified to be destroyed so far.
- In total 1,102 boxes have been identified as having either passed their destroy date or identified as no longer required to be archived according to the service's retention policy. This represents a saving of approximately £220.40 per month (1,102 X £0.20) to date but has potential to be more once all IAOs have completed the task.

3.25.7 The review has identified several issues for officers to resolve which they are working on, the IT Infrastructure Team has been involved and have undertaken a site visit to Restore PLC.

3.25.8 The Principal Information Assurance Officer has given assurance that as part of the Information Management strategy implementation the IT Infrastructure Team will be reviewing and publishing guidance on records management to ensure storage is correct. This team will be overseeing GDPR compliance.

3.25.9 Internal Audit are now satisfied that the Project Officer has established a process to record and monitor changes to the records held off site and therefore support the monthly invoice submitted by Restore PLC. The review has required IAO's to focus on offsite storage and evaluate the adequacy of locally held records to support archived records. A procedure to deposit and retrieve records to the offsite storage facility has now been issued. Given the progress achieved by this review and the ongoing scrutiny afforded by the updates to CLT to ensure that all IAO engage with the project, the Priority 1 recommendation relating to document storage is considered closed

3.26 Children with Disabilities – Priority 1 Follow Up

3.26.1 The audit report was finalised in April 2018 and was reported to Members in May 2018. This report contained a priority 1 finding in relation to payments that had been made as detailed below. The Auditor liaised with management to determine the progress made on implementation of the priority one recommendation.

3.26.2 Issues arose with payments to three service users and one minor issue in respect of another case relating to the rate of payment included within a description field within Carefirst.

3.26.3 Sample 2 is currently in a residential boarding school placement from 11/9/17 at a cost of £3,072.85 per week and is a split funded between children's social care and SEN. It was confirmed that the service user has been attending 2 of the 5 nights per week as residential from October 2017 that are being funded currently and as a result we continue to fund for 5 nights.

3.26.4 In addition, there are 2 other service agreements for agency support in the home which cover the same time periods. One commenced on 7/9/16 for £288 per week for support over 3 days this has now been closed off with the date 10/9/17 on 6/2/18. The Central Placements Team (CPT) confirmed that no invoices have been paid since September 2017 and that they had queried this with the department on 3/11/17. The second service agreement commenced on 23/9/16 and is to cover a family support worker 3 hours per day for 5 days a week costing £720.00 per week which remains open and current at the time of testing. It was confirmed by the Senior Practitioner by email on 6/2/18 that this service user 'started having two overnights per week in October 17 but has not progressed to the full 4 nights per week. At a recent meeting, the service user's family indicated that the 2 nights per week are all that the service user can cope with and that they would not support it increasing. This has raised a query about whether LBB are funding the full residential cost or if a reduced fee has been negotiated'. There is also the issue about the 5 days a week support and whether this should be continued.

3.26.5 At the time of the audit the Auditor also checked with the SEN team as this is a joint funded placement regarding payments and it was confirmed that for the Autumn Term Children's Social Care had paid £15,070.32 and Education £16,844. It was confirmed that the placement is for 5 days a week and the Spring Term payment was due to go out at the end of the week ending 11/2/18.The Auditor asked that the Group Manager confirms that the payment is correct prior to the payment being made.

3.26.6 In October 2018, it was confirmed that this service agreement remained current and remained in payment. The Group Manager advised that this provider does not provide day placements and the service user continues to attend only 2 days of the 4 days funded. The Funding Decision sheet dated 28/7/17 has been provided to Internal Audit. Management advised Internal Audit that an alternative placement would have carried a greater cost and would not have been a viable option for the family due to the distance of an alternative placement. This has since been referred to senior management as Internal Audit requires further assurances that best value has been considered in this placement.

3.26.7 The Head of Service, Placements & Brokerage stated that their involvement was for the negotiation of the costs following the placement/provider decision made by SEN. They cannot say in this case that they were involved to establish the best value placement as this is an exercise they normally undertake before recommending a placement. Their involvement here was to negotiate the price once the placement had been agreed. [Where joint funding is agreed with SEN and CSC, SEN will take the lead for a 38 week placement and CPT will take the lead for a 52 week placement].

3.26.8 For Sample 10 there is a service agreement for a one off amount of £11,857.70 dated 23/2/17, which was authorised by the Head of Service. Retrospective approval of the service agreement on Carefirst was made on 31/7/17 for the period 13/2/17 to 24/7/17 as detailed within the Outreach form which was authorised by the Head of Service and the Disabled Children's Team Managers. The Head of Service confirmed that this period of time was prior to his start at Bromley. This service agreement had not been actioned by previous management and retrospective approval was required as a result.

3.26.9 The Group Manager advised that it is correct that retrospective sign off was completed due to previous line manager leaving at short notice, however had been discussed and they were in agreement. The Head of Service, Placements & Brokerage advised that a retrospective request had to be made as previous Head of Service had left before it was signed off and in order that we could pay the provider.

3.26.10 A further service agreement dated 19/6/17 for £2,221.60 per week, does not reconcile to the breakdown provided on Carefirst and had been calculated incorrectly also for the mileage. The calculation includes 37.6 miles @ 0.45p per mile which is £16.92 but the calculation includes 37.60.which is an overpayment of £20.68 per week.

3.26.11 In October 2018, it was found that the service agreement ended on 25/2/18. The Group Manager advised that the administrative cost of claiming the costs back for petrol (if paid incorrectly) would be disproportionate to the time taken to resolve this issue.

3.26.12 Costs are sometimes predicted in resource request form and are an 'up to' amount with the amount paid is only as stated within the invoice.

3.26.13 The Group Manager advised that the rates of payment differed from one month to the next and the set fee of £2,221.60 detailed on Carefirst was not paid weekly. It has since been confirmed by the Group Manager and the Finance & Data Officer that the petrol costs fluctuate each month and are no longer an issue.

3.26.14 For Sample 13 the service commenced on 4/9/17 for £69.92 per week and the direct payment covers 4 hours support per week at the rate of £17.92.However, 4x17.92 = £71.68 which equates to a shortfall in the direct payment of £1.76 per week.

3.26.15 In October 2018, the Group Manager advised that the provision provided was through a nursing agency so the amount of money paid was in line with agency invoice. A different service is now being provided so the service agreement is no longer relevant. No evidence of this has been seen by Internal Audit.

3.26.16 In respect of Sample 16 the service agreement commenced on 27/3/17 at the rate of £21.46 per week which equates to the direct payment rate of £10.73, the children's direct payment rate. However, on Carefirst the service agreement notes specify that the rate is £21.56 causing confusion.

3.26.17 In October 2018, it was found that this service agreement had been ended on 11/3/18. The Group Manager advised that the correct amount of £21.46 has been paid to family. The service agreement now clearly states £21.46.

3.26.18 Further testing on the original cases and interviews with management; indicate that further evidence of adequate progress is needed on some of the issues raised to conclude that this recommendation has been implemented. These cases will be reviewed again and updated to committee in February 2019.

3.27 Review of Waivers – Priority 1 Follow Up

3.27.1 Both Priority 1 recommendations are being progressed through the ongoing development of the Corporate Contracts Database and associated guidance and procedures that have been put in place.

3.27.2 The Contracts Database is currently in the final stages of development to include the functionality of an electronic authorisation process for all relevant contract actions, including extensions, exemptions and variations. The electronic authorisations development is now moving to User Acceptance Testing (UAT), following which it is planned to be rolled out in late 2018/early 2019 subject to the outcome of UAT.

3.27.3 The electronic authorisations process will generate and securely store formally approved authorisations in accordance with the Council's Contract Procedure Rules, so that there is one agreed and auditable record for every contract authorisation. Training will be provided to Contract Owners to facilitate a clear understanding of the process.

3.27.4 The recommendations are therefore in progress but remain open.

3.28 Agency Staff – Priority 1 Follow Up

3.28.1 The final report on agency staff, issued in March 2018, contained three Priority 1 recommendations. The first of these three recommendations related to the need for governance arrangements to be put in place for the recruitment and management of agency staff across the Council. The Director of HR is progressing this and an update will be provided by the Head of Audit at the Audit Sub-Committee meeting. At this time the recommendation remains outstanding.

3.28.2 The second Priority 1 recommendation was for Directors to review, by 30 April 2018, their agency staff engagements which currently exceed six months and obtain approval from the Director of HR where there is a need to extend the engagement. The Director of HR asked Directors to do this and we are currently carrying out follow up testing. An update will be provided by the Head of Audit at the Audit Sub-Committee meeting. At this time the recommendation remains outstanding.

3.28.3 As reported at the May 2018 meeting, the remaining Priority 1 recommendation related to HR reminding managers of the need to ensure that when an agency worker leaves the Council, the process of removing the IT systems access and recovering the security pass and any Council equipment, is carried out promptly. The Head of HR Strategy and Education revised and updated the guidance on agency staff for managers and this was issued to managers, publicised at the manager's briefing in June and put on the Council's intranet site. We consider that this recommendation has, therefore, been implemented.

3.28.4 Members may wish to note that a report regarding the use of agency staff across all the Departments went to the Executive & Resources Policy Development and Scrutiny Committee in October and the annual performance monitoring report relating to Adecco will be going to the Executive, Resources and Contracts Policy Development and Scrutiny Committee on 22 November.

3.29 IR35 – Priority 1 Follow Up

3.29.1 The IR35 procedure was updated on OneBromley in May and reinforced to managers subsequently via the Managers' Briefing and the Inform June 2018 newsletter.

3.29.2 Since June 2018 there has only been one incident where a business case has not been completed and submitted to HR prior to the engagement of an officer. The relevant Director was notified and a business case was completed subsequently. This showed that the engagement was outside the scope of IR35 and no further action was necessary. In the circumstances we consider that the recommendation has been implemented.

3.30 We also carried out the following:

- Planned audit work with the focus on completion of the 2017/18 Internal Audit Plan and commencement on the 2018/19 plan.
- Fraud and investigations – the results of which are reported in Part 2 of this agenda.
- Advice and support – Internal Auditors are available to offer advice and consultation to all officers. The input required from Internal Audit varies; ad hoc enquires will be received by e-mail, phone or in person. Requests are not always settled by one response and have generated audit review work. Internal Audit also attend working groups to advise on system controls and good practice.
- Monitoring/authorisation role for the Greenwich Fraud partnership.
- Liaison work with our external auditors in preparation of their audit of the 2017/18 accounts.
- Committee work.
- Internal Liaison with the Commissioning Board; Corporate Leadership Team/Directors' Group; Directorate Management Teams and Corporate Risk Management Group.
- External liaison with the various London Audit Groups, the Kent Audit Group and our External Auditors

3.30.1 The Council has had a partnership agreement with the Royal Borough of Greenwich (RBG) since 2002, for the investigation of fraud. Whilst the service has worked well since its inception and this partnership does not contravene any EU procurement regulations (as set out in Regulation 12(7) of the said rules as it is an agreement between two public authorities aimed at carrying out jointly their public service tasks and is governed only by considerations relating to the public interest) there is a duty to ensure that best value is being obtained. Therefore a business case review was undertaken resulting in a Gateway report which was a formal consultation on outline service proposals and procurement strategy on Counter Fraud services. This was considered for pre- decision scrutiny by the Executive, Resources & Contract PDS on 5 September 2018 recommending that the partnership agreement with RB Greenwich is renewed for a period of 5 years starting 1 April 2019 with the option of two one year extensions (5 plus 1 plus 1) at a whole life value of £910,000. It was also agreed that the

Council's Legal Services Team will carry out arrangements for prosecution going forward, at no additional cost to the Council.

3.31 Troubled families claim for September 2018

3.31.1 The Troubled Families Programme is a government agenda led by the Ministry of Housing, Communities and Local Government, in partnership with the Departments for Education, Health, Work and Pensions and Ministry of Justice. A local authority can claim a results payment if it can demonstrate that an eligible family has achieved significant and sustained progress against all problems identified at the point of engagement and during the intervention or if an adult in the family has moved into continuous employment.

3.31.2 We analysed a random sample of eight individual claims for the claim period between 1 April 2018 and 30 September 2018. From our testing we found that there was documentary evidence to support that the individual claims met the employment or significant and sustained criteria, enabling a claim to be made.

3.31.3 We also confirmed that the total amount claimed for payment by results for the 84 individual claims submitted between the period 1 April 2018 and 30 September 2018 was £67,200. Two were employment claims and 82 were for significant and sustained progress made.

3.32 London Transport Capital Block Funding Specific Grant Determination 2017/18: No 31/2951 (Pothole Action Fund)

3.32.1 On 9th February 2018, the Department for Transport confirmed, by letter, that a 'maximum capital funding allocation of £112,940 for 2017/18' had that day been paid to the London Borough of Bromley under 'Local Transport Capital Block Funding (Pothole Action Fund) Specific Grant Determination (2017/18): No.31/2951.

3.32.2 The Chief Executive and Chief Internal Auditor of each of the recipient authorities were required to sign and return to the team leader of the Local Infrastructure team in the Department for Transport a declaration, to be received no later than 30th September 2018, in the following terms: 'To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to the Transport Capital Block Funding (Pothole Action Fund) Specific Grant Determination (2017/18) No. 31/2951 have been complied with'.

3.32.3 The Grant Conditions stated in Annex A of the letter state that 'Grant paid to a local authority under these determination may be used only for the purpose that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003.

3.32.4 Based on discussions with officers and a review of the records held, Internal Audit has gained appropriate assurance that the conditions of the grant determination are met, with the signed declaration submitted on 19th September 2018.

3.33 Waivers

3.33.1 Members of this Committee took the decision to only report on waivers sought under the Contract Procedure Rules 3 and 13.1 and to therefore exclude specific exemptions provided to officers under the Council's Scheme of Delegation which relate to social care placements. As required by the Contract Procedure Rules (CPR) this Committee has to be updated on waivers sought across the Authority at six monthly intervals.

3.33.2 As previously reported to this Committee the methodology to obtain the waivers is labour intensive and relies on manual records maintained by the Directors PA's. There has been concern that not all waivers may be captured and reported to Committee.

3.33.3 Internal Audit acknowledges the work of the Commissioning Department to develop the Contract Database specifically the presentation of contract documents including waiver templates. Mandatory training and online support has improved officer's understanding and application of the waiver process.

3.33.4 For the purposes of this Committee, Internal Audit has worked with the Assistant Director Governance and Contracts to source the information shown at Appendix C. The list of reports submitted to the Commissioning Board since April 2018, meeting the criteria of waivers to be reported to this Committee, identified qualifying contracts and contract owners. To source the required documentation, gateway report, minuted approval and the officer sign off sheet, the contract database was accessed in the first instance but if the documents had not been uploaded the contract owner was contacted directly. The waivers reported should include all exemptions, extensions and variations as defined in 13.1 of Contract Procedure Rules with reference to 3.1, 3.5.5 and 23.7. The formal extensions have not been reported this time and will be included in the next cycle. This exercise has identified that there are still issues with the availability of documents and uploading to the contract database and therefore it is possible that the information reported at Appendix C is incomplete.

3.33.5 The Assistant Director Governance and Contracts will be contacting all contract owners to remind officers of the requirement to comply with contract procedure rules, including the upload of information to the contract database. Internal Audit is working with Commissioning to ensure that the process to collect and collate waivers to be reported to this Committee is simplified and complete. Going forward contract owners will be asked to evidence the required documentation to Internal Audit for the bi annual update to this Committee. Internal Audit have two planned corporate audits planned for 2018/19, Strategic Commissioning and Procurement Control Framework Compliance, that will consider this process.

3.33.6 Members are asked to review this list and comment as necessary, preferably prior to the meeting so that officers can extract the details on queried waivers.

3.34 Publication of Internal Audit Reports

3.34.1 Exemptions are being sought for this cycle that is explained in part 2 of this agenda.

3.34.2 Since the last cycle of this Committee we have published a further 20 redacted final reports, listed below. At the request of Members of this Committee we have included the audit opinion given to each audit. Follow up audits for implementation of previous recommendations are not given an opinion.

AUDIT	OPINION
St Olave's School	Limited
Reablement	Limited
Reablement (Follow Up)	N/A
Contract Management of Adult Mental Health	Limited

Adults Safeguarding	Substantial
Continuing Healthcare Funding	Substantial
Council Tax	Substantial
IT Project Management	Substantial
Creditors	Limited
Home Tuition	Limited
Direct Payments	Limited
Edgebury Primary School	Substantial
Family Placements	Limited
Leaving Care	Limited
Temporary Accommodation and Rent Accounts	Substantial
Housing Benefit (Follow Up)	N/A
Penalty Charge Notices	Substantial
Vehicle Crossovers	Substantial
Winter Maintenance Service	Substantial
Troubled Families Claim	N/A

3.35 Letter of Representation

3.35.1 The Letter of Representation is attached to this report for information. It sets out the key undertakings given by the Director of Finance to the External Auditors in relation to the 2017/18 Statement of Accounts. Members are asked to note the Letter of Representation attached as Appendix D.

3.36 Code of Transparency

3.36.1 The Department for Communities and Local Government (DCLG) published a revised Transparency Code in February 2015. The Code sets out key principles for local authorities in creating greater transparency through the publication of public data. The Government believes that local people are interested in how their authority tackles fraud and have introduced a mandatory requirement in respect of fraud data. Attached as Appendix E is our publication on the Council's web site of the fraud statistics for 2017/18.

3.37 Annual Audit Letter

3.37.1 The Annual Audit Letter for 2017/18 issued by the external auditors is attached as Appendix F. The headlines to note are as follows: They issued an unqualified opinion on the Authority's financial statements on 26 July 2018. This means that they believe the financial statements

give a true and fair view of the financial position of the Authority and of its expenditure and income for the year. The financial statements include those of the pension fund.

3.37.2 They issued a qualified 'except for' conclusion on the Authority's arrangements to secure value for money (VFM conclusion) for 2017-18 on 26 July 2018. This means they are satisfied that during the year the Authority had appropriate arrangements for securing economy, efficiency and effectiveness in the use of its resources except for the area of children's services where the Authority received an 'inadequate' Ofsted inspection in June 2016 and these findings had not yet been fully remediated. This is an ongoing issue from previous years.

3.37.3 To arrive at their conclusion they looked at the Authority's arrangements to make informed decision making, sustainable resource deployment and working with partners and third parties.

3.38 Objections to the accounts

3.38.1 An elector has raised objections to the 2016/17 and 2017/18 accounts. The objections centred on waste collection and waste management services but also include grounds maintenance, street cleansing and empty Civic Centre Offices. These are still being reviewed by the External Auditor. As a result of these objections the audit cannot be formally concluded and an audit certificate issued.

4. IMPACT ON VULNERABLE ADULTS AND CHILDREN

The contents of this report have implications for both adults and children in respect of cost and possible care implications.

5. POLICY IMPLICATIONS None

6. FINANCIAL IMPLICATIONS

Some of the findings identified in the audit reports mentioned above will have financial implications.

7. PERSONNEL IMPLICATIONS

Staff in breach of financial rules or procedures or acting inappropriately against the Council's legal and financial interests may subject to disciplinary or/and criminal investigations.

8. LEGAL IMPLICATIONS

There is a statutory requirement to provide an internal audit function in the Accounts & Audit Regulations 2015.

9. PROCUREMENT IMPLICATIONS

The contents of this report may have implications for procurement relating to contract procedure rules, financial regulations and VFM issues.

Non-Applicable Sections:	Policy
Background Documents: (Access via Contact Officer)	None