**Agenda Item No. 8**

## Audit Committee – 1 September 2010

## No or Limited Assurance Internal Audit Reports

**Summary of report**:

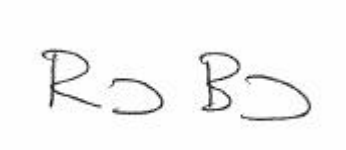
This report presents audit reports which have been provided with a 'no' or 'limited' assurance opinion that have been finalised since 1 April 2010.

**Background papers**:

Internal audit reports/files/working papers.

**Recommendation**:

1. To scrutinise the contents of the reports.
2. To determine the Audit Committee's approach for scrutinising 'no' and 'limited' assurance audit reports for future meetings.



**Rory Borealis – Executive Director (Resources)**
**13 August 2010**

**MODIFIED APPROACH**

This report presents audit reports which have been provided with a 'no' or 'limited' assurance opinion that have been finalised since 1 April 2010.

Audit committee will be aware that internal audit has a standard assurance opinion rating as follows:

- FULL ASSURANCE - Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed.
- SIGNIFICANT ASSURANCE - Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.
- LIMITED ASSURANCE - Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.
- NO ASSURANCE - No assurance as weaknesses in control, or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed.

In the case of school audits, internal audit test schools' compliance against the Department for Children, Schools and Families' financial management standard in schools (FMSiS) and provide an opinion of compliant or non compliant.

Since 1 April 2010, the following reports have been finalised with a 'limited' assurance rating:

- Home Care
- Community Alarm Service
- Direct Payments, Personal Budgets & Individualised Budgets
- Homelessness Establishment – Dolphin House
- Inventories & Stock – Links to Work
- Information Security Management

No audit reports have been issued since 1 April 2010 with a 'no' assurance rating.

The following school was found to be 'non compliant' with the financial management standard in schools (FMSiS):

- Frank F Harrison Engineering College.

These reports are detailed within the attached appendices for audit committee scrutiny and a summary of each of the reports is given in the section below.

This represents a modified approach to the Audit Committee's previous method of seeking assurance on the control environment, which was to select up to 3 reports detailed within internal audit's quarterly progress report for detailed scrutiny. This modified approach is intended to improve upon the Audit Committee's effectiveness by directing its attention towards areas of most concern. Audit Committee are asked to determine their preferred approach for scrutinising 'no' and 'limited' assurance audit reports for future meetings.

## SUMMARY OF LIMITED AND NO ASSURANCE AUDIT REPORTS

Home Care

An audit review of home care was undertaken during November and December 2009 as part of the annual audit plan.

The home care service provides personal care and domestic tasks to vulnerable adults in Walsall to help them to be as independent as possible. Care is provided 24 hours a day, 7 days and week and includes:

- personal care;
- shopping;
- laundry and ironing; and
- escorting.

The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed audit report actions and to seek assurance that:

- procedures are clearly defined, regularly reviewed and available to all officers for the administration of homecare;
- the council regularly undertake an analysis of demand for the service and a resource plan is prepared which is monitored against actual service demand;
- the entitlement criteria for homecare is clearly defined, documented and approved before being widely publicised;
- home care providers are selected in accordance with the authority's financial and contract rules;
- appropriately authorised and sufficiently detailed budget request forms (BRF) are raised for all homecare services requested, supported by an authorised care plan, which generate an official order;
- timesheet evidence to support all homecare service provided, signed by the homecare worker and verified by the client, exists;
- all BRF, official orders, care plans and invoices are matched prior to payment;
- invoices are appropriately authorised and promptly processed;
- urgent and manual payments are adequately controlled;
- payments are allocated to an appropriate expenditure code;
- VAT has been correctly accounted for;
- effective budget monitoring arrangements are in place;
- processing of credit notes is adequately controlled;
- there is an adequate segregation of duties between ordering, authorising timesheets and certifying invoices for payment;
- fees and charges in relation to client contributions for homecare services are promptly and accurately recovered and controlled; and
- there are sufficient processes in place to regularly monitor the quality of homecare provision.

The conclusions detailed within the final report attached at **Appendix 1** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating within home care services.

Some good practices were noted during the audit, including;
- flowcharts have been produced to map out the processes of brokering, monitoring and payment of care packages;
- the older people's service plan is monitored on a quarterly basis;
- the brokerage team record an appropriate Oracle code on all invoices submitted to consolidated creditors for payment; and
- the service accountant provides monthly budget monitoring information to the service manager and strategic commissioning manager.

Most areas reviewed required significant improvement. Procedural documentation would benefit from review and update; controls regarding entitlement to homecare, the procurement section's monitoring of home care providers; the use of non contracted home care suppliers; and the effectiveness of controls over ordering and payments to home care providers, require strengthening.

The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

A total of 28 actions for improvement were identified as part of the review with 17 being at high priority.

An internal audit follow up memo is due to be sent out in September 2010.

Community Alarm Service

An audit review of the community alarm service was undertaken as part of the annual audit plan. The community alarm service provides home safety and personal security systems which enables the elderly and disabled to live independently. This is achieved through a 24-hour telephone link to the social care and inclusion response centre. There are approximately 8000 homes throughout the borough which the service supports.

The community alarm service is currently in the process of a full service restructure.

The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed audit report actions and to seek assurance that:

- policies and procedures are recorded in writing, regularly reviewed and available to all staff;
- robust arrangements are in place for applications for and amendments to, service provision;
- adequate systems are in place for call management;
- assets are appropriately managed and there is an approved programme of routine maintenance, servicing and installation of alarm equipment;
- an inventory is maintained in accordance with financial and contract rules;
- there is an approved scale of charges and income is promptly recovered;
- procurement is in accordance with the authority's financial and contract rules;
- joint working with other council services and partnerships with external bodies are utilised to their full potential;
- adequate security controls are in place;
- adequate management information and budgetary control is in place;
- petty cash is appropriately administered;
- use of the council's vehicles is adequately controlled; and
- performance management systems are followed, including those relating to risk management, IPM, communication, sickness management, equalities and health and safety.

The conclusions detailed within the final report attached at **Appendix 2** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating within community alarm service.

Some good practices were noted during the audit, including; the service being Telecare service accredited, the use of the PNC5 system to log telephone calls; and partnership working with NHS Walsall to jointly deliver a pilot scheme for Tele Health services.

Most areas tested require significant improvement, including ensuring:

- that day to day operational procedures are comprehensively documented;

- that referrals for alarm installation are promptly and appropriately managed and recorded, including on PARIS;
- that a robust system for processing amendments or cessations to alarm provision is introduced;
- call management procedures are tightened;
- that urgent follow up action is taken where monthly test calls to ensure that alarms are still working are not responded to by service users;
- that equipment repair and maintenance procedures are managed;
- the inventory register is promptly updated;
- controls regarding income, specifically the private purchase of equipment are reviewed;
- procurement controls, including those regarding contracts, are tightened; and
- performance management issues are addressed.

The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

A total of 40 actions for improvement were identified as part of the review with 23 being at high priority.

An internal audit follow memo was sent to the assistive technology & telehealthcare manager and the strategic commissioning manager on 3 August 2010.

Direct Payments, Personal Budgets & Individualised Budgets

An audit review of direct payments, personal budgets and individual budgets was undertaken during March 2010 as part of the annual audit plan.

The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements and to seek assurance that:
- procedures are documented in writing, regularly reviewed, in line with Department of Health guidelines and issued to appropriate staff;
- individuals' needs are formally assessed before a direct payments / personal budget offer is made;
- individuals are given appropriate guidance on the schemes and assistance available to them including any changes in legislation;
- appropriate paperwork is completed and retained to support all direct payment / personal budget offers;
- direct payment / personal budget agreements between the council and the individual have been formally established, documented and signed;
- direct payments / personal budgets are regularly reviewed in accordance with Department of Health guidelines;
- appropriate arrangements are in place to control direct payments to a third party when required by an individual;
- individuals in receipt of direct payments are required to provide evidence that direct payment allowances are being used to purchase goods and services as specified in the direct payments policy and regular compliance checks are undertaken to ensure that payments are appropriate;
- carers' 'one off grants' are robustly controlled;
- personal budgets are appropriately controlled and monitored;
- procedures have been established to recover any overpayments made;

- effective overall budget monitoring is undertaken;
- performance management information is regularly compiled and reported to the appropriate officers / groups;
- adequate arrangements are in place for the introduction of individual budgets; and
- previously agreed audit report actions have been fully implemented.

The conclusions detailed within the final report attached at **Appendix 3** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating within direct payments, personal budgets and individualised budgets.

A number of good practices were noted during the audit, including:
- procedure notes are in place documenting operational processes for direct payments;
- direct payment agreements have been developed which contain specific guidance for service users outlining their responsibilities and obligations in receiving direct payments;
- the direct payments audit team monitor recipients' use and eligibility of their direct payments;
- the use of Shaw Trust to assist service user's who lack capacity to manage their funds; and
- the plans in place for the introduction of personal and individual budgets.

There are, however, areas for improvement, most notably, ensuring that adequate supporting documentation is made available to the auditor during the audit. Without this, audit assurance cannot be given in these areas. A business solution review of the systems for capturing and recording information regarding the award of direct payments should be undertaken and controls in most areas require strengthening.

A total of 15 actions for improvement were identified as part of the review with 10 being at high priority.

Direct payments, personal and individualised budget is due to be re-audited later this month.

<u>Homelessness Establishment – Dolphin House</u>

An audit review of Dolphin House was undertaken during March 2010 as part of the annual audit plan.

Dolphin House is a statutory homelessness establishment which provides temporary accommodation to families and those assessed as having a priority need.

The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed actions and to seek assurance that:

- the service operates within the corporate performance management framework, including:
    - *workforce planning*
    - *IPM*
    - *risk management*
    - *communications*

- *equalities*
- *procurement*
- *budgetary control*
- *business continuity*
- *sickness management*
- *health & safety*
- *information governance*

- the council regularly undertake an analysis of demand for the service;
- policies and procedures are recorded in writing, regularly reviewed and available to all staff;
- controls are in place for the admission of clients into the establishment;
- entitlement to service provision is clearly defined, documented and approved;
- adequate arrangements are in place for rent calculation and collection;
- all rent arrears are monitored and action taken to ensure prompt recovery;
- property and assets are appropriately managed and there is an approved programme of routine maintenance and servicing;
- a planned programme of inspections is in place;
- the scale of utility charges is in accordance with the Office of Electricity Regulation;
- adequate controls are in place to administer leavers;
- an inventory is maintained in accordance with financial and contract rules;
- procurement is in accordance with the authority's financial and contract rules;
- adequate security controls are in place;
- adequate management information and budgetary control is in place;
- staff records e.g. flexi records, annual leave, car allowance log books are maintained to a good standard;
- petty cash is appropriately administered; and
- key controls are in place to guard against fraud and irregularity.

The conclusions detailed within the final report attached at **Appendix 4** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating at Dolphin House.

Some good practices were noted during the audit, including;

- a business continuity plan is in place which is reviewed on an annual basis;
- a monthly statistical analysis of Dolphin House data is completed including voids, occupancy rates, income, referrals, planned and unplanned moves;
- support workers have regular support sessions with families to help them move on to permanent accommodation;
- the entitlement criteria for Dolphin House is clearly defined and included in the staff information & procedure manual; and
- an income maximisation policy is in place which is subject to review on a 2 yearly basis.

A number of areas for improvement have, however, been identified, including; ensuring that an options appraisal for income collection methods is undertaken to avoid officers handling cash; that service users' entitlement to housing benefit is properly documented and managed by the service; that controls regarding arrears management are strengthened; and that utility costs are reviewed in the light of recent industry changes. The administration of leavers also requires review together with controls regarding the inventory, petty cash and budget management.

The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

A total of 27 actions for improvement were identified as part of the review with 12 being at high priority.

An internal audit follow up memo was sent to the homelessness & housing service manager and head of supported housing on 2 July 2010. A response to the memo is due on 10 August 2010.

Inventories and Stocks – Links to Work

An audit review of stocks and inventories was undertaken as part of the annual audit plan. Links to Work is a work preparation and supported employment service for people with disability or those disadvantaged by society. Links to Work maintains its own stocks and inventory records and most stock is third party owned, referred to as 'free issue'.

The overall objective of the audit was to assess the adequacy of controls governing financial and management arrangements and to seek assurance that:

- stock and inventories are maintained in accordance with financial and contract rules and local procedures;
- there is an inventory of all items of equipment above £50;
- there is documentary evidence to support all additions, disposals and amendments to the inventory;
- all assets are identified as belonging to the organisation;
- inventory/ store items and store/ inventory log are protected against loss and unauthorised access;
- all write offs and disposals of obsolete or damaged stock are supported by adequate documentation and are in line with agreed procedures;
- the store records are complete, up to date and accurate;
- the issue and return of store items are accurate and promptly recorded;
- the financial accounts are accurate and up to date;
- stocks are maintained at an appropriate level;
- ordering of stock for the stores is supported by adequate documentation;
- adequate documentation supports all payments for stock purchases; and
- previously agreed audit report actions have been fully implemented.

The conclusions detailed within the final report attached at **Appendix 5** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating within Links to Works' stock and inventories system.

Some good practices were noted during the audit including:
- all inventory checked as part of the audit could be physically located ; and
- all available procurement documentation is retained and easily accessible by staff.

Areas identified for improvement, including:
- procedure notes are not in place relating to stock and inventory;
- there is no regular check of inventory items; and
- weaknesses have been noted in the year end stock valuation.

A total of 5 actions for improvement were identified as part of the review with 1 being at high priority.

In receiving a response to an internal audit follow up memo on 7 July 2010, the links to work manager confirmed all of the 5 agreed actions had been fully implemented.

Information Security Management

An audit review of information security management arrangements was undertaken during February and March 2010 as part of the annual audit plan. Information is an asset that, like other important business assets, is essential to the delivery of Council services and consequently needs to be suitably protected. Information can exist in many forms. It can be printed or written on paper, stored electronically, transmitted by post or by using electronic means. Information security is the protection of information from a wide range of threats in order to ensure business continuity, minimise business risk, and maximise return on investments and business opportunities. Information security is achieved by implementing a suitable set of controls, including policies, processes, procedures, organisational structures and software and hardware functions.

The overall objective of the review was to report an opinion on controls in place to manage the risks that may compromise the security of information assets owned by the Council. Key controls have been audited against CIPFA computer audit guidelines and ISO27001 good practices required to achieve the following control objectives:

- a Council-wide approach to information security management is in place and is operating effectively, including records management; and
- processes and procedures have been established to support policy governing the security of information assets owned by the Council.

The conclusions detailed within the final report attached at **Appendix 6** were that:

Internal audit is able to give a limited assurance opinion on the system of internal control operating for the information security management process.

A number of good practices were noted during the audit, including;

- various risks that could compromise the security of information assets have been identified and quantified on the ICT service risk register;
- a records management policy has been implemented following legislative requirements;
- formal guidance and procedures are published on the Council intranet and provide some level of direction for the safeguarding of information assets;
- a library of information security control procedures has been documented and published for all staff to access and review; and
- information security requirements prescribed by the GSi code of connection have been implemented for staff working in the benefits service.

Some areas for improvement have been identified, including:

- the function that incorporates a corporate-wide approach to information security management should be promoted to the business;
- a process for raising and maintaining staff awareness of information security control requirements is required;

- an update to the overarching information security protocol statement that governs the security of information assets is required; and
- information security control procedures should be reviewed and updated.

A total of 5 actions for improvement were identified as part of the review with 4 being at high priority.

An internal audit follow up memo is due to be sent out in November 2010.

Frank F Harrison Engineering College

Following the FMSiS assessment on 16 and 17 November 2009, the information subsequently provided by the school and Walsall Children's Services – Serco, internal audit were unable to notify the DCSF of the school's continued compliance with the standard i.e. they were found to be non-compliant.

During the assessment, a number of matters were noted and these are addressed in the action plan attached at **Appendix 7**. Implementation of the actions outlined in the action plan together with the changes to procedures already agreed with Walsall Children's Services - Serco will assist in strengthening the school's financial procedures.

A total of 14 actions for improvement were identified as part of the review.

A follow up audit is due to be undertaken in October 2010.

**Resource and legal considerations**:

The cost of providing internal audit is charged to services based on audit activity. The audits detailed within this report were included within the annual risk assessed audit programme which is approved before the start of the respective financial year.

**Citizen impact**:

Report scrutiny assists in demonstrating that the council and its officers are protected and provides an assurance to stakeholders about the security of the council's operations.

**Performance and risk management issues**:

Many Audit Committee activities are an important and integral part of the council's performance/risk management and corporate governance frameworks. In reviewing specific reports which have been awarded no or limited assurance for detailed scrutiny, the committee is able to ensure that operational and control issues are being dealt with appropriately and that managers' agreed actions are being implemented. The committee can seek explanation from managers failing to progress agreed actions.

**Equality Implications**:

None arising from this report.

**Consultation**:

The annual audit work programme was discussed with relevant senior managers before the start of the year. Following completion of each audit review, the auditee's agreement to implement the agreed actions was sought before issuing the final report. Shortly afterwards, the relevant manager is asked to formally confirm that the agreed actions have been implemented.

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**Walsall Council**
**Internal Audit Service**

# Home Care Services

**Audit Report 2009 / 2010**
**July 2010**

## CONTENTS

# EXECUTIVE SUMMARY

## A. Introduction

1. An audit review of home care services was undertaken during November and December 2009 as part of the annual audit plan.

2. The home care service provides personal care and domestic tasks to vulnerable adults in Walsall to help them to be as independent as possible. Care is provided 24 hours a day, 7 days and week and includes:
   - personal care;
   - shopping;
   - laundry and ironing; and
   - escorting.

3. The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed audit report actions and to seek assurance that:

   - procedures are clearly defined, regularly reviewed and available to all officers for the administration of homecare;
   - the council regularly undertake an analysis of demand for the service and a resource plan is prepared which is monitored against actual service demand;
   - the entitlement criteria for homecare is clearly defined, documented and approved before being widely publicised;
   - home care providers are selected in accordance with the authority's financial and contract rules;
   - appropriately authorised and sufficiently detailed budget request forms (BRF) are raised for all homecare services requested, supported by an authorised care plan, which generate an official order;
   - timesheet evidence to support all homecare service provided, signed by the homecare worker and verified by the client, exists;
   - all BRF, official orders, care plans and invoices are matched prior to payment;
   - invoices are appropriately authorised and promptly processed;
   - urgent and manual payments are adequately controlled;
   - payments are allocated to an appropriate expenditure code;
   - VAT has been correctly accounted for;
   - effective budget monitoring arrangements are in place;
   - processing of credit notes is adequately controlled;
   - there is an adequate segregation of duties between ordering, authorising timesheets and certifying invoices for payment;
   - fees and charges in relation to client contributions for homecare services are promptly and accurately recovered and controlled; and
   - there are sufficient processes in place to regularly monitor the quality of homecare provision.

4. The scope of the audit is as set out on the contents' page. An overall opinion, points of good practice and an improvement action plan for each of the areas audited are attached. Actions for improvement, in general, are prioritised as high (***), medium (**) or low (*).

5. Within a short period of issuing the final audit report, the head of service will be contacted to formally confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

6. Under the Council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

7. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

8. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating within home care services**,** as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | Limited assurance | Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed. |
| | No assurance | No assurance as weaknesses in control, or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. Some good practices were noted during the audit, including;
   - flowcharts have been produced to map out the processes of brokering, monitoring and payment of care packages;
   - the older people's service plan is monitored on a quarterly basis;
   - the brokerage team record an appropriate Oracle code on all invoices submitted to consolidated creditors for payment; and
   - the service accountant provides monthly budget monitoring information to the service manager and strategic commissioning manager

3. Most areas reviewed required significant improvement. Procedural documentation would benefit from review and update; controls regarding entitlement to homecare, the procurement section's monitoring of home care providers; the use of non contracted home care suppliers; and the effectiveness of controls over ordering and payments to home care providers, require strengthening.

4. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

5. The 4 agreed actions which remain applicable from the last audit were confirmed as implemented by specialist debtor manager on 7 September 2007. Of these, 3 had been fully implemented at the time of this audit. The 1 unimplemented action has been reiterated in this report, marked (*) in the action plan.

6. Most actions within the report are considered to be of a high priority.

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Policies and Procedures | | ✓ | | |
| Analysis of Demand | | ✓ | | |
| Resource Plan Monitoring | ✓ | | | |
| Entitlement | | | ✓ | |
| Home Care Providers | | | ✓ | |
| Ordering Procedures | | | ✓ | |
| Timesheets | | | ✓ | |
| Receipt of Homecare Services | | | ✓ | |
| Timeliness of Payments | | ✓ | | |
| Urgent Payments | ✓ | | | |
| Manual Payments | - | - | - | - |
| Allocation of Financial Codes | ✓ | | | |
| VAT | - | - | - | - |
| Budget Monitoring and Management Information | ✓ | | | |
| Credit Notes | | | ✓ | |
| Segregation of Duties | | ✓ | | |
| Income | | | ✓ | |
| Quality Monitoring | | ✓ | | |

## D. Acknowledgements

1. Please thank the all officers involved, for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

## 1. Policies and Procedures

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Flowcharts have been produced to map out the processes of brokering, monitoring and payment of care packages.
- All procedures documented within the in-house homecare policies manual include a review section for responsible policy officers to sign and date on review.
- A brokerage check list is in place detailing the stages of brokering a care package.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | ** | From a sample of 16 financial administration and support services procedure notes selected, it was found that 15 had not been updated since at least 2007. | Out of date procedures.<br><br>In the event of query the preparing officer may not be identifiable. Officers may be unable to conclude whether procedures are current/in date. | The financial administration and support services procedure notes will be reviewed. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed and amendments made where appropriate. | Specialist Debtors Manager<br><br>31 July 2010 |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.2 | *** | From a sample of 7 brokerage procedure notes selected, it was found that<br>• 4 had not been subject to a periodic review.<br>• 2 were not signed and dated by the completing officer.<br><br>It was further noted that:<br>• no reference is made to relevant statutory guidelines in procedures notes.<br>• a procedure for allocating invoices as either block or spot payments is not in place.<br>• there are no guidelines in place for the requesting and checking of timesheets for spot and block summary invoices. | Out of date procedures.<br><br>In the absence of certain officers, other staff may not be aware of their roles and responsibilities.<br><br>In the event of query, the preparing officer may not be identifiable. Officers may be unable to conclude whether procedures are current/in date. | All brokerage administrative procedures will be reviewed. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed and amendments made where appropriate.<br><br>Procedures will incorporate all relevant statutory guidelines for homecare, where appropriate.<br><br>Procedure notes will be produced for all tasks undertaken within the brokerage team including allocating invoices as block or spot payments and requesting and checking timesheets. | Locality Manager<br><br>31 July 2010 |
| 1.3 | ** | The guidance note for submission of invoices for non-contracted providers has not been reviewed since July 2008 and includes out of date contact details. The guidance note does not include the completing and reviewing officers. | Out of date procedures.<br><br>In the event of query the preparing officer may not be identifiable. Officers may be unable to conclude whether procedures are current/in date. | The guidance note for submission of invoices for non-contracted providers will be reviewed. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed and amendments made where appropriate. | Locality Manager<br><br>31 July 2010 |

## 2. Analysis of Demand

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- On a weekly basis each brokerage officer inputs onto a staff weekly worksheet summarising the number of care packages commissioned and variations/queries raised.
- A provider capacity check is completed on weekly basis and used for monitoring purposes.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | *** | A monitoring analysis of each block provider including cost and hours ordered and delivered is provided by the brokerage team to commissioning managers. This has not been updated and provided since 29 September 2009. | In-sufficient monitoring undertaken.<br><br>Potential for budget over spends.<br><br>Under-performing providers may go unnoticed. | Block contract monitoring information has been updated and is now completed on a monthly basis and sent to commissioning managers. | Locality Manager<br><br>Implemented |

## 3. Resource Plan Monitoring

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The older people's service plan is monitored on a quarterly basis.
- An action plan is put in place to address any remedial activity.
- The 2009/10 older people's service plan was authorised by the assessment & care management service manager and strategic commissioning manager.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 4. Entitlement

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Service users are assessed against the Fairer Access to Care Services (FACS) criteria. The assessment is undertaken by the social worker.
- The brokerage team receive and broker all care package requests.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.1 | *** | From a sample of 20 service users receiving care from external providers selected, it was found that:<br>• in 5 cases the panel funding request held on Paris was not authorised. (ref 6213, 200031, 176785, 171810, 48024)<br>• in 1 case a case note was recorded on PARIS stating that the head of service for older people had approved the care package but did not sign the panel funding request form as she was not registered to use PARIS. (ref 21430)<br>• in 1 case a panel funding request to support additional care hours was not held on PARIS. (ref 169253) | Unauthorised care packages. | Panel funding requests are now fully completed and approved on PARIS by the relevant authorised signatory prior to care being brokered.<br><br>All appropriate paperwork is now checked by the funding panel and second checked by brokerage prior to the brokering of a care package. | Locality Manager<br><br>Implemented |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.2 | *** | From a sample of 10 service users receiving care provided by the in-house provision, it was found that:<br>• in 2 cases there was no panel funding request held on PARIS. (Ref 15351, 157901)<br>• in 1 case the panel funding request held on PARIS had not been authorised. (Ref 42868)<br>• in 2 cases it did not appear that annual client monitoring had been undertaken. (Ref 141779, 120299)<br>• in 2 cases, a client monitoring review had not been undertaken for over 18 months. (Ref 15351, 157901)<br>• in 8 cases there was no evidence on the service user files that an initial 4 weekly review had been undertaken. (Ref 141779, 3164, 132648, 42868, 120299, 38929, 157901, 132737).<br>• in 1 case contact sheets were not held on file. (Ref 176038)<br><br>Each service user file includes a checklist which should be signed and dated to signify the various stages of monitoring undertaken, it was found that:<br>• In 6 cases the checklist had not | Unauthorised care packages<br><br>Changes in service user needs may not be addressed and appropriately actioned.<br><br>The provision of providing a duty of care to its service users may not be met.<br><br>Incomplete records maintained.<br><br>Unable to identify officer undertaking monitoring in the event of a query. | Panel funding requests are now fully completed and approved on PARIS by the relevant authorised signatory prior to care being brokered.<br><br>Client monitoring is now completed on an annual basis and reviews undertaken in accordance with timescales set.<br><br>Service users are now contacted 4 weeks after commencement of care to ensure they are satisfied with the home care service provided. A service user review sheet is completed to record the review and the checklist updated accordingly.<br><br>Contact sheets are now retained on file.<br><br>The checklist is now completed to document the various stages of monitoring undertaken including the date and signature of the completing officer. | Assistant Home Care Manager / Head of Provider and Directorate Services<br><br>Implemented<br><br>Assistant Home Care Manager<br><br>Implemented<br><br>Assistant Home Care Manager<br><br>Implemented<br><br>Assistant Home Care Manager<br><br>Implemented<br><br>Senior Care Officers<br><br>Implemented |

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| | | been completed (Ref 141779, 3164, 132648, 42868, 15351, 157901).<br>• In 1 case a checklist was not on file. (Ref 120299).<br>• In 3 cases the checklist included dates of monitoring but had not been signed by the relevant officer. (Ref 176038, 38929, 132737). | | | |

## 5. Home Care Providers

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- A quarterly monitoring form is issued to all contract providers and on an annual basis a contract monitoring form and quality self assessment form are issued.
- Contracts are monitored in accordance with the contract monitoring framework guidance.
- A reactive monitoring process is undertaken to investigate all concerns / complaints received.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.1 | *** | From a sample of 5 contract providers selected, it was found that:<br>• In 2 cases, a quarterly contract monitoring form had not been submitted by the provider and this had not been followed up by the procurement section. (Ref Care 2 U, Network Health and Social Care)<br>• In 2 cases, a return for quarter ending 30/09/09 was not followed up by the procurement section until 30/12/09. (Ref Care 2 U, Sevacare)<br>• In 1 case, a return for quarter ending 31/03/09 was not followed by up the procurement section until 01/07/09. (Sevacare)<br><br>Further, the provider is not required to submit evidence to support information detailed in the completed | Insufficient monitoring undertaken.<br><br>Under-performing providers may go unnoticed. | Prompt follow up action is now taken for the non-return of quarterly contract monitoring forms.<br><br>Due to the lack of procurement staff resources available, management reporting mechanisms are used to determine if and when monitoring visits are required in order to ensure that limited resources are targeted in the areas of highest risk to the Council and service users. | Procurement Manager<br><br>Implemented |

| | | | | | |
|---|---|---|---|---|---|
| | | contract monitoring forms. Procurement officers do not carry out contract provider site visits unless there is a concern raised or a provider has rated their selves as low on a contract monitoring form. This is due to the restricted number of officer resources available. | | | |
| 5.2 | *** | Following an initial pre-audit meeting, the brokerage support officer expressed concern, via email, that there is currently no provision to claw back a block provider charge if it exceeds the pre-set amount. This has led to:<br>• block providers being paid irrespectively of whether hours have been delivered to meet block allocations.<br>• overpayments being made to block provider who are not filling their blocks.<br>• payments being made to block providers who have been suspended. | Providers may be paid for work that has not been undertaken.<br><br>Non-compliance with contract provisions.<br><br>Potential budget overspend. | As a matter of urgency, a review of block provider contact arrangements will be undertaken to ensure there is provision to claw back block provider charges if they exceed the pre-set amount.<br><br>Procedures will then be documented, approved and issued to all relevant staff.<br><br>All underperforming block providers will be suspended by the end of May 2010.<br><br>The use of block contracts will be discontinued as part of the planned re-tendering process. | Locality Manager<br><br>30 June 2010 |
| 5.3 | ** | The contract monitoring framework guidance has not been reviewed / updated since October 2007. | Procedures may not be relevant of current working practices. | The contract monitoring framework is updated as and when changes in legislation occur.<br><br>A review of the contract management framework will be undertaken during 2010/2011 in accordance with key Care Quality Commission regulatory changes and to make it fit for future 'personalisation agenda' changes. | Procurement Manager<br><br>31 December 2010 |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.4 | *** | There are no contracts in place with non-contracted providers and there is no evidence that financial and contract rules have been complied with when engaging such providers.<br><br>The commissioning manager is currently undertaking a review of all service users who are receiving home care from non-contracted providers in order to address the issues surrounding the use of non-contracted providers. | Potential non-compliance with financial and contract rules.<br><br>Services users may be put at risk if providers not sufficiently vetted.<br><br>Value for money may not be obtained.<br><br>Lack of contractual protection in the event of query / challenge. | The use of non contracted suppliers is being reviewed to transfer non contracted providers over to contracted providers in order to comply with financial and contract rules. | Locality Manager<br><br>31 July 2010 |

## 6. Ordering Procedures

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Officers that complete risk assessments in respect of the in-house home care provision have achieved CIEH level 3 in risk assessment.
- Care plans are completed by senior care officers and supporting seniors.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.1 | *** | From a sample of 20 external provider orders selected, it was found:<br>• In 12 cases a budget request form (BRF) was not signed by the officer brokering the care. (Ref 88721, 49303, 6213, 200031, 21430, 169253, 193379, 176785, 41597, 178730, 48024, 20899)<br>• In 1 case a care plan was not held on PARIS. (Ref 190289)<br>• In 1 case a BRF was not signed by the inputting officer. (Ref 72018)<br>• The brokerage team have not updated the 'all brokered care to date file' since the increase to home care charges in October 2009. As a result of this, 13 cases were noted where the FISCOM order value did not match the charge that was stated | Incomplete / inaccurate / inconsistent records maintained.<br><br>Unable to identify inputting officer in event of a query.<br><br>Hours of care may be under/over stated. | Budget request forms will, in the interim, be fully completed, signed and dated by the officers brokering and inputting the care. Following a review of brokerage functions, BRF's will be replaced by a revised form.<br><br>A copy of all care plans will be held on PARIS.<br><br>It will be ensured that records held by brokerage and FISCOM are accurate, consistent and agree with supporting documentation.<br><br>The 'all brokered care to date' file will be updated on a regular basis to ensure that the correct weekly charges are included.<br><br>A standard time recording format will be agreed. | Locality Manager<br><br>30 June 2010 |

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|---|---|---|---|---|---|
| | | on brokerage records, including the 'all care brokered to date' file. (Ref 4480, 4167, 200031, 72018, 169253, 193379, 176785, 41597, 203665, 171810, 58780, 48024, 20899).<br>• In 1 case a BRF was incorrectly totalled due to the time proportioning format used. (Ref 72018)<br>• In 1 case the cost of care was incorrectly calculated on the BRF. (Ref 72018)<br>• In 1 case, the weekly total hours of care was not recorded on the BRF. (Ref 20899)<br>• In 1 case, the weekly hours stated on a FISCOM order were under stated by 2 hours. (Ref 171810)<br>• In 6 cases it was identified that there was an inconsistency in the time proportioning format which has led to the total hours of care per month being understated on the 'all care brokered to date' spreadsheet. For example 30 minutes is recorded as both 0.3 and 0.5. (Ref 4480, 88721, 72018, 21430, 41597, 48024) | | A reminder has been sent to the FISCOM team to ensure the correct rates of contracted providers are used. | Performance & Audit Manager<br><br>Implemented |
| 6.2 | *** | The referral form for simple home care services i.e. 5 hours or less care per week for a maximum of 3 weeks, does not include a section for officer approval. | Unauthorised care brokered. | A brokerage referral form will be introduced to cover all types of homecare. The form will include an approval section and be second checked by brokerage prior to the brokering of a care package. | Locality Manager<br><br>31 July 2010 |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.3 | ** | From a sample of 10 in-house clients examined, it was found in 1 case that an order request form could not be located at the time of the audit. (Ref 15351) | Lack of evidence that order raised.<br><br>Lack of audit trail. | Order request forms for in-house care are now saved electronically,<br><br>The order request form, for the exception identified, has been located and placed on file. Care is taken to ensure handwritten initial telephone referrals are retained on file. | Home Care Performance Management Analyst<br><br>Implemented<br><br>Senior Care Officers<br><br>Implemented |

## 7. Timesheets

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.1 | *** | From a sample of 20 service users being cared for by external providers, it was found that:<br>• in 5 cases timesheets were not provided following a number of requests made to the provider. (Ref 4480, 49303, 72018, 193379, 203665)<br>• in 1 case the hours recorded on the timesheet were higher than the invoiced hours. Also a timesheet was not available to support the care provided on 13/09/09. (Ref 41597)<br>• in 1 case the hours recorded on the invoice were 6 hours higher than those on the timesheet. (Ref 49303) | Lack of audit trail.<br><br>Under / over payments may have been made. | Providers have been notified that timesheets must be made available on request.<br><br>The two cases where timesheets do not match invoices have been investigated and adjustments made to provider payments where necessary.<br><br>Where charges for care do not match the care ordered, investigations are now undertaken by brokerage officers, in accordance with current procedures, to determine and resolve the reason for the discrepancy, prior to the payment being made.<br><br>Spot checks of timesheets are now regularly undertaken.<br><br>The introduction of electronic call monitoring by December 2011 will address the above. | Locality Manager<br><br>Implemented<br><br>Locality Manager<br><br>31 December 2011 |

## 8. Receipt of Home Care Services

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The in-house provision requires a statement of permission to be signed by both the service user and home care worker when the care involves dealing with a service user's medication requirements.
- A reminder letter is issued to block providers who fail to submit invoices within a specified timescale.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 8.1 | *** | From a sample of 20 external provider payments selected it was found:<br>• In 5 cases individual invoices were not provided at the time of the audit despite several requests being made to the provider. (Ref 88721, 4167, 6213, 169253, 74948).<br>• In 3 cases the provider had invoiced for less hours than were included on the FISCOM order. These had, however, been addressed by brokerage. (Ref 178730, 21430, 72018).<br>• In 1 case the provider had invoiced for more hours than were included on the FISCOM order. This had, however, been addressed by brokerage. (Ref 203665).<br>• In 1 case, hours stated on the care plan and BRF did not match the corresponding FISCOM order and | Inaccurate / out of date records maintained.<br><br>Under / over payments may have been made. | Providers have been notified that individual invoices must be made available on request.<br><br>Records held by brokerage and FISCOM are now accurate, consistent and agree with supporting documentation.<br><br>Each exception has been investigated and resolved.<br><br>A reminder has been sent to the FISCOM team to ensure that records are accurate. | Locality Manager<br><br>Implemented<br><br>Performance & Audit Manager<br><br>Implemented |

| | | | | | |
|---|---|---|---|---|---|
| | | invoice. (Ref 4480). | | | |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 8.2 | ** | In July 2009 a review was undertaken of the brokerage payments and validation process. A number of process improvements were recommended. However, there has been no follow up action taken since the review to ensure recommendations have been implemented. | Recommended process improvements may not have been implemented. | A follow up of the recommendations made following the brokerage payments and validation process review will be undertaken to ensure that all agreed actions have been implemented. | Locality Manager<br><br>30 June 2010 |
| 8.3 | *** | There are currently a large number of unpaid invoices being held at the brokerage team, mainly due to outstanding queries regarding hours of care provided. A tracker spreadsheet is used to log each outstanding query, however, due to high workloads, the spreadsheet contains a number of entries that are yet to be resolved. | Inaccurate / out of date information. | The tracker query spreadsheet has been reviewed and is now updated by a designated officer on a regular basis to ensure that outstanding entries are promptly investigated and resolved. | Locality Manager<br><br>Implemented |

## 9. Timeliness of Payments

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 9.1 | ** | From a sample of 20 external provider invoices selected, it was found in 7 cases that the invoice was not paid within 15 days from date of receipt. (Ledger ref 731168, 725493, 775845, 775675, 791367, 747063, 711193) | Potential non-adherence to agreed payment targets and non achievement of BVPI8.<br><br>Poor supplier relationships. | All invoices are now paid as soon as practically possible, and within 15 days from the date of receipt, unless contract terms specify otherwise. | Locality Manager<br><br>Implemented |

## 10. Urgent Payments

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

| | |
|---|---|
| • At the time of the audit only one urgent payment had been made which had been authorised by the head of older people's services. | |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 11. Manual Payments

*AUDIT OPINION*

**Manual payments are not made in respect of home care services.**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 12. Allocation of Financial Code

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The brokerage team record an appropriate Oracle code on all invoices submitted to consolidated creditors for payment.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 13. VAT

*AUDIT OPINION*

**VAT is not chargeable on home care services**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 14. Budget Monitoring and Management Information

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**
**For the financial year 2009/10 the profiled budget to January 2010 totals £3,421,748. Actual net expenditure for the same period totals £3,117,549, an under spend of £304,199. Current budget forecast reports prepared by the senior accountant for older peoples service indicate an under spend of £324,776 at year end.**

Good practice includes:

- A 2009/10 accountability memo was signed by the head of service.
- The service accountant provides monthly budget monitoring information to the service manager and strategic commissioning manager.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 15. Credit Notes

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Over payments are identified through the weekly and monthly brokerage monitoring.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 15.1 | *** | A procedure note for the identification of credit balances is not in place. | In the absence of certain officers, other staff may not be aware of their roles and responsibilities. | A procedure note for the identification of credit balances will be documented, approved and issued to all relevant staff.<br><br>The procedure will be reviewed on a regular basis, ideally annually. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed and amendments made where appropriate. | Locality Manager<br><br>30 June 2010 |
| 15.2 | *** | A report was provided by brokerage services of credit notes received from providers during the year and from a sample of 10 credit notes selected it was found that:<br>• In 4 cases it took longer than 15 days to process a credit note from the date of its receipt. (Ledger ref – 13893, 11526, 11508, 11529)) | Potential that performance targets may not be met.<br><br>Lack of audit trail. | Credit notes are now processed promptly and within 15 days of receipt to ensure creditor targets are met.<br><br>Credit notes are now being held securely.<br><br>The two missing credit notes have been located and it has been ensured that they have been processed on Oracle. | Locality Manager<br><br>Implemented |

| | | | | | |
|---|---|---|---|---|---|
| | | • In 1 case a credit note could not be located at the time of the audit. (Ledger ref – 12611)<br>• In 1 case, a credit note could not be located at the time of the audit and neither could it be traced to Oracle. (Credit note ref – 6279)<br>• In 1 case, the original invoice number was not recorded on the credit note and therefore the invoice could not be traced. (Credit note ref – CRED1) | | The original invoice number is now recorded on all credit notes to enable the invoice to be easily traced. | |

## 16. Segregation of Duties

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- An adequate segregation of duties exists throughout the home care payment processing function, including; BRF's being raised by a brokerage officer and order raised by the FISCOM team.
- An adequate segregation of duties exists between the in-house home care team submitting an order request and it being set up by the FISCOM team.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 16.1 | *** | Due to staff shortages there are not always two officers segregated from the brokering of care and the validating of invoices. | Errors may go unnoticed.<br><br>Inadequate segregation of duties. | The restructure of the brokerage team will ensure that separate officers will broker care and validate invoices. | Locality Manager<br><br>31 July 2010 |

## 17. Income

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Charges for care are automatically calculated on the financial assessment database.
- The financial assessment database is updated on an annual basis in line with revised benefit rates.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 17.1 | ** | Financial assessment data input onto the financial assessment database to calculate the service user charge is not checked by a second officer. | Inaccurate charges may be made. | It is not considered necessary to undertake a second check upon calculation of the service user charge as assessment forms are completed by the visiting services team and the paperwork sent to the specialist debtors team for input onto the system prior to producing a charge notification. | Not applicable |
| 17.2 | ** | From a sample of 10 service users selected, it was found that:<br>• in 2 cases there was a delay by the specialist debtor team in calculating the charge for care. (Ref 21704 37 days & ref 21637 68 days)<br>• financial assessment reviews are not undertaken. In 5 cases service user contributions had not been reviewed since completion of the original financial assessment, over 3 years ago.(Ref 18638, 19688, 8616,16202, 15888) | Unnecessary delays in client notification.<br><br>Charges may not be reflective of client income.<br><br>Loss of income to the authority.<br><br>. | Charges for care are now calculated promptly.<br><br>Changes in a service user financial situation are reviewed on a regular basis. (*) | Specialist Debtors Manager<br><br>Implemented |

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 17.3 | *** | It was found that the same officer within the specialist debtor's team prepares monies for banking, pays the money into the banking hall and completes the bi-weekly cash summary reconciliation. | Inadequate segregation of duties.<br><br>Potential for fraud and theft.<br><br>Errors / discrepancies may go unnoticed. | To maintain segregation of duties, a second officer now countersigns the paying in slip.<br><br>Bank reconciliations are now signed and dated by an independent officer to confirm the amounts banked. | Specialist Debtors Manager<br><br>Implemented |
| 17.4 | ** | The safe contents reconciliation procedure does not include the process for the bi-weekly income reconciliation. | Inconsistencies in processes.<br><br>In the absence of certain officers, other staff may not be aware of their roles and responsibilities. | The safe contents reconciliation procedure will be updated to include the process for the bi-weekly income reconciliation. | Specialist Debtors Manager<br><br>30 June 2010 |
| 17.5 | *** | A procedure for recovering debts on custom card is not in place. | Inconsistency in chasing debts.<br><br>Officers may not be aware of debt recovery procedures.<br><br>Potential loss of income to the authority. | A project officer has been appointed to review the process of recovering of debts on custom card.<br><br>Following the review, a procedure for recovering debts on custom card will be documented, approved and issued to all relevant officers.<br><br>The procedure will be reviewed on a regular basis, ideally annually. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed and amendments made where appropriate. | Specialist Debtors Manager<br><br>30 September 2010 |

## 18. Quality Monitoring

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Performance indicator data is reported to the performance improvement group on a monthly basis.
- A social care and inclusion scorecard is updated on a quarterly basis and reported to the performance improvement group.
- On an annual basis the performance & outcomes team complete two returns (Adults Self Assessment and Referrals, Assessments & Packages of care) to the Care Quality Commission and the national statutory inspectorate.
- On a quarterly basis the in-house home care provision completes a 10% audit check of service user files.
- The in-house homecare provision submit an annual quality assurance assessment to the Care Quality Commission.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 18.1 | ** | The quality of the contracted-out provision is not compared to the quality of the in-house provision. | Inconsistencies in home care services provided. | Consideration will be given to undertaking a comparison exercise between the quality of care provided by the contracted-out and the in-house provision. | Locality Manager<br><br>31 August 2010 |
| 18.2 | * | Brokerage information, including the monitoring of referrals, was previously reported to the Domiciliary Care Action Group. However, due to a staffing restructure, these meetings no longer take place. | Key officers may not be aware of current service performance.<br><br>Inability to address potential performance issues. | Brokerage information, including the monitoring of referrals is now reported to the commissioning manager. Any concerns raised are reported to the head of older people's service. | Strategic Commissioning Manager<br><br>Implemented |

**Walsall Council**
**Internal Audit Service**

# Community Alarm Service

**Audit Report 2009 / 2010**
**June 2010**

## CONTENTS

## EXECUTIVE SUMMARY

## A. Introduction

1. An audit review of the community alarm service was undertaken as part of the annual audit plan. The community alarm service provides home safety and personal security systems which enables the elderly and disabled to live independently. This is achieved through a 24-hour telephone link to the social care and inclusion response centre. There are approximately 8000 homes throughout the borough which the service supports.

2. The community alarm service is currently in the process of a full service restructure.

3. The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed audit report actions and to seek assurance that:

   - policies and procedures are recorded in writing, regularly reviewed and available to all staff;
   - robust arrangements are in place for applications for and amendments to, service provision;
   - adequate systems are in place for call management;
   - assets are appropriately managed and there is an approved programme of routine maintenance, servicing and installation of alarm equipment;
   - an inventory is maintained in accordance with financial and contract rules;
   - there is an approved scale of charges and income is promptly recovered;
   - procurement is in accordance with the authority's financial and contract rules;
   - joint working with other council services and partnerships with external bodies are utilised to their full potential;
   - adequate security controls are in place;
   - adequate management information and budgetary control is in place;
   - petty cash is appropriately administered;
   - use of the council's vehicles is adequately controlled; and
   - performance management systems are followed, including those relating to risk management, IPM, communication, sickness management, equalities and health and safety.

4. The scope of the audit is as set out on the contents' page. An overall opinion, points of good practice and an improvement action plan for each of the areas audited are attached. Actions for improvement, in general, are prioritised as high (***), medium (**) or low (*).

5. Within a short period of issuing the final audit report, the head of service will be contacted to formally confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all

cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

6. Under the Council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

7. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

8. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating within community alarm service as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | Limited assurance | Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed. |
| | No assurance | No assurance as weaknesses in control, or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. Some good practices were noted during the audit, including; the service being Telecare service accredited, the use of the PNC5 system to log telephone calls; and partnership working with NHS Walsall to jointly deliver a pilot scheme for Tele Health services.

3. Most areas tested require significant improvement, including ensuring:
   - that day to day operational procedures are comprehensively documented;
   - that referrals for alarm installation are promptly and appropriately managed and recorded, including on PARIS;
   - that a robust system for processing amendments or cessations to alarm provision is introduced;
   - call management procedures are tightened;
   - that urgent follow up action is taken where monthly test calls to ensure that alarms are still working are not responded to by service users;
   - that equipment repair and maintenance procedures are managed;
   - the inventory register is promptly updated;
   - controls regarding income, specifically the private purchase of equipment are reviewed;
   - procurement controls, including those regarding contracts, are tightened; and

- performance management issues are addressed.

4. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

5. The 27 agreed actions which remain applicable from the last audit were confirmed as implemented by the community alarm service manager on 11 January 2007. Of these, 17 had been fully implemented at the time of this audit. The 10 unimplemented, or partially implemented, actions have been reiterated in this report, marked (*) in the action plan.

6. Most actions in the report were considered to be of a high priority.

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Policies and Procedures | | | ✓ | |
| Applications and Amendments to Service Provision | | | ✓ | |
| Call Management | | | ✓ | |
| Asset Management | | | ✓ | |
| Inventory | | | ✓ | |
| Income | | | ✓ | |
| Procurement | | | ✓ | |
| Partnerships | ✓ | | | |
| Security | ✓ | | | |
| Budget Monitoring and Management Information | | ✓ | | |
| Petty Cash | | ✓ | | |
| Fleet Vehicles | ✓ | | | |
| Performance Management | | | ✓ | |

## D. Acknowledgements

1. Please thank all relevant staff for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

## 1. Policies and Procedures

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- A call handling procedure manual is in place which has been authorised by the community alarm service manager and is Telecare service accredited.
- A flowchart is in place mapping the community alarm service process from receiving a referral to issuing service user customer satisfaction surveys.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | ** | The call handling procedure manual provided to the auditor at the time of the audit refers to 'Tunstall PNC4' the previous operating version of the community alarm service.<br><br>In addition, certain aspects of the manual such as; the mission, health and safety policy, and confidentiality of information held sections were due to be re-issued in July 2007. Other sections of the manual were due to be re-issued in July 2008. There was no evidence that these re-issues had taken place. | Procedures may not be reflective of current arrangements.<br><br>In the absence of key staff, other staff may not be aware of their duties and responsibilities. | All written procedures will be reviewed on a regular basis. Where procedural documentation indicates a 're-issue' date, this date will be diarised and adhered to.<br><br>Once a review has taken place, the reviewing officer will sign and date the procedure manual to evidence that a review has been completed and amendments made where appropriate.<br><br>Procedures will then be issued to relevant staff who will sign to acknowledge receipt of and confirmation of their intention to comply fully with them. | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br><br>Implemented |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.2 | *** | While a call handling procedure manual is in place, basic procedure notes have not been written for administrative tasks undertaken, for example, how to administer alarm service referrals and amendments to service provision, staffing administration, petty cash procedures or ordering procedures. | In the absence of key staff, other staff may not be aware of their duties and responsibilities. | All administrative procedures will be comprehensively detailed in writing. Once completed, procedures will be issued to relevant staff who will sign to acknowledge receipt of and confirmation of their intention to comply fully with them.<br><br>Thereafter procedures will be reviewed on an annual basis and signed and dated by the completing officer. | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br><br>31 July 2010 |
| 1.3 | * | The flowchart mapping the community alarm service process from receiving a referral to issuing service user customer satisfaction surveys has been manually amended. | Unapproved amendments may be made to procedural documentation unnoticed.<br><br>Unclear / misleading records. | Only approved amendments will be made to procedural documentation.<br><br>The manual amendments to the flowchart will be reviewed, formally approved and incorporated into the electronic version of the document before being issued to staff. | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br><br>31 July 2010 |

## 2. Applications and Amendments to Service Provision

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- An assessment to determine eligibility for the provision of an alarm is completed by a number of services and organisations, including; YADS, locality teams, hospitals, intermediate care, district nurses, occupational health and social workers.
- Phone calls made to service users to arrange a date for their alarm equipment to be fitted are voice recorded.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | *** | A sample of 10 referrals for alarms was tested. The following exceptions were noted:<br>• In 3 cases, the receipt of installation was not signed by the engineer.<br>• The auditor could not be provided with a contact details form or a job appointments sheet for any of the sample selected.<br>• In 1 case, alarm equipment was not installed within 3 weeks from receipt of the referral. There was no evidence to support follow up action had been undertaken.<br>• There was no signed SLA on file in all 10 cases. The auditor was informed that SLA's have not been issued to service users since April 2009. | In the event of query / dispute, no evidence of terms of installation is available.<br><br>Terms and conditions for the service provision may be unclear to service users.<br><br>Lack of audit trail.<br><br>In the event of an emergency, contact details may not be available / accurate.<br><br>Non adherence to targets. Delays in issuing equipment represent a less than efficient service. | All receipt of installations will be signed by the engineer to evidence installation of equipment.<br><br>Job appointment sheets and contact details forms, including those in the audit sample, have been obtained and are now held securely.<br><br>Alarm equipment will be installed within 3 weeks or as soon as practically possible. Follow up action is now recorded on the referral form to evidence the date and time of contact with the service user, progress of further information requests, installation arrangements and where the 3 week installation target is not met.<br><br>All service users in receipt of alarm equipment since April 2009 will be issued with and asked to sign a service level agreement. Thereafter, a service level agreement will be issued to all service users | Assistive Technology & Telehealthcare Manager<br><br>Implemented<br><br>Assistive Technology & Telehealthcare Manager |

| | | | | | |
|---|---|---|---|---|---|
| | | | | upon the receipt of alarm equipment. | 30 June 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.2 | * | The clerical assistant at the community alarms service informed the auditor that details on referral forms are not always fully completed by the service/organisation requesting installation of an alarm. The clerical assistant often has to contact the individual who completed the referral form to obtain missing information. This can delay installation of the alarm. | Delays in alarm installation. | Awareness sessions for referring organisations will be carried out on an ongoing basis in joint partnership with Tunstall. | Assistive Technology & Telehealthcare Manager<br><br>31 August 2010 |
| 2.3 | ** | Although the community alarm service set an informal target of 3 weeks to install the alarm from the date of referral, there is no formal monitoring system in place to determine whether this target is being met. | Inability to evidence that targets are being met.<br><br>The service is unable to identify where this target is not met and whether corrective action is needed. | This is an informal target.<br><br>It is not considered necessary at this time to introduce a formal monitoring system to record the service's performance against the 3 week target as it does not form part of the service's KPI's and is neither a Telecare Service Association reporting requirement.<br><br>Contact dates and times are recorded on individual referral forms. | Not applicable |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.4 | *** | There is no system in place for processing amendments or cessations to alarm service provision. For example, there is:<br>• no standard notification or amendment process;<br>• no amendment form on which amendments / cessations are documented;<br>• no means by which amendments are checked to ensure that they are promptly or accurately processed;<br>• no evidence that all obsolete equipment resulting from ceased / amended alarm service provision has been recovered; and<br>• no reporting mechanism to detail service users who have received an amendment to alarm equipment or those where alarm equipment is no longer required. | Notification of amendments / cessations of alarm provision may go unprocessed, unnoticed.<br><br>Errors on inaccuracies in processing amendments / cessations to service may go unnoticed.<br><br>Obsolete equipment which could be recycled and used elsewhere may go un-used. | A system for processing amendments or cessations to alarm service provision will be introduced. This will include the introduction of:<br>• a procedure to document the amendment / cessations process;<br>• a process by which amendments are checked to ensure that they are promptly or accurately processed;<br>• evidence that all obsolete equipment resulting from ceased / amended alarm service provision has been recovered; and<br>• detail of service users who have received an amendment to their alarm equipment or those where alarm equipment is no longer required is logged on the service users record on the PNC5 system.<br><br>An amendment form to record amendments/cessations to alarm equipment is not considered necessary. Instead, amendments are recorded on a new referral form which form part of the quarterly SA data. | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br><br>31 August 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.5 | *** | No documentation was provided to support the input of equipment details onto PARIS for the audit sample of 5 service users selected prior to July 2009.<br><br>It was identified that this was because equipment details in respect of community alarms, have not been input onto PARIS since July 2009.<br><br>Further, the clerical assistant is the only officer on the team who has access to PARIS. | Incomplete/ out of date records.<br><br>Unable to identify current equipment used.<br><br>In the absence of certain officers, other staff may not be aware of roles and responsibilities. | It will be ensured that all outstanding alarm equipment details are recorded on PARIS. Thereafter, alarm equipment details will be entered onto PARIS in a timely basis upon installation of equipment.<br><br>A request will be submitted to enable a second officer to have access to PARIS. The officer will be appropriately trained to enable them to input the appropriate service user and equipment details. | Assistive Technology & Telehealthcare Manager<br><br>31 July 2010<br><br>Assistive Technology & Telehealthcare Manager<br><br>31 July 2010 |
| 2.6 | ** | Notification is not always received when alarm equipment is no longer required. | Missing equipment may go lost or stolen. | A system for monitoring issued alarm equipment will be introduced. This will include a follow up call on the non-return of the annual contact details form and where the service user does not make contact with the service for a period of time a test call will be made, where possible.<br><br>Consideration will be given to introducing a system where by service users make a deposit on receipt of alarm equipment. This may encourage service users and or their representatives to alert the community alarm service where an alarm is no longer required. | Senior Community Alarms Service Officer<br><br>31 August 2010<br><br>Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | The service level agreement includes a section which service users sign to confirm they must return equipment when it is no longer required. | |

## 3. Call Management

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Various types of call log form are used, dependant upon the type of call received.
- The PNC5 system logs the time and date of the call.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.1 | *** | A sample of 10 call logs were selected for examination. The following was identified:<br>• In 1 case, a call was not logged on the PNC5 system.<br>• In 7 cases the time of the call received on the PNC5 system differed to that recorded on the call log sheet.<br>• In 1 case the date of the call was not recorded.<br>• In 3 cases the officer did not sign and date the noise complaints log to confirm the call had been passed to the appropriate section.<br>• The telephone message sheet and warden log do not include a section for the officer to sign to confirm the call has been passed on to the appropriate section. | Inaccurate records.<br><br>Incomplete data.<br><br>Calls may not be passed promptly to the relevant section.<br><br>Unable to determine the officer recording the call.<br><br>Unable to confirm the call has been passed to the relevant section.<br><br>Inconsistency in recording of information. | Officers will ensure:<br>• The reason for the call not being logged on the PNC5 system will be determined and action taken to correct this as appropriate.<br>• Sufficient and accurate information will be detailed on the Tunstall (PNC5) database regarding telephone calls received from community alarm users. (*)<br>• The time of the call received on the PNC5 system will be reconciled to that recorded on the call log sheet.<br>• The date of the call will always be recorded.<br>• Officers will sign and date the noise complaints log to confirm they have passed the call on to the appropriate section.<br>• Documents will be retained in accordance with the council's document retention guidance. | Senior Community Alarms Service Officer<br><br>31 July 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | • The emergency duty log and warden log do not include a section for the officer to sign to confirm they have logged the call.<br>• All call log sheets do not include a section for officers to record the date and time as to when the call was passed on. Due to this, In 8 cases the date and time as to when the call was passed on were not recorded.<br><br>The above exceptions were noted and when the auditor requested the evidence it was found that it had been shredded. | | • The telephone message sheet and warden log will be amended to include a section for the officer to sign to confirm the call has been passed to the appropriate section.<br>• The emergency duty log and warden log will be amended to include a section for the officer to sign to confirm they have logged the call.<br>• Call log sheets will be amended to include a section for officers to record the date and time as to when a call was passed on. | Assistive Technology & Telehealthcare Manager<br><br>31 July 2010 |
| 3.2 | *** | Key contact information has not been updated to enable officers to forward calls on to the relevant section due to the officer responsible for this retiring. | Key contact information may become out of date.<br><br>Delays may be experienced in the event of an emergency. | Key contact information will be regularly reviewed to ensure data is still current and evidence of the review detailed.<br>(*) | Senior Community Alarms Service Officer<br><br>31 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.3 | *** | Service users are expected to make a test call to the centre on a monthly basis. No follow up action is taken to contact service users who fail to make a test call.<br><br>Further, monitoring is not undertaken to ensure service users who have not made a recent test call still have a need for the equipment. The service is only made aware of when an alarm is no longer required by either notification by the service user or their representative or via the weekly death list. | Faulty equipment may not be identified. In the event of an emergency, a service user may not then be able to contact the service for help.<br><br>In instances where equipment is no longer required may not be promptly identified by the service. | Procedures will be established to ensure follow up action is promptly taken where service users fail to make regular test calls to the centre. This will be included in the call handling manual.<br>(*)<br><br>Monitoring arrangements have been considered to check whether service users who have not made a recent test call to the centre still have a need for the equipment. This has been considered in conjunction with action 2.5.<br>(*)<br><br>Due to limited staff resources and the volume of service users who are in receipt of alarm equipment, there are ongoing problems in finding suitable and manageable monitoring arrangements to address this issue. Consideration has been given to introducing a respondent service which will include designated officers who will be responsible for the monitoring of and making visits to service user homes who have made no contact for a period of time. | Senior Community Alarms Service Officer<br><br>31 July 2010<br><br>Senior Community Alarms Service Officer<br><br>31 August 2010 |

## 4. Asset Management

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- A fault equipment reporting form is completed to record faults and retained on file upon completion of a repair.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.1 | *** | The scheme checker system was unavailable between March and October 2009 due to the temporary location of the service at the Broadway Disaster Recovery Site. To identify faults, officers had to manually dial into each scheme, due to this, faulty equipment may not have been identified and in the event of an alarm needing to be used it may not have been fully operating. | Faulty equipment may not be identified.<br><br>In the event of an emergency, a service user may not then be able to contact the service for help. | Alternative arrangements will be made to ensure future scheme checker system down time is appropriately managed. This will include regular scheme checks to identify faulty schemes to enable corrective action to be taken promptly. | Assistive Technology & Telehealthcare Manager<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.2 | *** | From a sample of 5 equipment reporting forms selected, it was found:<br>• In 1 case the engineer did not complete the time the repair was completed and sign to confirm the job was complete. (I.D ref – 42)<br>• In 1 case it took 73 days from the equipment fault initially reported to the completion of the repair. (ID ref 42)<br>• In 1 case the date and time of the completed repair did not agree with the fault reporting details. The job was completed at 10:13, however, the fault was reported at 13:40 (ID ref – 5902)<br>• In 1 case an old format equipment fault reporting form was used. The reporting and completed job details were displayed in a format different to another previous format reporting form. (ID ref – 1276) | Incomplete records.<br><br>Repairs may not be complete.<br><br>Non-achievement of a duty of care to service users.<br><br>Inconsistency in completion of records. | The community alarm service manager will remind engineers that all sections of equipment reporting forms should be completed accurately and signed.<br><br>Repairs will be completed as promptly as possible.<br><br>Only current standard format reporting forms will be utilised.<br><br>Follow up action will be taken promptly and details recorded of action taken for all faults reported. (*)<br><br>The use of a different engineer has addressed the above. | Assistive Technology & Telehealthcare Manager<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.3 | ** | There is no programme of routine maintenance and servicing for alarm equipment within the current contract. | Faults may go unnoticed, ultimately impacting upon service user safety. | At this time, it is not considered feasible to introduce a routine maintenance and servicing programme for all community alarm service equipment. | Not applicable |
| 4.4 | ** | A procedure note detailing a new stock management system is still in progress. | Incomplete / unauthorised documents.<br><br>Officers may be unaware of their duties and responsibilities with regard o the new stock management system. | The stock management procedure note has been finalised, approved and issued to all relevant officers.<br><br>Thereafter, the procedure will be updated in line with timescales set for review. | Senior Community Alarms Service Officer<br><br>Implemented |

## 5. Inventory

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- An official inventory book is used which includes the value of each asset.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.1 | *** | The inventory register has not been updated for the purchase or disposal of assets since March 2009. | Missing items may not be promptly identified for officers to take appropriate action.<br><br>In the event of theft / fire, stolen / recovered items may not be easily identifiable.<br><br>Unauthorised disposals may occur unnoticed.<br><br>Non-compliance with financial and contract rule 6.2. | In accordance with financial and contract rules, the inventory register will be updated promptly upon the purchase and disposal of assets. | Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.2 | *** | The auditor was informed that some items of office equipment were disposed of in March 2009. There was no evidence provided during the audit to confirm disposal forms are completed or that the disposal had been completed in accordance with financial and contract rule 6.2. | Unauthorised disposal.<br><br>Lack of audit trail in the event of a query.<br><br>Failure to adhere to financial and contract rule 6.2. | A disposal form will be completed promptly upon the disposal of inventory to record the item, reason and authorisation of disposal.<br><br>All assets will be disposed of in accordance with financial and contract rule 6.2. | Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |
| 5.3 | *** | Due to a recent office move, the officers assigned to complete the annual inventory check have yet to be confirmed. | Non-completion of inventory checks. | The community alarm service manager will designate two officers to complete the annual inventory check and ensure that it is carried out appropriately. | Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |

## 6. Income

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Copies of completed debtor requisitions are retained on file.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.1 | *** | A charging policy for privately purchased community alarm equipment is not in place. | In the absence of certain officers, other staff may not be aware of their roles and responsibilities.<br><br>Inconsistency in pricing methods.<br><br>In the event of query / challenge pricing methods may be unclear.<br><br>Over / under charging may occur.<br><br>Prices not properly authorised. | A pricing policy for privately purchased equipment will be documented, approved and followed.<br><br>The pricing policy will be approved by the assistant director (or other officer under written delegation) in accordance with the council's constitution.<br><br>Thereafter, the policy will be reviewed on a timely basis in accordance with deadlines set for review. The annual review of charges will ensure that prices are reflective of those charged by other local authorities/suppliers and are consistent with service aims and expected demand. (*) | Assistive Technology & Telehealthcare Manager<br><br>Strategic Commissioning Manager<br><br>31 December 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.2 | *** | There are no arrangements in place to recharge clients in the event of equipment either not being returned to the authority in the event of the service users' death or for any damage to equipment caused by the service user. | No financial reimbursement claimed for loss/damage to authority owned equipment. | Consideration will be given to the introduction of a procedure whereby clients or their relatives are charged for the cost of any unreturned or damaged equipment. Colleagues from legal services and audit will be consulted. (*) | Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |
| 6.3 | *** | A log of privately purchased equipment is not maintained. | The service may be unable to determine the value of privately purchased equipment. | A log is now maintained of all privately purchased equipment. This also includes the relevant debtor requisitions raised and income received. | Implemented |
| 6.4 | *** | A debtor requisition for the private purchase of alarm equipment in August 2009 was not signed by the requesting and authorising officers, neither submitted to consolidated debtors to enable an invoice to be raised. | Loss of income.<br><br>Non-compliance with corporate debt procedures. | It is ensured that debtor requisitions are fully completed and signed by the requesting and authorising officers. Debtor requisitions are now promptly submitted to consolidated debtors to enable an invoice for payment to be raised.<br><br>The invoice detailed in the finding will be raised and income recovered immediately. | Assistive Technology & Telehealthcare Manager<br><br>30 June 2010 |

## 7. Procurement

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

- 100% of the invoices sampled for testing were paid within 15 days of receipt.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.1 | *** | A sample of 10 invoices were selected, it was found:<br>• In 1 case an invoice could not be located at the time of the audit. (Ledger ref: 735121).<br>• In 8 cases, the same officer authorised the order and the invoice. This is due to the small size of the team and currently there being just 2 officers (clerical assistant & community alarm service manager) located at the social care & inclusion response centre (Ledger ref: 707065, 746371, 710716, 735353, 708,231, 729458, 690275, 711049).<br>• In 2 cases the date paid stamp did not agree with the date paid on Oracle (Ledger ref: 707065, 708231). | Missing invoices may go unnoticed.<br><br>Lack of audit trail.<br><br>Inadequate segregation of duties increases the risk of fraud and error<br><br>Inaccurate records. | Care is now taken to ensure records are held securely.<br><br>Where possible to maintain segregation of duties, officers involved in the payment of accounts now ensure that orders and corresponding invoices are authorised by different officers.<br><br>Care is now taken to ensure that invoices are date stamped with the correct date of processing. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.2 | *** | The Tunstall contract has not been subject to a tendering exercise since commencement of the contract in 2003.<br><br>The Care Necessities contract was introduced in 2008 and has not been subject to a periodic review. | Unable to demonstrate value for money in procurement.<br><br>Lack of adherence to the council's financial and contract rules. | The Northern Housing Consortium, on behalf of the community alarm service, identify best value maintenance services with the use of their procurement's assistive technology framework. This enables the community alarm service to make an assessment of the potential tendering of maintenance services.<br><br>A timetable has been formulated to identify responsibilities and timescales to ensure the Tunstall contract is tendered.<br>(*)<br><br>Further, a review of the Care Necessities contract will be undertaken. | Assistive Technology & Telehealthcare Manager<br><br>31 December 2010 |
| 7.3 | *** | The Care Necessities contract could not be found during the audit. The community alarm service manager requested a copy of the contract from Care Necessities but a copy was not forwarded to the auditor. | In the event of query / challenge the council and contractors obligations may not be clear. | The Care Necessities contract has been obtained and is held securely. This will assist in the review of this contract as suggested in 7.2 above. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

## 8. Partnerships

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The service works in partnership with NHS Walsall to jointly deliver TeleHealth services. TeleHealth is used to provide health equipment to service users to enable them to manage long term health conditions. The partnership is currently operating on a pilot basis.
- TeleHealth meetings take place on a bi-monthly basis and are minuted.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 8.1 | * | The Tele Health partnership is coordinated by the NHS. A terms of reference, operational policy and operational procedure have been produced by the NHS but are currently in draft status. | Unauthorised / incomplete documents.<br><br>Unclear partnership arrangements. | Arrangements have been made with the NHS to enable the Tele Health partnership documents to be finalised. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

## 9. Security

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Every visitor to the social care and response is required to sign in.
- The PNC5 system is password protected and has various access levels assigned.
- Files are stored in locked cupboards in accordance with the Telecare Service Association guidelines

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 10. Budget Monitoring and Management Information

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**
**At the time of the audit, current budget forecast reports prepared by the accountant for older peoples service indicate an under spend of £15,191 at year end due to projected overspend on salaries offset by under spends on equipment and PCT income.**

Good practice includes:

- The community alarm service manager and accountant have recently completed an exercise to remove cost centres which are no longer used.
- The service accountant provides the community alarm service manager with monthly budget monitoring information.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 10.1 | * | There is currently no monitoring undertaken of the cost of the in-house and contracted out alarm provision. | Insufficient monitoring.<br><br>Unable to demonstrate value for money. | The cost of in-house and contracted-out alarm provision is now monitored on a regular basis and reviewed by senior officers to ensure that the most cost effective methods of service provision is provided.<br>This has led to an agreement with the fire service to install basic alarm equipment and the possible recruitment of 2 in-house engineers. | Assistive Technology & Telehealthcare Manager<br><br>31 December 2010 |
| 10.2 | * | The community alarm service manager and the accountant do not meet on a regular basis and instead most queries are resolved via the phone or email. | Potential significant under/over spends may not be appropriately addressed.<br><br>Lack of communication. | The community alarm service manager and accountant now meet on a quarterly basis to discuss the current financial position and to take corrective action where appropriate. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

## 11. Petty Cash

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Petty cash is securely stored and access limited to authorised officers.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 11.1 | * | A deputy petty cash officer has not been designated to administer the petty cash in the absence of the key officer. | In the absence of certain officers, other staff may not be aware of their roles and responsibilities.<br><br>Petty cash may be unobtainable in the event of urgent need. | A deputy petty cash officer has been designated to administer the petty cash in the absence of the key officer. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |
| 11.2 | ** | Petty cash vouchers were not available during the audit as they had been submitted to support the reimbursement claim. Copies of vouchers are not retained on file and at present a photocopier is not available at the response centre. | Lack of audit trail in the event of a query.<br><br>Incomplete / unauthorised records. | Copies of petty cash vouchers will be retained on file to support the entries in the petty cash book.<br><br>To assist in this, the service now has use of a photocopier. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

## 12. Fleet Vehicles

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 13. Performance Management

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Community alarm service performance data is reported on a quarterly basis.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 13.1 | ** | The Walsall community alarms service leaflet provides contact details. The numbers listed will soon be invalid due to the service restructure. | Outdated / inaccurate information. | The Walsall community alarm service guide has now been updated. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |
| 13.2 | ** | Due to the nature of the service being primarily shift work, full team meetings do not take place on a regular basis. | Unclear roles and responsibilities.<br><br>Poor communication. | Full staff meetings are now undertaken on a regular basis and minutes produced to ensure decisions made and actions necessary are appropriately recorded. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |
| 13.3 | *** | There is currently no health and safety risk assessments and supporting action plan in place for the Social Care & Inclusion Response Centre.<br><br>Further, a health and safety assessment was not completed for the temporary location of the service at the Broadway control room. | Potential health and safety risks to staff may exist un-noticed.<br><br>Staff members may be at risk. | A health and safety risk assessment and associated action plan has been undertaken for the Social Care & Inclusion Response Centre.<br><br>In addition, if future temporary service relocations occur, it will be ensured that the site is health and safety risk assessed prior to relocation to ensure any health and safety risks are mitigated. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 13.4 | *** | A risk assessment for the service was completed in 2007, however, a review has not been undertaken since. It was further identified that a supporting action plan was not in place to manage the risks identified. | Non-compliance with corporate procedures.<br><br>Risks affecting the service may not be identified / addressed. | A risk management action plan will be documented to incorporate all risks identified within the risk assessment and ways in which each risk can be mitigated. The action plan will be monitored on a regular basis and signed and dated to evidence the update. | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br><br>31 August 2010 |
| 13.5 | ** | Staff training records are not maintained. | Inability to demonstrate attendance at training in the event of query / challenge. | Staff training records will be maintained and updated on a regular basis. | Assistive Technology & Telehealthcare Manager<br><br>31 July 2010 |
| 13.6 | ** | IPMs have not been completed for over 12 months. The auditor was informed that they were to be completed in December 2009. | Non-compliance with corporate procedures. | IPM's will be carried out every 6 months, in accordance with the council's guidelines. | Assistive Technology & Telehealthcare Manager<br><br>Implemented |
| 13.7 | ** | An action plan to achieve Telecare Service Assoication (TSA) recognition and to ensure a performance management framework is established has not been compiled. | TSA accreditation may not be promptly achieved if necessary actions are not identified and assigned to a responsible officer for implementation. | An action plan will be established to assist with the achievement of TSA recognition and ensure a performance management framework is established.<br>(*) | Assistive Technology & Telehealthcare Manager<br><br>Senior Community Alarms Service Officer<br>30 September 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 13.8 | *** | The service plan within which the community alarm service falls could not be established. | Non-compliance with corporate procedures.<br><br>Unclear service aims and priorities. | The service plan within which the community alarm service falls, will be established and authorised by the appropriate senior officer.<br><br>Thereafter, regular monitoring will be undertaken to ensure service aims and priorities are achievable and corrective action taken to address non-achievement. | Strategic Commissioning Manager<br><br>Implemented |
| 13.9 | *** | Benchmarking with similar organisations is not currently undertaken. | Weakness in performance management. | Benchmarking with other local authorities and similar organisations is now undertaken, performance compared and corrective action taken where weaknesses are identified. (*) | Assistive Technology & Telehealthcare Manager<br><br>Implemented |

**Walsall Council**
**Internal Audit Service**

# Social Care & Inclusion
# DIRECT PAYMENTS, PERSONAL BUDGETS & INDIVIDUALISED BUDGETS

**Audit Report 2009/10**
**July 2010**

***CONTENTS***

## EXECUTIVE SUMMARY

### A. Introduction

1. An audit review of direct payments, personal budgets and individual budgets was undertaken during March 2010 as part of the annual audit plan.

2. The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements and to seek assurance that:
   - procedures are documented in writing, regularly reviewed, in line with Department of Health guidelines and issued to appropriate staff;
   - individuals' needs are formally assessed before a direct payments / personal budget offer is made;
   - individuals are given appropriate guidance on the schemes and assistance available to them including any changes in legislation;
   - appropriate paperwork is completed and retained to support all direct payment / personal budget offers;
   - direct payment / personal budget agreements between the council and the individual have been formally established, documented and signed;
   - direct payments / personal budgets are regularly reviewed in accordance with Department of Health guidelines;
   - appropriate arrangements are in place to control direct payments to a third party when required by an individual;
   - individuals in receipt of direct payments are required to provide evidence that direct payment allowances are being used to purchase goods and services as specified in the direct payments policy and regular compliance checks are undertaken to ensure that payments are appropriate;
   - carers' 'one off grants' are robustly controlled;
   - personal budgets are appropriately controlled and monitored;
   - procedures have been established to recover any overpayments made;
   - effective overall budget monitoring is undertaken;
   - performance management information is regularly compiled and reported to the appropriate officers / groups;
   - adequate arrangements are in place for the introduction of individual budgets; and
   - previously agreed audit report actions have been fully implemented.

3. Within a short period of issuing the final audit report, the head of service will be contacted to confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

4. Under the Council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

5. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

6. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating within direct payments, personal budgets and individualised budgets as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | **Limited assurance** | **Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.** |
| | No assurance | No assurance as weaknesses in control or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. A number of good practices were noted during the audit, including:
   - procedure notes are in place documenting operational processes for direct payments;
   - direct payment agreements have been developed which contain specific guidance for service users outlining their responsibilities and obligations in receiving direct payments;
   - the direct payments audit team monitor recipients' use and eligibility of their direct payments;
   - the use of Shaw Trust to assist service user's who lack capacity to manage their funds; and
   - the plans in place for the introduction of personal and individual budgets.

3. There are, however, areas for improvement, most notably, ensuring that adequate supporting documentation is made available to the auditor during the audit. Without this, audit assurance cannot be given in these areas. A business solution review of the systems for capturing and recording information regarding the award of direct payments should be undertaken and controls in most areas require strengthening.

4. Of the 28 agreed actions which remain applicable from the last audit of direct payments, all were confirmed as implemented by the strategic lead – self directed support officer on 4 March 2009. At the time of this audit review, 22 agreed actions had been fully implemented. The 6 unimplemented or partially implemented actions have been reiterated in this report, marked (*) in the action plan.

5. Most actions within the report are of a high priority.

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Procedure notes | | ✓ | | |
| Needs assessment | | | ✓ | |
| Guidance for service users | | | ✓ | |
| Direct payment agreements | | | ✓ | |
| Funding provision reviews | | | ✓ | |
| Third party payments | | | ✓ | |
| Direct payments usage | | | ✓ | |
| One off grants | | | ✓ | |
| Personal budgets | | ✓ | | |
| Overpayments | | | ✓ | |
| Budget monitoring | ✓ | | | |
| Performance management | | ✓ | | |
| Introduction of individual budgets | | ✓ | | |

## D. Acknowledgements

1. Please thank all officers involved during the course of the audit for their help and co-operation.

## 1. Procedure Notes

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Procedure notes are in place for relevant teams who process and monitor direct payment transactions.
- The responsibility to review and refresh procedure notes has been assigned to specific members of staff within respective teams.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | * * | The PARIS system is used to record appropriate details / documentation for a wide range of service users.<br><br>It was noted at the time of the audit testing that documentation was not always recorded consistently within each of the service user's electronic file. | In the event of query, information may not be easily located.<br><br>This could lead to a lack of effective and efficient use of resources in officer time locating required documentation. | Officers will ensure that all details / documentation in support of service user's direct payments are consistently and clearly filed on PARIS to ensure ease of location / retrieval.<br><br>The strategic lead – self directed support officer will ensure that standard guidelines for data recording of direct payments recipient information on PARIS are developed and issued to all relevant staff. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.2 | * * | Although procedure notes providing day to day operational guidance for current working practices within direct payments are in place, these will need to be amended to include arrangements for the forthcoming implementation of personal and individual budgets. | The forthcoming implementation of personal and individualised budgets may not be immediately underpinned by relevant procedure notes. | As part of the planned implementation of both personal and individual budgets, procedure notes detailing the operational aspects of administering personal and individual budgets will be drafted and made available to all relevant staff. The plan for this will be as follows: | |
| | | | | • Production of guidance on an interim process for personal budgets. | Strategic Lead – Self Directed Support Officer<br>30 July 2010 |
| | | | | • Amendments reflecting the roll out of personal budgets and the piloting of individual budgets will be included in revised direct payments guidance to operational staff. | Strategic Lead – Self Directed Support Officer<br>30 July 2010 |
| | | | | • Procedural notes with detailed guidance on the operational aspects of personal budgets | Strategic Lead – Self Directed Support Officer<br>24 September 2010 |
| | | | | • Production of guidance on an interim process for the piloting of individual | Strategic lead – Self Directed Support Officer<br>30 September 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | budgets.<br><br>• Procedural notes with detailed guidance on the operational aspects of individual budgets | Strategic Lead – Self Directed Support Officer<br>31 January 2011 |

## 2. Needs Assessment

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Needs assessments are undertaken by social workers, the results of which are uploaded on to the PARIS system, where appropriate.
- The needs assessment is documented via a care plan. The care plan records the required outcomes, the issues that need to be addressed to reach those outcomes and the services that need to be provided.
- The specific requirements of a service user are recorded within the care plan. The care plan is made available to the care user and outlines the services that are to be procured. The care plan therefore underpins the direct payment process by providing service users with details of which services can be paid for from their direct payment funding.
- Care plans provide significant detail and outline a 'service timetable'. The timetable documents the services that are required and the timescales within which those actions should be performed.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | * * * | The audit walk through testing confirmed that needs assessments are produced by social workers to establish the services that a user requires. The results of the needs assessment are recorded in a care plan and where direct payments are appropriate; a direct payment agreement is produced and signed by both parties.<br><br>A random sample of the care plans of 20 service users in receipt of direct payments was selected for audit examination.<br><br>Despite the strategic lead – self directed support officer requesting the selected care plans from operational staff and issuing a further reminder, only 1 care plan was made available to the auditor for testing. | Lack of audit trail.<br><br>Internal audit are unable to provide assurance that needs assessments, articulated in care plans, are in place.<br><br>The failure to undertake, complete or make available needs assessments results in the direct payments process being severely undermined. | Supporting documentation, in particular care plans, will, without exception, be retained in all cases and made available to relevant staff for scrutiny (*).<br><br>Officers will be advised that failure to comply with the above and respond promptly to audit requests may result in action, not excluding disciplinary, being taken against them.<br><br>As internal audit have not been able to provide assurance in this area, appropriate senior managers have decided that a further audit is required early in the new financial year to rectify this. The audit will be undertaken before 30 September 2010. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010<br><br>Internal Audit Manager<br>Major Projects Manager<br>Strategic Lead – Self Directed Support Officer<br><br>30 September 2010 |

## 3. Guidance for Service Users

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Direct payment agreements have been developed which contain specific guidance for service users outlining their responsibilities and obligations in receiving direct payments.
- In order to ensure that appropriate guidance is cascaded to staff, the strategic lead for self directed support has been charged with responsibility to monitor and act upon legislative changes.
- Guidance notes clearly outline the means by which direct payments are calculated and the purpose of the payment.
- Specific guidance is provided to direct payment recipients, for example outlining the legal requirements of employing a carer. This extends to the requirement for CRB checks and the tax implications of becoming an employer.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.1 | * * | Policy and practice guidelines, dated May 2006, which were issued to officers on 22 June 2006, state that the use of direct payments to purchase equipment is under development. Guidelines have not been reviewed or refreshed since 2006.<br><br>These guidelines form part of the direct payments agreement but do not provide appropriate reference to the purchase of equipment. | Insufficient guidance is provided to service users which may result in their acquisition of items that are not in accordance with the care plan. | The guidance notes which form part of the direct payments agreement will be updated and subjected to regular review and refresh. Evidence of the review will be retained. (*)<br><br>The guidance notes will be updated to make specific reference to the purchase of equipment. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.2 | * * * | Walk through testing has confirmed that guidance material is provided to service users as part of the direct payments agreement. The agreement is signed by relevant parties, a copy of which is left with the service user.<br><br>In addition, prior to initial checks by the direct payments audit team, additional guidance is issued to service users outlining the information that will be required from them.<br><br>A random sample of direct payment agreements of 20 service users in receipt of direct payments was selected for audit examination.<br><br>Despite the strategic lead – self directed support officer requesting the selected direct payment agreements from operational staff and issuing a further reminder, no agreements were made available to the auditor for testing. | Lack of audit trail.<br><br>Internal audit are unable to provide assurance that guidance has been issued to service users.<br><br>The failure to make available guidance to service users results in the direct payments process being severely undermined. | Supporting documentation, in particular direct payment agreements, will, without exception, be retained in all cases and made available to relevant staff for scrutiny (*).<br><br>Officers will be advised that failure to comply with the above and respond promptly to audit requests may result in action, not excluding disciplinary, being taken against them.<br><br>As internal audit have not been able to provide assurance in this area, appropriate senior managers have decided that a further audit is required early in the new financial year to rectify this. The audit will be undertaken before 30 September 2010. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010<br><br>Internal Audit Manager<br>Major Projects Manager<br>Strategic Lead – Self Directed Support Officer<br><br>30 September 2010 |

## 4. Direct Payment Agreements

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- The direct payments agreement and associated guidance is contained in one document, the 'Walsall direct payment scheme direct payments standard agreement'.
- The term of the agreement is clearly referenced, together with an outline of the roles and responsibilities of both the council and the individual signing the agreement.
- The agreement records the engaged parties, namely Walsall council and the 'consenting direct payments recipient' or the 'third person'. The third person being a nominated individual responsible to receiving direct payments on behalf of the service user.
- Under section 6 of the agreement, reference is made to the user's assessment. The assessment (care plan) outlines the specific requirements of the service user. When issued with details of the care plan the service user is able to use the contents as a guide to engage services from an external organisation.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.1 | * * * | A service user's direct payments are considered both at the time of their initial needs assessment and on an ongoing basis with each re-assessment. Where direct payments is appropriate, a standard agreement is available that formalises arrangements between the council and the service user.<br><br>A random sample of 20 direct payment agreements was selected to ensure that they were complete and appropriately signed; however, supporting documentation was not made available to the auditor for any of the sample. | Lack of audit trail.<br><br>Internal audit are unable to provide assurance that direct payment agreements have been agreed by service users in receipt of direct payments.<br><br>The failure to demonstrate service user agreement results in the legal status of the provision of direct payments being undermined. | Officers will ensure that direct payment agreements signed by all relevant parties are retained in all cases and made available to relevant staff. (*)<br><br>Officers will be advised that failure to comply with the above and respond promptly to audit requests may result in action, not excluding disciplinary, being taken against them.<br><br>As internal audit have not been able to provide assurance in this area, appropriate senior managers have decided that a further audit is required early in the new financial year to rectify this. The audit will be undertaken before 30 September 2010. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010<br><br>Internal Audit Manager<br>Major Projects Manager<br>Strategic Lead – Self Directed Support Officer<br><br>30 September 2010 |

## 5. Funding Provision Reviews

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Funding provision reviews are undertaken by the direct payments audit function.
- A database is maintained documenting all completed direct payment audit work and the dates of audit reviews.
- Completion of the funding provision reviews are recorded on a central spreadsheet which contains all known direct payment recipients.
- The central spreadsheet, maintained by the direct payments audit team, records relevant contact details (where a nominee has been used), the frequency of payment (to differentiate one off payments), the date that guidance has been forwarded to service users and the results of specific audit reviews.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.1 | * * * | Difficulties were encountered by the auditor in attempting to identify all recipients of direct payments, as details are not stored on a single database / spreadsheet other than that maintained by the direct payment audit function.<br><br>Members of the direct payment audit team are informed of new direct payment recipients on an informal basis by social workers. | Failure to develop a central record of all direct payment recipients may prevent the adequate and efficient monitoring of direct payment funding.<br><br>Inadequate management information / information recording / audit trail. | A re-constituted list of direct payment recipients will be produced and maintained with discipline and resilience; and stored on a shared drive to enable access to other relevant officers. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 5.2 | * * * | Direct payment assessments are undertaken and payments commenced on a prompt basis to ensure that the service user can engage appropriate support.<br><br>A subsequent assessment is made of the financial status of the service user and consideration is made on the ability of the service user to self fund.<br><br>If the service user is capable of self funding the direct payment is not ceased. Instead, there are arrangements to recover the funds via the 'fairer charging policy'. | The council may be incurring unnecessary processing costs due to a failure to reduce the direct payment by the proportion that can be self funded. | The strategic lead – self directed support officer will co-ordinate a piece of work to reach a decision on whether direct payments are paid gross or net of user contribution. This work will involve the direct payments audit team, specialist debtors' manager, operational staff and strategic lead - stakeholder engagement. | Strategic Lead – Self Directed Support Officer<br><br>30 September 2010 |

## 6. Third Party Payments

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- The direct payments agreement has been designed to require the agreement of both the council and a third party where the service user lacks capacity to manage their own direct payments.
- The third party or 'nominee's' role is clearly outlined in the agreement.
- Where direct payments are considered appropriate, but the service user lacks capacity to manage funds and an appropriate third party is not available, Shaw Trust has been engaged to act as the nominated recipient.
- Shaw Trust is a national charity which supports disabled and disadvantaged people to prepare for work, find jobs and live more independently.
- The council's contract with Shaw Trust is due to expire in August 2010 and the responsibility to review and refresh the contract has been assigned to a procurement officer.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.1 | * * * | The direct payments agreement requires the signature of the third party recipient in those cases.<br><br>There are currently no procedures in place to ensure that evidence of the status of people who are nominated to act on behalf of the recipient of a direct payment is retained on file, for example, evidence of their status as a third party / nominee or relevant identification checks.<br><br>From a random sample of 20 third party payments from the 2009/10 financial year, no evidence to support the identification of third parties had been filed. | Direct payments may be made to inappropriate third parties. | Evidence of status and identification details of all nominated third parties will be obtained and recorded on file. (*)<br><br>Status and identification checks will be included in the revised direct payments guidance to be issued to operational staff. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

## 7. Direct Payment Usage

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- The direct payments audit team have been engaged to review service users' application of direct payments.
- The direct payments audit team have now been assigned the authority to stop direct payments where breaches of the agreement have been noted.
- Whilst all purchases must adhere to the general requirements of the direct payments agreement, specific restrictions on the goods and service that can be purchases are contained within the care plan.
- Following investigations, standard letters are issued to the service user as appropriate, to confirm that monies are being used correctly to meet the assessed needs. Where actions are required, these are detailed in an action plan, which is made available to service users and their social workers.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.1 | * * * | Shaw Trust is engaged to facilitate the transfer of direct payments funding to a group of service users who have requested their financial assistance. Payments are made to Shaw Trust who in turn allocate the funds to the required service users.<br><br>The auditor noted that a list of direct payment recipients, banking details and payment amounts are forwarded to Shaw Trust on a monthly basis by the direct payments audit team. There is therefore a reliance on the direct payments audit team for provision of these details rather than the maintenance of records at Shaw Trust. | Ineffective and inefficient processes. | As part of the review and refresh of the Shaw Trust contract, clarification will be obtained with reference to service users' banking details.<br><br>The accountable body for hosting this information will be identified.<br><br>Following clarification, clear roles and responsibilities will be documented and issued to relevant staff. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.2 | * * * | The direct payments audit team are responsible for ensuring that funds provided to service users via the direct payments process are spent in accordance with the care plan.<br><br>The care plan being a formal assessment of service users needs.<br><br>Where weaknesses are identified, for example, the failure to provide adequate supporting documentation for direct payments spend, the service user is informed in an attempt to resolve these concerns going forward.<br><br>The auditor's discussions with the direct payment audit team indicated that weaknesses identified are documented in action plans which are communicated to relevant social care and inclusion staff. Responses are however not provided to ensure that weaknesses have been addressed by relevant staff. | Ongoing weaknesses in the direct payments process are identified but not escalated. | The strategic lead – self directed support officer will clarify expectations of direct payments audit team and operational staff in an escalation procedure through which the direct payments audit team will report concerns regarding weaknesses identified.<br><br>This will include communication of direct payment audit team action plans to practitioner, team managers and locality managers (with arrangements for escalation to head of service if needed). This will be included within the revised direct payments guidance which will be issued to all relevant staff. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

## 8. One Off Grants

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Standard documentation in the form of carers' review forms have been completed and made available to all relevant staff.
- The carers' review form records details of both the carer and the cared for person, a narrative is also detailed outlining the purpose of the carer's one off grant.
- The carers' review form prompts the assessment of the 'current support' that is being offered and any improvements that could be made to ensure 'continuation of the caring role'.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 8.1 | * * * | One-off grant payments are made solely to the carer and can be spent on a range of goods or services such as garden or home improvements. Eligibility to receive one off grants is recorded on a 'carers' review' form. The review form is then reviewed and approved by a relevant manager.<br><br>A random sample of 20 one off grants selected for examination identified the following:<br>• In 1 case supporting documentation i.e. a carer's review form was not available.<br>• In 6 cases there was no evidence to suggest that carers' review forms had been approved.<br>• In 3 cases relevant details of the 'assessor' had not been recorded | Failure to adequately record or approve the assessment of eligibility for one-off grants undermines the payment process.<br><br>This may result in inappropriate payments being made and potential breach of grant conditions. | The strategic lead – self directed support officer will ensure that all carers' review forms are available, completed and appropriately assessed and approved prior to payments being made. (*)<br><br>The quality assurance framework which includes sampling of case recording and files by senior managers for compliance and casework quality, will also include direct payment cases. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010<br><br>Head of Service, Assessment and Care Management<br><br>30 July 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | (name and /or number). | | | |

## 9. Personal Budgets

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Details relating to personal budgets have been published on the council's website.
- The national consultation on the Departments of Health White Paper 'our health, our care, our say' has been has been summarised and made available to relevant staff via the intranet. This summary outlines the governments' expectations and the point at which the personalisation agenda and delivery programmes will be underway.
- The personalisation agenda will be implemented as part of the people first programme within the council which incorporates; personal budgets, individual budgets and self directed support.
- A review group of multi agency representatives has been put in place to establish the working arrangements required to implement personal budgets.
- In order to assess the means by which personal budgets will be made available, the fairer charging policy has been reviewed and the required changes to the system have been identified.
- Diagrammatic representation of how personal budgets, individual budgets and self directed support fit within the personalisation agenda have been provided to all relevant staff.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | See finding 13.1 | | | |

## 10. Overpayments

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- A timetable of direct payment dates has been completed and made available to all relevant officers, including both financial and social work staff, to ensure that all staff are aware of the payment cut off dates by which variations or cancellations should be submitted.
- Where variation forms are submitted, they are processed on FISCOM promptly.
- Variations are submitted on standard documentation, outlining clearly the information required to process the amendment.
- Variation forms are retained in support of all amendments processed within the system.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 10.1 | * * * | As payments are made on a monthly cycle, overpayments can occur when finance have not been promptly informed of the requirement to stop a payment e.g. in the event that a service user dies or leaves the country for an extended period.<br><br>A random sample of 20 over payments from the 2009/2010 financial year was tested to ensure appropriate recovery action had taken place. Whilst recovery action had been implemented in all cases, 3 instances were noted where there was a significant delay (11 months) between the 'effective date' (when the direct payment should have ceased) and the 'approved date' (where the notification to cease payment had been authorised by social work staff). | Unnecessary overpayments may be made, which may be difficult to recover, leading to a financial loss to the council. | All relevant staff will be reminded of the importance of ensuring amendments to direct payment provision are notified to processing sections promptly. The strategic lead – self directed support officer will review instances where delays have occurred and take appropriate action to avoid repetitions in further cases.<br><br>Process improvements to avoid unnecessary duplications will be discussed with the direct payment audit team and subject to agreement, will be included in revised direct payments guidance which will be issued to all relevant staff. | Strategic Lead – Self Directed Support Officer<br><br>30 July 2010 |

## 11. Budget Monitoring

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- The budget responsibility lies with the head of service and commissioning managers who sign off the non residential placement budgets at the beginning of each financial year.
- Budget monitoring is undertaken by the accountant for commissioning on a monthly basis.
- The accountant for commissioning obtains FISCOM reports on a monthly basis which outline non residential budgetary figures. Direct payment details are outlined on each of the non residential budgets and are assessed as part of the monthly budget monitoring mechanism.
- FISCOM reports are produced on a consistent and timely basis to facilitate budget monitoring.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 12. Performance Management

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- The direct payments agreement outlines the complaints process.
- A 'care review' is completed when the initial term of a direct payment ends. This process reviews the current care plan objectives and records the service users' comments and any amendments that are required to the agreement. The care plan is renewed which results in the development of a refreshed DP agreement.
- The monthly collation, monitoring and reporting of the financial aspects of the direct payments initiative is currently undertaken as part of the corporate performance management function.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 12.1 | * * | The direct payments audit team undertake reviews of service users' adherence to the terms and conditions of their direct payment agreements.<br><br>A mechanism is in place whereby the time to complete an audit is recorded. However, the results of this measurement rely heavily on the relative complexity of each review. It is not possible to place a performance measure of, for example, a standard number of days for each review.<br><br>The direct payments audit team are currently not able to easily quantify their performance and therefore cannot conclude whether improvements have been made in | Inability to identify performance levels. | A performance framework is now in place, which will be formalised and reported through the management structure. | Performance & Audit Manager<br><br>30 July 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | the provision of their service year on year. | | | |

## 13. Introduction of Individual Budgets

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area.**

Good practice includes:

- Details relating to individual budgets have been published on the council's website.
- Diagrammatic representation of how personal budgets, individual budgets and self directed support fit within the personalisation agenda have been provided to all relevant staff.
- The national consultation on the Departments of Health White Paper 'our health, our care, our say' has been has been summarised and made available to relevant staff via the intranet. This summary outlines the governments' expectations and the point at which the personalisation agenda and delivery programmes will be underway.
- The personalisation agenda will be implemented as part of the people first programme within the council which incorporates; personal budgets, individual budgets and self directed support.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 13.1 | * * | A review of the council's website confirmed that strategic level documentation, such as a summary of the Departments of Health White Paper and diagrammatic representations of the personalisation agenda have been made available to all relevant staff.<br><br>The auditor's discussions with operational staff identified however that they are relatively unaware of the council's operational plans for implementation of both personal budgets and individual budgets, including where responsibility for these functions would lie. | Lack of operational staff awareness may impede the effective implementation of personal and individual budgets. | Arrangements for communicating the council's plans for the implementation of personal and individual budgets to operational staff, has been reviewed to ensure that there is effective awareness and consultation. The following is planned:<br>• The roll out of self directed support already has a stakeholder engagement plan, within which is a communications plan for all stakeholders including SC&I and partner operational staff. Arrangements for communicating with staff will be incorporated into the plan.<br>• The SC&I approved training plan for 2010/11 focuses on personalisation and delivery of self directed support (notably personal budgets) by operational staff. An intensive programme during summer 2010 ready for | Major Projects Manager<br><br>30 July 2010<br><br>Major Projects Manager<br><br>30 July 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | personal budget roll out from the autumn is planned. A pilot for individual budgets will also be incorporated in the training programme. | |

**Walsall Council**
**Internal Audit Service**

# Homelessness Establishment – Dolphin House

**Audit Report 2009 / 2010**
**May 2010**

## CONTENTS

## EXECUTIVE SUMMARY

## A. Introduction

1. An audit review of Dolphin House was undertaken during March 2010 as part of the annual audit plan.

2. Dolphin House is a statutory homelessness establishment which provides temporary accommodation to families and those assessed as having a priority need.

3. The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, to assess the implementation of previously agreed actions and to seek assurance that:

- the service operates within the corporate performance management framework, including:
  - workforce planning
  - IPM
  - equalities
  - procurement
  - budgetary control
  - business continuity
  - risk management
  - communications
  - sickness management
  - health & safety
  - information governance
- the council regularly undertake an analysis of demand for the service;
- policies and procedures are recorded in writing, regularly reviewed and available to all staff;
- controls are in place for the admission of clients into the establishment;
- entitlement to service provision is clearly defined, documented and approved;
- adequate arrangements are in place for rent calculation and collection;
- all rent arrears are monitored and action taken to ensure prompt recovery;
- property and assets are appropriately managed and there is an approved programme of routine maintenance and servicing;
- a planned programme of inspections is in place;
- the scale of utility charges is in accordance with the Office of Electricity Regulation;
- adequate controls are in place to administer leavers;
- an inventory is maintained in accordance with financial and contract rules;
- procurement is in accordance with the authority's financial and contract rules;
- adequate security controls are in place;
- adequate management information and budgetary control is in place;
- staff records e.g. flexi records, annual leave, car allowance log books are maintained to a good standard;
- petty cash is appropriately administered; and
- key controls are in place to guard against fraud and irregularity.

4. The scope of the audit is as set out on the contents' page. An overall opinion, points of good practice and an improvement action plan for each of the areas audited are attached. Actions for improvement, in general, are prioritised as high (***), medium (**) or low (*).

5. Within a short period of issuing the final audit report, the head of service will be contacted to formally confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

6. Under the Council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

7. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

8. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating at Dolphin House**,** as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | **Limited assurance** | **Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.** |
| | No assurance | No assurance as weaknesses in control, or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. Some good practices were noted during the audit, including;
   - a business continuity plan is in place which is reviewed on an annual basis;
   - a monthly statistical analysis of Dolphin House data is completed including voids, occupancy rates, income, referrals, planned and unplanned moves;
   - support workers have regular support sessions with families to help them move on to permanent accommodation;
   - the entitlement criteria for Dolphin House is clearly defined and included in the staff information & procedure manual; and
   - an income maximisation policy is in place which is subject to review on a 2 yearly basis.

3. A number of areas for improvement have, however, been identified, including; ensuring that an options appraisal for income collection methods is undertaken to avoid officers handling cash; that service users' entitlement to housing benefit is properly documented and managed by the service; that controls regarding arrears management are strengthened; and that utility costs are reviewed in the light of recent industry changes. The administration of leavers also requires review together with controls regarding the inventory, petty cash and budget management.

4. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

5. The previous audit review was completed during 2001 and prior to the introduction of internal audit's follow up procedures. There were 5 agreed actions which remain applicable from the last audit. Of these, 4 had been fully implemented at the time of this audit. The 1 unimplemented action has been reiterated in this report, marked (*) in the action plan.

6. There are 12 high priority actions, as follows:-

| Section | Action Plan Ref. | Agreed Action |
|---|---|---|
| Rent Calculation and Collection | 6.1 | The service manager will undertake an options appraisal for income collection methods for establishments such as Rivers House.<br><br>Options to be appraised will include swipe card payments and direct debit. Officers within business change will be consulted.<br><br>In the interim, arrangements for handling cash in respect of Dolphin House residents' payment of their service charge will be immediately reviewed. |
| | 6.2 | It will be ensured that :<br>• the weekly cost of the full rent of the property recorded on the housing benefit agreement form agrees to the housing benefit breakdown form;<br>• the weekly cost of the full rent is recorded on the housing benefit agreement;<br>• a copy of the housing benefit application form is available on the service users file;<br>• a copy of the housing benefit decision notice is available on file; and<br>• landlord payment notification statements are obtained where appropriate<br><br>Officers will ensure that service users' entitlement to housing benefit is managed and documented as completely and |

| | | |
|---|---|---|
| | | promptly as possible. |

| Section | Action Plan Ref. | Agreed Action |
|---|---|---|
| | 6.3 | An overall monthly reconciliation of housing benefit credits received to the corresponding debit (rental charge) will be performed.<br><br>The reconciliation will be completed by a designated officer and signed and dated to confirm their completion.<br><br>The reconciliation will then be checked by a senior/independent officer and signed and dated to evidence their review. |
| | 6.4 | Care will be taken to ensure that payment record sheets agree with supporting receipts.<br><br>Security collection receipts will be held securely and retained on file.<br><br>Payment record sheets will be signed and dated by the preparing and checking officers.<br><br>The missing Oracle income entry will be investigated and rectified.<br><br>A consistent format will be agreed and adopted for the recording of service user names on receipts and supporting documentation, including payment recording sheets.<br><br>A service charge reconciliation will be completed on a monthly basis and signed and dated by the preparing officer.<br>The reconciliation will then be checked by a senior/independent officer and signed and dated to evidence their review.<br><br>The manual cash up sheet will be amended to ensure the correct Oracle code is correctly recorded. |

| Section | Action Plan Ref. | Agreed Action |
|---|---|---|
| Rent Arrears Management | 7.2 | It will be ensured that supporting arrears documents agree with service user rent cards.<br><br>The income maximisation policy will be followed to ensure service user arrears are acted upon promptly.<br><br>Service user rent cards will be signed by the officer receiving the payment to confirm receipt of cash.<br><br>Payment agreement plans will be made with service users where ever possible. |
| Utility Services | 10.1 | The service charge has been reviewed in light of the industry increase in utility charges to ensure all costs are being adequately recovered.<br><br>Thereafter, utility charges will be reviewed on an annual basis and the service charge increased/decreased accordingly to reflect any industry fluctuations. |
| | 10.2 | A review of the current electricity arrangements with N Power will be undertaken. |

| Section | Action Plan Ref. | Agreed Action |
|---|---|---|
| Leavers | 11.1 | It will be ensured that all appropriate documentation, including exit inspection forms and post communication forms are completed prior to service users leaving Dolphin House.<br><br>In accordance with the supported housing procedures, it will be ensured that service users receive a follow up call within 1 month of leaving Dolphin House and there is documentary evidence to support this.<br><br>Housing benefit leaver notifications will be held securely on file.<br><br>It will be ensured that, where possible outstanding service charge arrears and any damage costs are paid prior to the service user leaving the accommodation. |
| Inventory | 12.1 | A full inventory check will be completed on an annual basis and updated to record all equipment additions, disposals and amendments as they occur.<br><br>Inventories will be maintained in accordance with financial and contract rule 6.2. |
| Budget Monitoring and Management Information | 15.1 | The restructure has now addressed the issue.<br><br>Monthly meetings between the supported housing manager and accountant are now taking place to ensure tight budget monitoring is undertaken. |
| Petty Cash | 17.1 | Petty cash is now held separately to other service monies. |
| | 17.2 | The petty cash reconciliation is now checked by a second independent officer who signs and dates the appropriate records to evidence their review. |

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Performance Management | | ✓ | | |
| Analysis of Demand | | ✓ | | |
| Policies and Procedures | | ✓ | | |
| Admissions | | ✓ | | |
| Entitlement to Service Provision | | ✓ | | |
| Rent Calculation and Collection | | | ✓ | |
| Rent Arrears Management | | | ✓ | |
| Repairs and Maintenance | ✓ | | | |
| Inspections | ✓ | | | |
| Utility Services | | | ✓ | |
| Leavers | | | ✓ | |
| Inventory | | | ✓ | |
| Procurement | | ✓ | | |
| Physical Security | | ✓ | | |
| Budget Monitoring and Management Information | | | ✓ | |
| Staff Records | ✓ | | | |
| Petty Cash | | | ✓ | |
| Fraud and Irregularity | ✓ | | | |
| Joint Working | | ✓ | | |

## D. Acknowledgements

1. Please thank all officer involved for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

## 1. Performance Management

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- A personal evacuation plan has been completed for all service users and staff who have a disability to ensure their needs are met in an emergency.
- A mandatory training list detailing all training for supported housing staff.
- A business continuity plan is in place and reviewed on an annual basis.
- A training matrix is updated as and when training is received.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | * | The supported housing health and safety action plan is still in draft status and has not been updated since 2008/09. | Potential health and safety risks to staff may exist unaddressed, which may pose a potential health and safety risk to staff. | The supported housing health and safety action plan will be finalised and thereafter reviewed on an annual basis. | Policy Officer<br><br>30 June 2010 |
| 1.2 | ** | The project staff generic risk assessment is not subject to annual review. | Potential health and safety risks to staff may exist unaddressed, which may pose a potential health and safety risk to staff. | The project staff generic risk assessment will be reviewed on an annual basis and signed and dated to confirm the review has been undertaken. | Supported Housing Manager<br><br>31 July 2010 |

## 2. Analysis of Demand

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- A monthly statistical analysis of Dolphin House data is completed including voids, occupancy rates, income, referrals, planned and unplanned moves.
- The monthly statistical analysis is collated and reported to the performance board on a quarterly basis.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | ** | A monthly statistical report is produced in which information such as voids, occupancy rates and applicants are reported.<br><br>The auditor noted that a number of fields on the monthly report are left incomplete / blank e.g. void data. | Incomplete records, which may compromise managers' ability to make informed decisions. | Monthly reports are no longer used and instead statistical data is reported on a quarterly basis.<br><br>Quarterly reports will be fully completed to ensure key data can be easily determined. | Homelessness & Housing Service Manager<br><br>30 June 2010 |
| 2.2 | ** | At the time of the audit, monthly reports for January and February 2010 had not been completed due to staff absence. | Lack of management information may compromise managers' ability to make informed decisions.<br><br>Poor performing areas may not be promptly identified and consequently corrective action taken to resolve. | As per agreed action 2.1. | Homelessness & Housing Service Manager<br><br>30 June 2010 |

## 3. Policies and Procedures

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The procedure manual and all other corresponding procedure notes are available on a shared drive and can be accessed by all supporting housing staff including those based at homelessness establishments.
- The staff information and procedure manual, covering all aspects the service, was last reviewed in October 2009 following a service restructure.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.1 | ** | The staff information and procedure manual is still in draft format. | In the event of query / challenge, the preparing and reviewing officers may not be known.<br><br>Unapproved procedural guidance may exist unnoticed.<br><br>Procedures may become out of date and therefore not reflective of current practice. | The accommodation services procedure manual will be finalised; signed and dated by the completing and approving officers.<br><br>It will then be issued to all relevant staff who will sign to acknowledge receipt of and intention to comply fully with it.<br><br>Further, a timetable for review and refresh of the manual will be put in place. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 4. Admissions

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Duties are discharged in accordance with the Housing Act 1996 and Homeless Act 2004.
- Families are placed in a bed and breakfast when there are no vacancies at Dolphin House.
- The support worker allocated to the case has regular support sessions with families to help them move on to permanent accommodation.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.1 | ** | From a sample of 10 service users' files selected, it was identified that:<br>• in 5 cases a risk assessment had not been completed by the support worker prior to the service user/s residing in Dolphin House. (Ref – CE, RG, JD, SD, DL).<br>• in 1 case the consent form had not been completed by the service user. (Ref – SD) | Incomplete records.<br><br>Risks may not have been identified and managed.<br><br>Inability to demonstrate service users consent in the event of query / challenge. | Officers will ensure that:<br>• a risk assessment is completed for all service users prior to their residing at Dolphin House. In support of this, a new risk assessment is currently being piloted at all homelessness establishments;<br>• a consent form has been completed, signed by the service user; and;<br>• a homeless application form is completed for all returns. | Homelessness & Housing Service Manager<br><br>Service Improvement & Support Manager<br><br>30 June 2010 |
| 4.2 | ** | At the time of the audit, the residents register has not been updated since 28 January 2010. | Out of date / incorrect information. | Officers will ensure that the residents' register is updated promptly. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 5. Entitlement to Service Provision

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Service users are accommodated immediately following they meet the relevant entitlement criteria as laid out in legislation.
- The entitlement criteria for Dolphin House is clearly defined and included in the staff information & procedure manual.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 6. Rent Calculation and Collection

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- An income maximisation policy is in place which is subject to review on a 2 yearly basis.
- A receipt is issued to service users on payment of the service charge and a copy retained on file.
- Service users are provided with written notification 4 weeks prior to the annual rent increase.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.1 | *** | Dolphin House service charge payments are collected by the duty officer at Rivers House reception.<br><br>The service charge can be paid at any time and is handed over to the duty officer who updates the rent card to record the payment, issues a receipt to the service user and places money in the safe.<br><br>All staff have access to the safe.<br><br>The key to the safe is held in the Rivers House office at all times. | Potential for misappropriation / loss of cash. | The service manager will undertake an options appraisal for income collection methods for establishments such as Rivers House.<br><br>Options to be appraised will include swipe card payments and direct debit. Officers within business change will be consulted.<br><br>In the interim, arrangements for handling cash in respect of Dolphin House residents' payment of their service charge will be immediately reviewed. | Homelessness & Housing Service Manager<br><br>31 August 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.2 | *** | From a sample of 10 housing benefits selected, it was identified that:<br>• in 1 case the weekly cost of the full rent of the property recorded on the housing benefit agreement form did not agree with the housing benefit breakdown form. (Ref – JG)<br>• In 1 case the weekly cost of the full rent was not recorded on the housing benefit agreement. (Ref – DL)<br>• In 3 cases a copy of the housing benefit application form was not available on the service users file. (Ref – JG, RG, JD)<br>• In all In all 10 cases the housing benefit decision notice was not available on file.<br>• (Ref – JG, CE, KH, EO, RG, DT, JD, DL, SD, DL).<br>• In 1 case, a landlord payment notification statement could not be obtained during the audit to verify receipt of housing benefit.<br>• (Ref – DL) | Documents may be misplaced / lost<br><br>Incomplete records.<br><br>Rent income via housing benefits may not be received in a timely manner. | It will be ensured that :<br>• the weekly cost of the full rent of the property recorded on the housing benefit agreement form agrees to the housing benefit breakdown form;<br>• the weekly cost of the full rent is recorded on the housing benefit agreement;<br>• a copy of the housing benefit application form is available on the service users file;<br>• a copy of the housing benefit decision notice is available on file; and<br>• landlord payment notification statements are obtained where appropriate<br><br>Officers will ensure that service users' entitlement to housing benefit is managed and documented as completely and promptly as possible. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.3 | *** | There is no overall monthly reconciliation of housing benefit credits received to the corresponding debit (rental charge) on Oracle. | Errors / omissions may go unnoticed.<br><br>Under / over payments.<br><br>Housing benefits paid at incorrect rates may go unnoticed. | An overall monthly reconciliation of housing benefit credits received to the corresponding debit (rental charge) will be performed.<br><br>The reconciliation will be completed by a designated officer and signed and dated to confirm their completion.<br><br>The reconciliation will then be checked by a senior/independent officer and signed and dated to evidence their review. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 6.4 | *** | From a sample of 3 bankings selected, it was found:<br>• in 1 case, a receipt did not agree with the amount recorded on the payment record sheet. In addition, the payment record sheet was incorrectly totalled. (Ref - week ending 28/02/10)<br>• in 2 cases the security collection receipt was not available at the time of the audit. (Ref - week ending – 07/03/10, 15/03/10)<br>• in 1 case a payment record sheet was not signed by the preparing officer. (Ref - week ending 28/02/10)<br>• in 1 case an amount banked could not be traced to Oracle. (Ref – week ending 15/03/10)<br>• through examination of payment record sheets it was identified that there was an inconsistent format in the recording of service user names on receipts and payment recording sheets.<br>• service charge reconciliations are not completed. | Inaccurate records.<br><br>Lack of audit trail.<br><br>Errors / omissions may go unnoticed.<br><br>The risk of misappropriation / loss of cash is increased. | Care will be taken to ensure that payment record sheets agree with supporting receipts.<br><br>Security collection receipts will be held securely and retained on file.<br><br>Payment record sheets will be signed and dated by the preparing and checking officers.<br><br>The missing Oracle income entry will be investigated and rectified.<br><br>A consistent format will be agreed and adopted for the recording of service user names on receipts and supporting documentation, including payment recording sheets.<br><br>A service charge reconciliation will be completed on a monthly basis and signed and dated by the preparing officer. The reconciliation will then be checked by a senior/independent officer and signed and dated to evidence their review.<br><br>The manual cash up sheet will be amended to ensure the correct Oracle code is correctly recorded. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | • In all 3 cases the Oracle code was incorrectly recorded on the manual cash up sheet. (Ref – week ending 28/02/10, 07/03/10, 15/03/10) | | | |
| 6.5 | ** | The Dolphin House income sheet only includes a gross rent total. This is not broken down further into service charge and rent due. | Income targets may be misleading / incorrect.<br><br>Incomplete records.<br><br>Income targets may not be easily determined. | The Dolphin House income sheet will be reviewed in light of the findings. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 7. Rent Arrears Management

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Families are informed of the procedures regarding arrears and recovery action during the induction process.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.1 | ** | The rent arrears list has not been updated since 29 January 2010. The file is held electronically and access is restricted to the supported housing manager. | Inaccurate / out of date records. | The rent arrears will be updated by on a weekly basis.<br><br>Designated officers will be allowed access to the rent arrears file. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 7.2 | *** | From a sample of 5 service users' arrears selected, it was identified that:<br>• in 1 case, as at 29/01/10, service user arrears stated on the arrears list did not agree with the rent card balance. (Ref - room 16).<br>• in 3 cases the arrears procedure, included within the income maximisation policy, was not followed. (Ref – room 48, 16, 28)<br>• in 1 case, a rent card was not signed by the receiving officer. (Ref - room 48)<br>• in all 5 cases arrears balances had accumulated over a period of time ranging from £50-100, however, payment agreement plans were not completed.<br>• in 2 cases, service users had not made payment towards their arrears balances. (Ref – room 20, 16) | Non-compliance with income maximisation policy.<br><br>Inaccurate records.<br><br>Potential for misappropriation of cash.<br><br>Loss of income.<br><br>Lack of audit trail in the event of a query. | It will be ensured that supporting arrears documents agree with service user rent cards.<br><br>The income maximisation policy will be followed to ensure service user arrears are acted upon promptly.<br><br>Service user rent cards will be signed by the officer receiving the payment to confirm receipt of cash.<br><br>Payment agreement plans will be made with service users where ever possible. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 8. Repairs and Maintenance

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Reports of faults and breakdowns are acted upon and repaired promptly.
- An SLA with property services for emergency building repairs will take effect from 1 April 2010.
- Annual maintenance and servicing is completed for; gas, electric, PAC, fire inspection and legionnaires in order to comply with statutory requirements.
- A repairs sheet is completed for every fault reported.
- Annual maintenance and servicing certificates and supporting documentation are comprehensive and retained on file.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 9. Inspections

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Families are notified in writing 48 hours prior to a health and safety inspection of their room.
- The support worker carries out support sessions in the family flat which enables them to also identify any damage or maintenance issues.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 10. Utility Services

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Each flat has a pre-payment electric meter and it is the responsibility of the service user to purchase electricity credit.
- The weekly service charge covers water and gas.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 10.1 | *** | The service charge has not been recently reviewed in light of the industry increase in utility charges. | Charges may not be in line with industry standards.<br><br>Costs may not be fully recovered. | The service charge has been reviewed in light of the industry increase in utility charges to ensure all costs are being adequately recovered.<br><br>Thereafter, utility charges will be reviewed on an annual basis and the service charge increased/decreased accordingly to reflect any industry fluctuations.<br>(*) | Homelessness & Housing Service Manager<br><br>Implemented |
| 10.2 | *** | Residents are issued with a key to activate their electricity meter. Currently, keys used by previous residents are being re-issued due to the time delays experienced in N Power registering new residents and issuing new electric meter keys. | In the event of a query relating to meter usage/damage, liability may not be clear. | A review of the current electricity arrangements with N Power will be undertaken. | Homelessness & Housing Service Manager<br><br>31 July 2010 |

## 11. Leavers

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Families are referred to the settlement team where any additional support is required / identified following their exit from Dolphin House.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 11.1 | *** | From a sample of 10 leavers selected it was found:<br>• in 8 cases, an exit inspection form had not been completed. (Ref – EP, FM, CG, SF, DV, KW, GH/ KP, RG)<br>• in 1 case, an exit inspection form was not signed by the service user. (Ref – L P)<br>• in 9 cases, a post communication form had not been completed. (Ref – EP, FM, CG, SF, DV, SP, KW, GH/KP, RG)<br>• in all 10 cases there was no evidence on file to confirm a follow up call was made.<br>• in 1 case, a post communication form was not signed. (Ref – LP)<br>• in all 10 cases, the housing | Lack of audit trail.<br><br>Lack of evidence to demonstrate that leaver procedures have been undertaken.<br><br>Damages to council property may not be promptly identified. This mitigates potential recovery action.<br><br>Overpayment of benefits.<br><br>Loss of income. | It will be ensured that all appropriate documentation, including exit inspection forms and post communication forms are completed prior to service users leaving Dolphin House.<br><br>In accordance with the supported housing procedures, it will be ensured that service users receive a follow up call within 1 month of leaving Dolphin House and there is documentary evidence to support this.<br><br>Housing benefit leaver notifications will be held securely on file.<br><br>It will be ensured that, where possible outstanding service charge arrears and any damage costs are paid prior to the service user leaving the accommodation. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

| | | | | | |
|---|---|---|---|---|---|
| | | benefit leavers notification were not available on file.<br>• in 1 case outstanding rent arrears were not paid by the service user prior to them leaving. (Ref – SP) | | | |

## 12. Inventory

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

- Room inventory checks are completed prior to service users taking residence and leaving Dolphin House.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 12.1 | *** | At the time of the audit, it could not be established as to when the last full inventory check had been undertaken and neither could inventory records be located. | Non- compliance with financial and contract rule 6.2.<br><br>In the absence of an annual check, missing equipment may go un-noticed / un-investigated.<br><br>In the event of theft / fire, the value of lost assets for insurance purposes may not be known. | A full inventory check will be completed on an annual basis and updated to record all equipment additions, disposals and amendments as they occur.<br><br>Inventories will be maintained in accordance with financial and contract rule 6.2. | Homelessness & Housing Service Manager<br><br>31 August 2010 |

## 13. Procurement

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 13.1 | * | From a sample of 10 invoices selected it was found:<br>• in 1 case an order was duplicated on IPROC. (Order number – 1091765)<br>• in 1 case an invoice was not stamped as paid. (Ledger ref – 664182)<br>• in 2 cases it took more than 15 days for an invoice to be paid. (Ledger – 821555, 761471) | Goods may be received 'twice'.<br><br>Invoices may be paid twice.<br><br>Failure to adhere to creditor payment target. Poor supplier relationships. | A check will be made on I-Procurement prior to a requisition being raised to ensure it has not already been processed. The duplicate order will be removed from I-Procurement.<br><br>Invoices will be stamped as paid when they have been passed for payment.<br><br>Invoices will be paid within 15 days of receipt, unless contract terms state otherwise. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 14. Physical Security

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 14.1 | ** | Room keys are held in a cabinet and backup keys held in a second cabinet in the reception office. Both cabinets are not locked at any time. | Loss of keys.<br><br>Risk of theft. | Key cabinets will be locked when not in use. | Homelessness & Housing Service Manager<br><br>Implemented |

## 15. Budget Monitoring and Management Information

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- The homelessness & housing service manager receives monthly budget monitoring information from the service accountant.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 15.1 | *** | Current budget forecast reports prepared by the accountant for Dolphin House indicate an over spend of £23,874 at year end due to additional spend on agency staff and under recovery of housing benefit income. | Overspend at the financial year end for which resources are not available. | The restructure has now addressed the issue.<br><br>Monthly meetings between the supported housing manager and accountant are now taking place to ensure tight budget monitoring is undertaken. | Homelessness & Housing Service Manager<br><br>Implemented. |

## 16. Staff Records

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Leave cards selected for examination were found to be fully authorised and leave entitlement had not been exceeded.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| | | None. | | | |

## 17. Petty cash

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Upon each shift change, a handover sheet is signed by both the officer finishing and officer commencing duties to confirm the amount of money held in the safe (including petty cash) and also that all keys have been handed over.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 17.1 | *** | Petty cash and service user charge income are held together in the cash tin. | Inability to reconcile petty cash monies.<br><br>Misappropriation of monies.<br><br>Errors/discrepancies may go unnoticed. | Petty cash is now held separately to other service monies. | Supported Housing Manager<br><br>Implemented |
| 17.2 | *** | The petty cash book reconciliation is not subject to senior/independent review. | Errors or omissions may go undetected. | The petty cash reconciliation is now checked by a second independent officer who signs and dates the appropriate records to evidence their review. | Supported Housing Manager<br><br>Implemented |
| 17.3 | ** | There is no set limit as to the amount of cash which can be reimbursed at any one time. | Larger items of expenditure increase the risk of insufficient funds to meet requirements while awaiting reimbursement. | A de-minimus limit has been set for petty cash expenditure. Presently this limit is recommended to be £50. | Supported Housing Manager<br><br>Implemented |

## 18. Fraud and Irregularity

*AUDIT OPINION*

**Full assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- All complaints are investigated.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 18.1 | * | A formal system for resident complaints is not in place, instead service users verbally notify support workers of any complaints or concerns they have. | Unable to identify trends / common problems.<br><br>Inconsistencies in addressing and resolving complaints.<br><br>Insufficient monitoring. | Consideration has been given to introducing a formal resident complaints system however this is not considered necessary as the corporate 'tell us' system is used for complaint reporting.<br><br>The homelessness & housing service manager will provide staff with instructions as how to use the 'tell us' system. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

## 19. Joint Working

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- Dolphin House undertakes joint working with a number of organisations and services including; Education Walsall, Welfare, Child protection agency, Sure Start, Childrens safeguarding board, Walsall Housing Group.
- Joint working is determined on a case by case basis in order to achieve the best outcome for a family.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 19.1 | ** | The project manager was not aware of the partnership toolkit. | Non-compliance with corporate procedures.<br><br>Lack of awareness of partnership arrangements. | The project manager will be made aware of the partnership toolkit to enable partnership opportunities to be administered in accordance with council toolkit. | Homelessness & Housing Service Manager<br><br>30 June 2010 |
| 19.2 | * | A list of joint working contacts could not be obtained during the audit. | Other staff may not be aware of potential joint working opportunities.<br><br>Loss of opportunity to share data. | A list of joint working and partnership activity will be established, updated on an ongoing basis and made available to all staff. This will assist officers when searching for possible joint working opportunities. | Homelessness & Housing Service Manager<br><br>31 May 2010 |

**Walsall Council**
**Internal Audit Service**

# Stock and Inventories (Links to Work)

**Audit Report 2009/2010**
**May 2010**

## CONTENTS

# EXECUTIVE SUMMARY

## A. Introduction

1. An audit review of stocks and inventories was undertaken as part of the annual audit plan. Links to Work is a work preparation and supported employment service for people with disability or those disadvantaged by society. Links to Work maintains its own stocks and inventory records and most stock is third party owned, referred to as 'free issue'.

2. The overall objective of the audit was to assess the adequacy of controls governing financial and management arrangements and to seek assurance that:

   - stock and inventories are maintained in accordance with financial and contract rules and local procedures;
   - there is an inventory of all items of equipment above £50;
   - there is documentary evidence to support all additions, disposals and amendments to the inventory;
   - all assets are identified as belonging to the organisation;
   - inventory/ store items and store/ inventory log are protected against loss and unauthorised access;
   - all write offs and disposals of obsolete or damaged stock are supported by adequate documentation and are in line with agreed procedures;
   - the store records are complete, up to date and accurate;
   - the issue and return of store items are accurate and promptly recorded;
   - the financial accounts are accurate and up to date;
   - stocks are maintained at an appropriate level;
   - ordering of stock for the stores is supported by adequate documentation;
   - adequate documentation supports all payments for stock purchases; and
   - previously agreed audit report actions have been fully implemented.

3. The scope of the audit is as set out on the contents' page. An overall opinion, points of good practice and an improvement action plan for each of the areas audited are attached. Actions for improvement, in general, are prioritised as high (***), medium (**) or low (*).

4. Within a short period of issuing the final audit report, the head of service will be contacted to formally confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

5. Under the council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

6. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

7. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating within Links to Works' stock and inventories system, as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | **Limited assurance** | **Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.** |
| | No assurance | No assurance as weaknesses in control or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. Some good practices were noted during the audit including:
   - all inventory checked as part of the audit could be physically located ; and
   - all available procurement documentation is retained and easily accessible by staff.

3. Areas identified for improvement, including:
   - procedure notes are not in place relating to stock and inventory;
   - there is no regular check of inventory items;
   - weaknesses have been noted in the year end stock valuation.

4. As this is the first review of stocks and inventories at Links to Work, there are no previous actions to be followed up as part of this audit.

5. There is one high priority recommendation.

| Section | Action Plan Ref. | Agreed actions |
|---|---|---|
| Stock records | 3.1 | Management should review stock valuation methods and liaise with Corporate Finance to obtain appropriate guidance.<br><br>Additionally, the financial year end stock certificate should capture all stock retained by Links to Work. |

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Procedures | | | ✓ | |
| Inventory records | | ✓ | | |
| Stock records | | | ✓ | |
| Procurement | ✓ | | | |

## D. Acknowledgements

1. Please thank the project manager and staff at Links to Work for their help and co-operation during the audit and making records available.

## 1. Procedures

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- General procedure notes are distributed to all relevant staff and are retained in a folder in the main office.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | ** | Review of the procedure notes maintained by Links to Work and Links to Work Manufacturing identified that there are no specific procedure notes in place relating to stock and inventory.<br><br>It was also noted that Links to Work Manufacturing does not have procedure notes in place pertaining to the Access database, which is used to monitor work in progress stock. | The failure to maintain up to date and complete procedure notes may result in inconsistent or erroneous working practices developing. | Procedure notes will be revised to include guidance on the recording and monitoring of inventory and stock, including use of the work in progress database. | Project manager and Site Manager<br><br>Implemented |

## 2. Inventory records

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- All inventory items chosen for testing were found to be in the documented location.
- The inventory record is held securely in a safe.
- All inventory items viewed as part of the audit were noted as physically secure.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | ** | Our review of the inventory records identified that:<br>• an annual check of inventory is not undertaken; and<br>• some details and descriptions are either vague or incorrect. | In the absence of accurate and complete inventory records, there is a risk of theft or loss. | An annual check of inventory should be performed by two officers and appropriately recorded.<br><br>Additionally, details and descriptions of inventory items should be informative and clear. | Project Manager<br><br>Implemented |
| 2.2 | ** | Our physical review of inventory highlighted that not all items were appropriately security marked.<br><br>It was noted that the process of correctly security marking inventory was in progress at the time of the audit. | Without appropriate security markings the council may be at increased risk loss of the affected items. | All items should be appropriately security marked in a way that is visible to both council staff and third parties. | Project Manager<br><br>31 May 2010 |

## 3. Stock records

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 3.1 | *** | Review of the stock valuation certificates identified that:<br><br>• the 2008/09 stock certificate has been compiled using two valuation methods – cost and sale price; and<br><br>• a stock take performed in December 2009 indicates that some stock was not fully reflected in the 2008/09 stock certificate. | Stock is valued incorrectly and therefore is inaccurate.<br><br>Stock misappropriation remains undetected. | Management should review stock valuation methods and liaise with Corporate Finance to obtain appropriate guidance.<br><br>Additionally, the financial year end stock certificate should capture all stock retained by Links to Work. | Project Manager<br><br>31 May 2010 |

## 4. Procurement

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- All available procurement documentation is retained and easily accessible.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 4.1 | ** | During testing of a sample of 20 free issue orders it was identified that in 2 cases (10%) a supplier purchase order had not been received by Links to Work.<br><br>Furthermore, testing of 4 stock orders identified that in all cases a goods received note had not been received. | Stock records may not be complete and accurate. | Management should ensure that each stock order is matched with a supplier purchase order and goods received note. | Site Manager<br><br>Implemented |

**Walsall Council**
**Internal Audit Service**

# INFORMATION SECURITY MANAGEMENT

**Audit Report 2009 / 2010**
**May 2010**

## CONTENTS

# EXECUTIVE SUMMARY

## A. Introduction

1. An audit review of information security management arrangements was undertaken during February and March 2010 as part of the annual audit plan. Information is an asset that, like other important business assets, is essential to the delivery of Council services and consequently needs to be suitably protected. Information can exist in many forms. It can be printed or written on paper, stored electronically, transmitted by post or by using electronic means. Information security is the protection of information from a wide range of threats in order to ensure business continuity, minimise business risk, and maximise return on investments and business opportunities. Information security is achieved by implementing a suitable set of controls, including policies, processes, procedures, organisational structures and software and hardware functions.

2. The overall objective of the review was to report an opinion on controls in place to manage the risks that may compromise the security of information assets owned by the Council. Key controls have been audited against CIPFA computer audit guidelines and ISO27001 good practices required to achieve the following control objectives:
   - a Council-wide approach to information security management is in place and is operating effectively, including records management; and
   - processes and procedures have been established to support policy governing the security of information assets owned by the Council.

3. The scope of the audit is as set out on the contents' page. An overall opinion, points of good practice and an improvement action plan for each of the areas audited are attached. Actions for improvement, in general, are prioritised as high (***), medium (**) or low (*).

4. Within a short period of issuing the final audit report, the head of service will be contacted to formally confirm that the action plan has been implemented as agreed. Managers should be aware that a formal response will be required in all cases and that details of these responses will be included within the internal audit quarterly monitoring report to the Audit Committee.

5. Under the Council's corporate governance arrangements, the outcomes of audits are reported routinely to the Audit Committee. This includes providing an overall report opinion and details of agreed actions successfully implemented.

6. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation from executive and assistant directors failing to ensure that appropriate action is taken.

7. All audit reviews undertaken include checks that previously agreed actions have been implemented. Due to the disappointing level of overall achievement in this

area, executive directors have asked for regular updates on all internal audit reviews undertaken together with details of actions agreed and actually implemented. This is included as a standing item for discussion at all directorate management team meetings.

## B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating for the information security management process as described below:

| | ***Overall Audit Opinion*** | |
|---|---|---|
| | Full assurance | Full assurance that the system of internal control is designed to meet the organisation's objectives and controls are consistently applied in all the areas reviewed. |
| | Significant assurance | Significant assurance that there is a generally sound system of control designed to meet the organisation's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. |
| ➔ | **Limited assurance** | **Limited assurance as weaknesses in the design or inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed.** |
| | No assurance | No assurance as weaknesses in control, or consistent non compliance with key controls, [could result / have resulted] in failure to achieve the organisation's objectives in the areas reviewed. |

2. A number of good practices were noted during the audit, including;
   - various risks that could compromise the security of information assets have been identified and quantified on the ICT service risk register;
   - a records management policy has been implemented following legislative requirements;
   - formal guidance and procedures are published on the Council intranet and provide some level of direction for the safeguarding of information assets;
   - a library of information security control procedures has been documented and published for all staff to access and review; and
   - information security requirements prescribed by the GSi code of connection have been implemented for staff working in the benefits service.

3. Some areas for improvement have been identified, including:
   - the function that incorporates a corporate-wide approach to information security management should be promoted to the business;
   - a process for raising and maintaining staff awareness of information security control requirements is required;
   - an update to the overarching information security protocol statement that governs the security of information assets is required; and
   - information security control procedures should be reviewed and updated.

4. A previous audit of this area has not been performed.

5. There are 4 high priority actions, as follows:

| Section | Action Plan Ref. | Agreed Action |
|---|---|---|
| Council-wide approach to information security management | 1.1 | The function that incorporates the corporate wide approach to information security management will be promoted to all business areas. This will be incorporated as a possible stream of work as part of the Working Smarter programme. |
| | 1.2 | The risk of a breach of security of information assets will be quantified and included on the corporate strategic risk register if deemed sufficient to warrant concern. |
| | 1.3 | A process will be established to raise and maintain staff awareness of the Council information security control requirements. |
| Processes and procedures supporting Council policy | 2.1 | The overarching protocol statement governing the security and safeguarding of information assets will be reviewed and updated where necessary. As part of the review a decision will be made by senior management as to whether to convert the protocol into a formal Council policy that will then encompass all users of Council owned information assets. |

## C. Summary of Findings

| | Full Assurance | Significant Assurance | Limited Assurance | No Assurance |
|---|---|---|---|---|
| Council-wide approach to information security management | | | ✓ | |
| Processes and procedures supporting Council policy | | ✓ | | |

## D. Acknowledgements

1. The auditors would like to thank all staff involved for their time and assistance during the review.

## 1. Council-wide approach to information security management

*AUDIT OPINION*

**Limited assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- information security control procedures were developed and approved by senior management in October 2008 as part of the process to establish an information security management control framework.
- various risks that could compromise the security of information assets have been identified and quantified on the ICT service risk register.
- the information security requirements prescribed by the GSi code of connection have been implemented for staff working in the benefits service who process data classified as restricted.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.1 | *** | The function that incorporates a corporate wide approach to information security management has been established but has not been promoted to all business areas.<br><br>It is acknowledged that several elements of information security management have been implemented at an operational level, namely: freedom of information; data protection; and records management. It is also acknowledged that ICT and the Benefits services have implemented the requirements of the Government Connect programme of work to ensure the security of restricted information and data. | Increased risk of a breach of information security that may result in the following:<br>• theft or damage to information assets;<br>• breach of legislation (e.g. Data Protection Act);<br>• fines and unplanned costs being incurred; and<br>• severe damage to the reputation of the Council. | The function that incorporates the corporate wide approach to information security management will be promoted to all business areas. This will be incorporated as a possible stream of work as part of the Working Smarter programme. | Head of Business Solutions<br><br>31/10/2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 1.2 | *** | The corporate strategic risk register does not include the risk of a breach of security of information assets. | Failure to identify and quantify strategic risk leading to poor risk management and increased risk of a breach of information security. | The risk of a breach of security of information assets will be quantified and included on the corporate strategic risk register if deemed sufficient to warrant concern. | Corporate Risk & Insurance Manager<br><br>30/09/2010 |
| 1.3 | *** | A process has not been established to raise and maintain levels of staff awareness for information security control requirements that were approved by senior management over 18 months ago.<br><br>The recent theft of a Council laptop from a staff member's home address that contained unencrypted sensitive data associated with young people emphasizes the lack of awareness amongst staff for information security requirements. | Increased risk of a breach of security information security. Should sensitive data be disclosed to unauthorised individuals this could significantly damage the reputation of the Council. In extreme cases external legal and regulatory bodies such as the information commission could impose sanctions and fines for the breach of security. | A process will be established to raise and maintain staff awareness of the Council information security control requirements. | Head of Business Solutions<br><br>31/10/2010 |

## 2. Processes and procedures supporting Council policy

*AUDIT OPINION*

**Significant assurance can be given that controls are in place to meet objectives in this area**

Good practice includes:

- the records management policy, version 3 dated 13th June 2005, has been implemented following legislative requirements.
- the freedom of information team has been established to process all requests for access to publically available information under current legislation.
- a library of information security control procedures has been documented and published on the Council intranet for all staff to download and review.
- the information security control procedures provide a referencing system that allow staff to quickly access and view a specific security requirement within the library of 14 separate procedures.
- formal guidance and procedures are published on the Council intranet and provide some level of direction for the safeguarding of information assets.
- processes and procedures have been defined to ensure the Council complies with the legislative requirements of the Data Protection Act when collecting and processing person identifiable data/information.
- information security control procedures are broken down into a standard format of: introduction; user responsibilities; and ICT responsibilities.
- the retention schedule for corporate records, version 2 dated July 2006, has been developed and published on the intranet to provide staff with guidance on processes and procedures to adopt for records retention and destruction.

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.1 | *** | The protocol statement governing the security of information assets has not been reviewed since December 2008 and does not make any reference to it being Council policy. | Lack of policy for instilling a culture of information security awareness amongst all users of Council owned information assets. | The overarching protocol statement governing the security and safeguarding of information assets will be reviewed and updated where necessary. As part of the review a decision will be made by senior management as to whether to convert the protocol into a formal Council policy that will then encompass all users of Council owned information assets. | Head of Business Solutions<br><br>31/10/2010 |

*ACTION PLAN*

| Ref | Priority | Finding | Risk Exposure | Agreed Action | Responsibility & Timescale |
|---|---|---|---|---|---|
| 2.2 | ** | The current Council information security control procedures, version 0.02, include some instances of weak procedural wording where the word 'should' is used. The procedures were last updated in October 2008, approximately 18 months ago. | Use of weak wording could undermine the important security requirements of the procedure as this maybe interpreted differently by different members of staff. | A full review and update of the information security control procedures will be performed. The review will identify any instances of weak procedural wording and should be strengthened where controls exist to effectively police such requirements. | Head of Business Solutions<br><br>31/10/2010 |

## 1. LEADERSHIP AND GOVERNANCE

The standard:
1.2 School governance arrangements ensure that governors are able to fulfil their financial management roles, responsibilities and accountabilities properly

| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
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| C | The financial decisions by the Governing Body and Finance Committee, over the past 12 months, are set out clearly and communicated to relevant staff and monitored, where appropriate. | Minutes are not always clear. For example, the head teacher's revised virement limit (1.1 c), declaration of interests (1.5 d), benchmarking results discussions (3.2 c), Scheme for financing schools document approval (4.1 a), Financial and contract rules document approval (4.2 a), quotes and tender discussions (4.2 c). | Minutes should demonstrate discussions and, importantly, clearly record the decisions made. Where decisions relate to the approval of documents they should be listed individually to avoid any possible confusion. | A new revised Virement limit for the Headteacher and Chair of Governors has been done and will be presented at both the Finance and Full Governors meetings on 25th May 2010 – (1.1a) Business Manager<br>Declaration of Interest will be put on all future minutes. (1.5d) Clerk to the Governors - immediately<br>Future Benchmarking results will be discussed at Governors Meetings – Business Manager – September 2010<br>Scheme for Financing Schools and Financial and Contract rules documents (4.1a & 4.2a) were approved at Full Governors on 20th October 2009. Quotes and tender discussions will be clearly recorded in future minutes (4.2c) Business Manager – Immediately |

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| D | The number of Governors attending meetings over the past 12 months is sufficient to allow necessary decisions to be made. | Lead governor finance meetings on16/07/09 & 5/11/09 do not detail who was present at the meetings and minutes are not always ratified by the full governing body. | All those present at lead governor finance meetings should be recorded in the minutes of the meeting and the minutes referred to the governing body for ratification. | All those present at Lead Governor Finance will in future be recorded in the minutes of the meeting and minutes will be referred at the following Full Governors meeting for ratification. Business Manager - Immediately |

| The standard:<br>1.3 The Head Teacher and School Business Manager (if in post) operate with financial integrity setting an example to Governors and staff alike | | | | |
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| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
| B | The current budget is either balanced, aimed at recovering a previous deficit in the agreed manner, or intended to achieve only a prudent planned level of unspent balances. | At the time of the assessment a year end deficit of approximately £67k had been reported to the finance committee in November 2009. This has subsequently been increased to £371k at the meeting of the full governing body on 9 December 2009 (item 17). Walsall Children's Services – Serco are aware of the matter and are working with the school with a view to the budget being balanced within two years. | Governors will need ensure appropriate action and procedural changes are made and monitor the budget carefully to ensure that a balanced budget is achieved within the timescale approved. | The Business Manager and Finance Officer are working with Dawn Morris at Walsall Children's Services. The school is taking advice and is making the necessary changes for improvement. Monthly meetings have been set up to monitor the budget carefully to ensure the balanced budget is met within the next two years. Business Manager/Finance Officer - Immediately |
| D | There have been no subsequent significant changes to the budget that should have been included in the original budget. | The Business Manager indicated during the assessment that there had been no significant change to the original budget. Errors and omissions have subsequently resulted in additional expenditure being added to the budget increasing the predicted 2009/10 year end deficit to £371k reported to governors in December 2009 | | |

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| | | (see B above). | | |
| E | There are no serious adverse issues raised in internal audit or Ofsted reports on financial management matters that remain outstanding. | Walsall Childrens Services - Serco has raised concerns with regard to some procedures as a result of the likely budget deficit. | | |

| The standard:<br>1.5 The School has effective governance arrangements covering issues which include conflicts of interest and whistle blowing | | | | |
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| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
| D | There is no subsequent evidence that interests that should have been disclosed were not declared at the right time. | Mr Cain and Mr Hayward declared interests at the governing body meeting on 20/10/09 item 24. Minutes of the meeting do not indicate whether or not the people concerned left the room at the appropriate point. | Where interests are declared the minutes should clearly state when a person leaves the room and if applicable when they return. | Omission from the minutes – Mr Cain and Mr Hayward did leave the room – This action will be declared on all future minutes – Clerk to the Governors - Immediately |

## 2. PEOPLE MANAGEMENT

| The standard:<br>2.1 The Governing Body includes individuals who are able to: (i) be an effective "critical friend" on financial management issues, (ii) provide strategic leadership on financial management issues & (iii) ensure financial management accountability | | | | |
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| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
| A | Relevant Governors are aware of the financial management competencies as recommended by the Standard and there is an up to date completed self-evaluation of Governing Body competencies. | Since the formation of the federation, a finance committee no longer exists. Accordingly, there are no formal finance committee members. An R20 competency self evaluation matrix has not been completed by all lead finance governors. | Lead finance governors should complete a R20 competency self evaluation matrix to demonstrate the full range of competencies exist and to highlight any training requirements. | Further to the New Trust Board which was set up in February 2010. A new R20 competency matrix will be done by Governors – Business Manager – to be given out at meeting on 25th May 2010 |

## 3. POLICY & STRATEGY

The standard:
3.1 The School has procurement arrangements in place to secure value for money from all suppliers including the LA and outside contractors

| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
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| A | The School improvement / development plan has sufficient scope and depth of the financial implications and it is reflected in the school's three-year budget plans. | The current school development plan covers one year only as trust status is being sought. | Future school development plans should cover a three year period and include long term financial plans linked to the three year budget plan. | The school is working to the "New National Challenge Trust Improvement Plan" that has been compiled by the new Headteacher (copy enclosed) Immediately |

## 4. PARTNERSHIPS & RESOURCES

The standard:
4.2 The School has procurement arrangements in place to secure value for money from all suppliers including the LA and outside contractors

| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
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| A | The School's financial regulations and procedures require quotations and tenders at appropriate levels. | The school has adopted their own financial procedures document which includes the thresholds and contract information from the financial and contract rules. This document has not been formally approved, | The school's financial procedure document should be formally approved by governors. | The Financial Procedures Document was agreed and accepted at Full Governors on 20th October 2009 Presented by the Business Manager (A separate sheet for consideration was given to Governors) item 7 was agreed by the Governing Body but omitted from the list by the Clerk (see attached copy) |
| D | The Governing Body or delegated Committee discuss the options available to the School prior to the approval of continuation/cessation of contracts, including Local Authority sourced services. | Contracts were presented in a lead governor finance meeting but minutes were not ratified by the governing body. | Minutes of the lead governor finance meetings should be ratified by the governing body. | A Barker – Business Manager to make sure that contracts/local authority services are presented at Lead Governor Finance and Full Governing Body meetings. (May 25th 2010) |

## 5. PROCESSES

The standard:
5.6 The School maintains proper accounting records throughout the year

| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
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| F | Primary accounting documents show that they have all been properly authorised, processed correctly and have not been amended. | Purchasing<br>Majestic coach hire has taken over the schools transportation requirements from Elizabethan Travel. Although a confirmation letter has been received from Majestic Coach Travel it is understood that a contract did not exist with Elizabethan Travel.<br><br>An invoice for Lloyds TSB – Elizabethan Travel (£5200) has been signed by the business manager who has a delegated limit of £5000.<br><br>An order to Thirdforce EP UK Ltd (ES299246) and subsequent invoice has been authorised by a member of staff who has exceeded their delegated limit of £1000.<br><br>An order was not raised for the invoice relating to Adage Studios. | The school's transportation requirements should be market tested and a contract with clear dates of commencement and expiry put in place.<br><br>Orders and invoices should only be signed by staff with the appropriate level of authorisation.<br><br>Orders should be raised for all appropriate expenditure. | A verbal agreement with the previous Headteacher on this contract. The Finance Officer is in the process of sending out letters to contractors from the Local Authority listing asking for quotes for the new term in September 2010. Business Manager to ensure that a contract with clear dates of commencement and expiry are put in place. Angela Barker before the new term in September 2010<br><br>Departmental authorised signatories are being checked for delegated limits before orders are processed. The system has been changed from April 2010 – Central Purchasing. All orders to be done by Finance after departments are asked to complete an internal order form. Finance Officer/Immediately |

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| | | The site manager is not always aware of the exact product / charge to be provided by Starchaser Industries Ltd. In such cases the order value is shown as to be confirmed. (This was Science not site manager) | Where the order amount is not known a reasonable estimate should be made to enable the commitment to be recorded. | Estimates are now put on our Internal order forms and shown as a commitment on the spreadsheet to allow tighter control. Finance Officer/Business Manager – June 2010 |
| | | Only 2 quotations were sought for work to be undertaken by Brelmayne (order ref ES307862). Although the work was described as urgent, the contractor was requested to carry out additional work, with a value greater than that included in the original quote, while on site. In addition, the invoice was signed by the site manager who does not have the delegated authority to authorise payment for the amount incurred<br><br>The Investec invoice has been signed by the business manager who has exceeded her delegated limit. The agreement (ref no. 20675100) is dated as commencing on 23.02.06 and expiring on 30.04.06. Based on conversations with the business manager this is a typing error and the expiry date should be 30.04.11. The agreement was signed by the previous bursar. | Unless a genuine emergency exists, 4 written quotations should be sought for expenditure likely to exceed £2,500. Formal sealed tenders are required if it is likely to exceed £50,000. Care should also be taken to ensure that best value is achieved when consideration is given to allocating additional work to contractors already on site.<br><br>The error on the agreement should be amended. Only staff with the appropriate level of authority should sign agreements on behalf of the school and governors should approve all contracts and lease agreements which exceed the delegated authority of the headteacher. | We have not had any work done exceeding £50,000 but we are aware that we would need sealed tenders (following Local Authority guidelines). Generally the Premises Manager does seek four written quotations over £2,500 (following Local Authority guidelines). In this instance it was only possible to get two contractors to quote. We are aware that we must achieve "Best Value" Premises Manager/Business Manager June 2010<br><br>The Headteacher will sign all agreements for the school in the future with Governors approving the contracts and lease agreements which exceed the Headteachers delegated authority. Headteacher - Immediately |

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| | | The offer for breakfast was provided for children who attended to do extra work during the school holidays. A receipt was provided from a supplier and the supplier requested the amount owed for the breakfast provided to be paid in one payment. There was no supporting document retained other than a piece of paper listing the food items. | Adequate supporting documentation should be retained to support items of expenditure. | Adequate supporting documentation will be retained to support expenditure for all future purchasing.<br>Finance Officer-Immediately |

| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
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| F | Primary accounting documents show that they have all been properly authorised, processed correctly and have not been amended. | <u>Petty cash</u><br>Cash is being given to pupils as rewards. | Vouchers or similar incentives should be offered as rewards rather than cash payments. | The school is now only offering vouchers as a reward, no cash payments will be allowed.<br>Finance Dept - Immediately |
| | | It was noted that the petty cash imprest had been used for the purchase of flowers for a member of staff who was unwell. | The school base budget should be used for educational purposes only. | Gifts will not be taken from the base budget.<br>Finance Dept - Immediately |
| | | <u>Income Controls</u><br>One of 3 bankings (paying in slip no: 115211) could not be matched to the Oracle records | The records of income collected and banked should be reconciled to the Oracle records on a regular basis and the reconciliation reviewed by an independent officer. | On this occasion money was paid into the bank, the e-mail was sent to cash income without a paying in slip number. Oracle Team contacted our Finance Officer Oracle Team were going to add paying in slip number but unfortunately they paid it into Butts School code and not |
| | | A member of staff sells planners and memory sticks. No records are kept of what has been sold and the transfer of cash is not acknowledged. | Records of items sold and income collected should be kept. The transfer of money should be acknowledged by the signatures of both members of staff | |

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| | | | involved in the transaction. | ours (see evidence of transfer back). In future income will be reconciled to the Oracle records by the Finance Officer and reviewed by the Business Manager – Immediately<br>Records of items sold and income collected by the Reprographics clerk is now recorded. Transfer of all monies are signed for by the reprographics clerk and the finance officer. - Immediately |
| | | Voluntary Funds<br>The audited accounts have not yet been presented to governors. | The audited accounts should be presented at the next meeting of the governing body. | The School Fund was audited at the end of October 2009<br>The document will be presented at Finance and Full Governors on 25th May 2010 by Business Manager |
| | | Lettings<br>The current charges for lettings have incorporated increases in rates such as electricity and gas, the process for calculating the new charges however has not been formally documented. | The assumptions made and agreement for lettings charges should be formally documented. | A Service Level Agreement will be drawn up with our Community Association for their use of premises, gas and electricity. Business Manager July 2010 |

The Governors and staff have evidence that there is effective control over:

- financial management system
- income received
- payroll
- purchasing
- the banking system

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| | ➢ petty cash holdings and payments<br>➢ taxation system<br>➢ voluntary funds<br>➢ the School's assets | | | |
| | Assessment Criteria | Assessor Comments | Action Required | Responsibility and Timescale |
| A | The School has either been subject to a review by internal audit or has undertaken a controls self-assessment during the past 12 months. | The R52 risk and controls self assessment document has been completed but no evidence of its formal approval has been provided. | The R52 self assessment document should be discussed and approved as part of the SIC certification process. | The R52 has been completed and will be discussed at the Full Governors Meeting on 25th May 2010 Business Manager |