Agenda Item No.

Audit Committee – 24 January 2012

No or Limited Assurance Internal Audit Reports

Summary of report:

This report details the audit reports receiving a limited assurance opinion which were selected by Audit Committee on 14 November 2011.

Background papers:

Internal audit reports/files/working papers.

Recommendation:

1. To note the contents of this report
2. For members to obtain assurance from the relevant executive directors and appropriate managers at this 24 January 2012 meeting of the Audit Committee, that action is being taken to address concerns identified within the selected reports.

Rebecca Neill – Head of Internal Audit
10 January 2012

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 address issues identified.

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 agrees actions to ensure that control weaknesses identified in the audit are addressed.

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No and Limited Assurance Internal Audit Reports

The following audit reports receiving a limited assurance opinion were selected by Audit Committee of 14 November 2011:

Walsall Adult & Community College – **Appendix 1**;
Integrated Young Persons Support Service – **Appendix 2**;
Community Mental Health Integrated Team – **Appendix 3**;
Learning Disabilities – Satellite Offices – **Appendix 4**; and
Pinfold Day Centre – **Appendix 5**.
Grants - considered in the private session of this agenda.

All audit reports issued with a limited or no assurance opinion are subject to early follow up in the audit year in which they are finalised.

Appendix 1

Walsall Council
Internal Audit Service

Walsall Adult & Community College

Audit Report 2010 / 2011
August 2011

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6. Promotion
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8. Anti-fraud & irregularity
9. Crèche arrangements

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A Cash in transit policy
B Collections & deposits record

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of the Walsall Adult & Community College was undertaken as part of the annual audit plan.

2. The Walsall Adult & Community College was formed in August 2009 and provides courses and learning opportunities for persons aged 18 and above. There are some courses available for 16-18 years in construction and sport related activities.

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:

   - adequate planning, service strategies and customer consultation are in place;
   - service performance is monitored and managed;
   - 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
   - joint working with partners and other council services is effective;
   - procurement is adequately controlled and in accordance with the authority's financial and contract rules 2006 & contract rules 2010;
   - income, including grant income, is properly accounted for;
   - there are appropriate promotional activities;
   - service data and information is accurate, secure and of value to managers;
   - 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. At the request of the college's management, a review was also undertaken of the crèche facility and findings on this are also contained within this report. Additionally a special audit was undertaken on part of the college's payroll procedures and relevant systems findings have also been included. 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 will 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 the Walsall Adult & Community College, 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; performance reporting, funding returns, workforce planning, team communication, grant funding, joint working partnerships and promotional activity.

3. A number of areas for improvement have, however, been identified, including; cash income collection and security, outstanding fee collection, banking, procurement, computer & data security and operation of the crèche facility. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

4. There were 12 agreed actions in the last audit report. The Interim director of quality, confirmed that these had all been implemented on 12 April 2010. During this audit, 6 actions were found to have been implemented and 6 were not implemented. The 6 actions which have not been implemented have been reiterated in the report, marked (*) in the action plan.

5. There are 24 high priority actions in the report.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Service planning performance		✓		
Corporate performance management framework			✓	
Joint working partnerships	✓			
Procurement			✓	
Income			✓	
Promotion	✓			
Computer & data security			✓	
Anti-fraud & irregularity			✓	
Crèche arrangements			✓	

D. Acknowledgements

1. Please thank the college principal, the acting finance manager and all other staff who contributed to this audit for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

1. Service Planning & Performance

AUDIT OPINION

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

Good practice includes:

- College performance is regularly monitored by OFSTED and the Skills Funding Agency (SFA) with overall good feedback received.
- Performance is regularly reported to the governing body.
- The strategic plan aims and objectives are targeted to improving quality and sustainability.
- The college uses national averages to compare performance and identify any adverse performance which requires corrective action.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	**	Officers stated that benchmarking is completed via the Framework for Excellence website; however data provided to the auditor contained little detail and comparisons.	Lack of benchmarking with other local authorities to share best practice/identify areas of poorer performance.	Benchmarking now takes place where possible. There are, however, few organisations working within the FE sector who fall under local authority control. KPI's have now also been set which are monitored each month.	Director - Finance and Business Support Implemented

2. Corporate Performance Management Framework

AUDIT OPINION

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

Good practice includes:

- Workforce planning arrangements are regularly reviewed.
- Health & safety is monitored by a designated officer and there are arrangements to ensure that heath & safety training is undertaken.
- Staff are aware of equality policies & procedures and have recently attended equalities training.
- Core Brief (formerly News & Views) is communicated to staff via email and regular team meetings are held to discuss corporate, college & team issues, performance and ideas.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	*	Procurement reports are presented to Governors but do not always contain information on the actions taken by officers to comply with the rules.	Lack of available information to governors. Lack of procurement knowledge.	Procurement reports to Governors now outline the relevant contract rules and how the College has demonstrated compliance with these requirements.	Director - Finance and Business Support Implemented
2.2	**	It was identified during the audit that the nominal ledger coding structure had not been reviewed for some time. This has meant that budgets have been allocated against old/obsolete codes and actual expenditure has been coded against other codes.	Over and under spends might not be identified and corrected. Lack of accountability.	The coding structure has been re-aligned to ensure that budgets and expenditure are allocated correctly. Further budget re-alignment will be undertaken following the college reconfiguration.	Director - Finance and Business Support 1 September 2011
2.3	**	The service accountant informed the auditor that there has been irregular communication between the service accountant and the acting finance manager on budget monitoring.	Essential budget information may not be shared. Under/over spends might not be identified or corrected.	The college now works closely with the service accountant to ensure information is regularly and promptly shared and budget issues are addressed and corrected where necessary.	Finance Officer Implemented

2.4	**	The business continuity plan has not been updated within the last 12 months.	Lack of preparation in the event of an emergency.	The business continuity plan has now been updated and will be subject to regular review. The plan was presented to governors at the finance sub meeting on 08/02/11. (*) A copy of the plan has now been placed on Moodle (the college online learning application).	[redacted] Director - Finance and Business Support Implemented
2.5	**	Four out of 6 IPM's sampled could not be tested because copies were not available at the time of the audit.	Difficulty in clarifying staff performance targets / issues. Lack of audit trail.	EPA's will be completed in line with the college reconfiguration and copies will be retained. Training is to be provided to managers and staff.	[redacted] Director - Finance and Business Support 31 August 2011
2.6	**	One out of 2 IPM's tested did not detail targets, development points or training needs.	Staff may be unaware of their targets. Organisation objectives may not be delivered. Development / training needs may not be met.	EPA's will be fully completed in line with the college reconfiguration. Training is to be provided to managers and staff.	[redacted] Director - Finance and Business Support 31 August 2011
2.7	**	There was no evidence that a return to work had been completed in 1 in 6 occasions ([redacted]).	Non compliance with council sickness policy.	Return to works are now completed for all periods of sickness. Where possible, and taking into account shift patterns, all return to works are now completed within 3 days of the employee's return to work. (*)	[redacted] Director - Finance and Business Support Implemented

2.8	**	A service risk register is not in place. Risks are not managed at below the strategic or directorate risk appetite.	Key business risks may not be identified and therefore managed.	A review of risks will be incorporated into the annual service planning process. Risk management training was delivered to the college management team on 17 June 2011.	Principal 31 August 2011
2.9	***	The scheme of management has not been reviewed since the merger of the Walsall college of continuing education and Walsall community college.	Unclear roles and responsibilities and lack of accountability.	The scheme of management will be reviewed in 2011. (*)	Director - Finance and Business Support 31 December 2011

3. Joint Working Partnerships

AUDIT OPINION

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

Good practice includes:

- The college has a current SLA in place with the Bloxwich Community Partnership.
- Joint working partnerships have been established which assist the college in meeting their aims and objectives and to improve quality.
- There is liaison with the other local authorities to share best practice and help drive quality improvements.
- The college is aware of the partnership toolkit.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

4. Procurement

AUDIT OPINION

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

Good practice includes:

- All invoices tested were found to be fully checked and certified.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	**	One out of 10 invoices tested did not have a corresponding requisition form or purchase order (Inv 000000062806)	Unauthorised expenditure.	Fully authorised internal requisitions and purchase order are now raised prior to goods/service/works being received. (*)	Director - Finance and Business Support Implemented
4.2	**	One out of 10 invoices was authorised by the same person who authorised the requisition order. (Invoice: 4021)	Lack of segregation of duties, increasing the risk of fraud & corruption.	Segregation of duties has now been established. Orders are authorised by the principal ( ) or finance officer ( ) and invoices are authorised by the director of finance & business support ( ) or finance officer ( ).	Director - Finance and Business Support Implemented
4.3	***	Five out of 10 orders were identified as being raised after the invoice date. (Invoices 00066, 7, 55778893, 15554 & 02CB28)	Unauthorised expenditure. Unavailable budget, leading to budget overspends.	Authorised orders are now raised prior to the commissioning of goods/service/works.	Director - Finance and Business Support Implemented
4.4	**	Two out of 10 invoices had not been paid within 15 days. (Invoices: 15554 & 02CB28)	Poor supplier relationships.	Invoices are now paid within 15 days of receipt, unless contract terms state otherwise. (*)	Director - Finance and Business Support

					Implemented
4.5	**	One out of 10 invoices was not stamped as received (Inv 00066). Also, 3 out of 10 invoices were not stamped when paid (Invoices: 15554, 4021, SIN005136)	Processing information is not available. Inability to determine performance against processing targets.	All invoices are now stamped when received and on the date that they are paid.	Director - Finance and Business Support Implemented
4.6	***	The acting finance manager covering maternity leave has not completed an authorised signatory form.	Inappropriate authorisation of expenditure.	An authorised signatory form has now been completed for the acting finance manager.	Director - Finance and Business Support Implemented
4.7	***	The principal has an authorised signatory form in place but the approved spending limit has been authorised by the finance manager who reports to the principal.	Lack of appropriate authorisation for agreed delegation.	The principal's authorised signatory form has now been authorised by their line manager.	Director - Finance and Business Support Implemented

5. Income

AUDIT OPINION

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

Good practice includes:

- There is a designated officer responsible for having a "watching brief" and identifying new grant funding opportunities.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	A procedure for cash income is not in place and no communication has been sent to teaching staff regarding the cash income process or security of cash.	In the absence of key staff, other officers may not be aware of their duties/responsibilities in relation to cash income and banking. Risk of theft and fraud.	A procedure note for cash income and banking will be produced and approved. Once finalised, the procedure will be issued to all relevant staff who will sign to acknowledge receipt and their understanding of its contents.	Director - Finance and Business Support 31 August 2011
5.2	***	Following the review of 10 cash receipts, only 2 were signed by the receiving officer to acknowledge receipt of income.	It may not be clear who has received and taken responsibility for cash income. Lack of audit trail.	All receipts are now signed by the receiving officer.	Director - Finance and Business Support Implemented
5.3	***	Vending machine cash is collected by only one officer at the Hawbush and Whitehall sites. The cash income collected is taken to the finance office but a cash handover sheet is not completed.	Lack of segregation of duties. Risk of cash misappropriation is increased.	Where possible two people should be involved in the collection of vending machine cash income. A separate officer will be involved in the banking of this income. Bankings will then be recorded to the appropriate nominal ledger code by a	Director - Finance and Business Support 31 August 2011

		This officer is also involved in the banking process.		separate officer from the banking process.	
5.4	**	One person transports cash from the Whitehall centre to the finance office and from the finance office to the banking hall.	Risk to cash income and employee security.	The cash in transit policy is now adhered to. (See appendix A)	[redacted] Director - Finance and Business Support Implemented
5.5	***	Cash income handed from one officer to another is not recorded.	Lack of accountability. Risk of security of cash.	Cash income will be recorded on a collections and deposit record. (See appendix B)	[redacted] Director - Finance and Business Support 31 August 2011
5.6	***	Fees are entered onto the MIS system's learner profiles once paid; however a fees reconciliation is not completed to identify learners who have not paid and these have outstanding charges.	Non-payment of fees is not identified.	A continuous reconciliation will be maintained of learners and fees paid in order to clearly identify learners who have not paid fees. Timescales and methods of pursuing outstanding fees will be clearly detailed in a procedure to ensure that a consistent approach is adopted throughout the college.	[redacted] Director - Finance and Business Support 31 August 2011

6. Promotion

AUDIT OPINION

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

Good practice includes:

- Promotional activity is aimed at increasing learner enrolments including advertisements in local newspapers, leaflets, banners, posters and Walsall council newsletters.
- College improvements and positive performance is communicated to the public via newspaper articles.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

7. Computer & Data Security

AUDIT OPINION

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

Good practice includes:

- The college is aiming to work smarter and improve sustainability by reducing paperwork produced and increasing use of ICT

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	***	There is a generic password which is used by certain members of the finance team. This password allows full access to the management information system.	Unauthorised system amendments and data breaches.	It has been confirmed by the director of finance and business support that the generic password no longer exists.	Director - Finance and Business Support Implemented
7.2	**	The external data archiving provision is currently full and archived documents have not recently been reviewed for potential deletion to free up space.	Inefficient use of data storage facilities.	A review of the documents held in the data archive has been undertaken to release capacity. The review has been undertaken in line with the council's record management guidelines and financial information is kept for 6 years plus the current year.	Director - Finance and Business Support Implemented
7.3	***	An ICT service review of the college's ICT provisions identified that there is an insufficient number of software licences held by the college.	Potential litigation.	The recommendations following the ICT service review have now been implemented.	Director - Finance and Business Support Implemented

8. Anti-Fraud & Irregularity

AUDIT OPINION

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

Good practice includes:

- Stocks and stationary are controlled centrally by the finance team and all stationary orders are checked to stocks held prior to ordering.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.1	***	It was identified that when timesheets are provided to team leaders for authorisation, in some cases, hours being claimed are not checked to the contracted hours prior to being signed as authorised for payment.	Risk of additional hours being paid. Overspend on salary budget. Risk of fraud & irregularity.	The team leaders check the timesheets to confirm the hours worked. The finance department now ensures that claimed teaching hours are checked to contract hours prior to authorisation. Discrepancies are now promptly investigated prior to payment.	Director - Finance and Business Support Implemented
8.2	***	It was identified that timesheets were being returned to the employee once they had been signed.	Risk of fraud & irregularity due to unauthorised amendments.	Team leaders now retain all timesheets once they have been signed and send them directly to the finance office.	Director - Finance and Business Support Implemented
8.3	***	There are no in-house policies & procedures which detail key day to day operational, financial and administrative activities or guidance for finance and non-finance staff.	Lack of guidance and information for staff of key operational activities. Opportunity to review and improve the college's procedures is lost.	Policies & procedures will be written to include detailed instructions and guidelines for key day to day operational, financial and administrative activities completed including, petty cash, cash income, payroll, procurement and banking. The procedures will be issued to staff who will sign to	Director - Finance and Business Support 30 September 2011

				acknowledge receipt and their understanding and they will be reviewed on a regular basis.	
8.4	***	Cash is held in a locked safe. The spare key to the safe is held within a key cabinet.	Lack of security of cash. Non-compliance with insurance policy. Risk of theft and irregularity.	The safe will be moved to a secure location where key holders are able to access it. The spare key will be assigned to a responsible senior officer for access to the safe in the event that no other key holder is present. A key holder register will be completed to detail which officers have been assigned key responsibility. All keys to cash and valuable items will be removed from the premise overnight to ensure compliance with insurance requirements.	Director - Finance and Business Support 31 December 2011
8.5	***	The petty cash tin is obtained from the safe each morning by a member of the finance team and is left out all day. When cash income is brought up to the finance office by teaching staff or the maintenance technician, it is placed in a plastic tub until it is prepared for banking which is completed once a week. This cash is also kept out of the safe during the day.	Lack of security of cash. Non-compliance with insurance policy. Risk of theft and irregularity.	All cash will be kept in locked tins and when cash is not in use it will be locked in the safe.	Director - Finance and Business Support 31 August 2011
8.6	*	During petty cash testing, 1 petty cash claim form was identified which had been completed with the incorrect amount which when reconciled showed a £1.94 deficit balance.	Petty cash might not balance and the anomaly might not be identified until after the money has been receipted.	All petty cash claims are now accurately completed to avoid petty cash anomalies.	Director - Finance and Business Support Implemented

8.7	**	Only two in 10 receipts reviewed during petty cash testing had VAT receipts.	Lack if audit trail. Inability to provide evidence of VAT receipts in accordance with HMRC guidelines.	Staff now obtain VAT receipts for petty cash purchases so that VAT can be claimed back by the college.	Director - Finance and Business Support Implemented
8.8	**	Following discussions with the acting finance manager, the insurance cover for cash held in the safe was unknown.	Cash may not be recoverable in the event of a burglary or theft.	Details of the insurance held will be checked to ensure that it covers the cash income held on the premises. Cash income held will not exceed £1000 until the insurance details are checked.	Director - Finance and Business Support 31 August 2011
8.9	***	The inventory is currently in draft form and is being completed by one member of the IT team within the college. Following discussions with the acting finance manager the responsibility and monitoring of the inventory is unknown.	Incomplete records. In the absence of key staff other staff may not be aware of procedures.	Assets with a value of £100 and any portable/desirable items of equipment below this value will be entered onto the inventory. The inventory will be checked to physical items annually by two members of staff who will sign the inventory to evidence this check. This procedure will be detailed within a note and issued to all relevant staff. The inventory will be presented to governors for approval, including requests for write off of equipment. (*)	Director - Finance and Business Support 30 September 2011

9. Crèche Arrangements

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
9.1	***	The crèche was set up in 2004 under the instruction of the previous college principal. The provision of the crèche has not been through a competitive tendering process. There is only a verbal service agreement in place with the supplier. A 'blanket' order is completed at the start of the academic year for all sessions due to be held (except family learning sessions). This has not been completed for 2010/11.	Lack of adherence to financial and contract rules August 2006 and contract rules 2010. Lack of evidence that best value has been obtained. Lack of clarity over service standards in the event of a query or dispute.	The provision of the crèche services will be subject to competition and a formal tendering procedure in line with contract rules. Advice from procurement and legal services will be sought. In the interim, the relationship with the existing supplier will be documented and agreed with assistance from legal services.	Director - Finance and Business Support 31 January 2012 30 September 2011
9.2	***	No payment terms to the crèche supplier have been established. Invoices are currently paid in advance of the sessions being provided.	Payments made for services that have not been delivered.	Payment terms to the existing crèche supplier will be set out as part of the agreement detailed in action plan 9.1. In the interim, payment terms with the existing supplier will be documented as part of the interim agreement at 9.1.	Director - Finance and Business Support 31 January 2012 30 September 2011

9.3	***	There is a fixed rate paid to the crèche provider of £70 per session for larger venues and £50 per session for smaller venues. The charge is not based on the number of children attending the crèche.	Fees paid may not reflect the usage per child.	The fixed charge for the existing supplier has now been reviewed. Charges will ensure provision of service and value for money. This will be reviewed further as part of the contract review process as detailed in 9.1).	Director - Finance and Business Support Implemented 31 January 2012
9.4	***	The college will receive £7 per child per session from parents who are not on means tested benefits but there has been no recent uptake of this type.	Potential loss of income	The charge of £7 per child per session will be reviewed to ensure that this cost is appropriate. This cost will then be charged without exception. This will be reviewed as part of the contract review process as detailed in 9.1). In the interim, the session charge of £7 will be reviewed, with consideration to updating the fee to reflect and cover current crèche costs.	Director - Finance and Business Support 31 January 2012 30 September 2011
9.5	**	Attendance records are completed for each crèche session held but these are not always fully completed and signed by the parent.	Inaccuracy in attendance records. Lack of evidence of actual attendance.	Attendance records are now completed fully and all parents are required to sign to evidence their child's attendance.	Director - Finance and Business Support Implemented
9.6	***	Following the review of invoices and supporting attendance sheets, it is not clear that the attendance records provided corresponds to the number of sessions held detailed on the invoices.	Insufficient back up information. Delay in invoice payments.	Invoices now clearly detail the dates of the sessions held and match to supporting attendance records. These are now reconciled thoroughly to the invoice to ensure that payments are only made for sessions delivered.	Director - Finance and Business Support Implemented

9.7	***	When the attendance at a crèche session is 3 or less the session will be cancelled but, having reviewed the attendance sheets over the past 6 months, sessions have continued to be held with 3 or less children attending.	Lack of cost effectiveness.	Where possible, sessions are not held if there is less than the stipulated minimum number of children attending. This will be reviewed as part of the contract review process as detailed in 9.1).	Director - Finance and Business Support Implemented 31 January 2012
9.8	***	Room charges for Alumwell and Bentley Drive are not included in the costs for the crèche provision; instead this is paid by the college.	Full costs of the crèche are not clear.	A room charges policy has now been documented. Room charges will be reviewed as part of the contract review process as detailed in 9.1).	Director - Finance and Business Support Implemented 31 January 2012

Appendix 2

Walsall Council
Internal Audit Service

Integrated young people's support services

Audit Report 2010 / 2011
August 2011

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AUDIT OPINION & ACTION PLAN

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3. Corporate performance management
4. Joint working partnerships
5. Procurement
6. Income
7. Activities Programme & Promotion
8. Anti-fraud & irregularity

APPENDICES

1 Collections & deposits record
2 Cash in transit policy

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of integrated young people's support services (IYPSS) was undertaken as part of the annual audit plan. As part of this audit, visits were made to Rosehill, Pelsall and Aldridge Manor youth centres as well as an in depth review of the head office functions and the youth justice service.

2. It should be noted that the audit was undertaken in a period of transition and significant change within integrated young people's support services. During this period three service areas (Connexions, Youth Services & the Youth Offending service) were being integrated into one integrated service with a relatively new leadership team which was not fully embedded until early 2011. During the integration the leadership team were addressing some areas of control weakness within the services. As part of the reconfiguration process, a number of the key staff with previous responsibilities have now left the service and new designated responsibilities and practices have been implemented. IYPSS now has 5 areas of responsibility including:
    - Positive activities/youth work;
    - Active involvement;
    - Youth justice service;
    - Targeted youth support: and
    - IAG prospects.

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:

    - adequate planning, service strategies and customer consultation are in place;
    - service performance is monitored and managed;
    - the service operates within the corporate performance management framework, including:
        - workforce planning
        - IPM, now EPA
        - equalities
        - procurement
        - budgetary control
        - business continuity
        - risk management
        - communications
        - sickness management
        - health & safety
        - information governance
    - joint working with partners and other council services is effective;
    - procurement is adequately controlled and in accordance with the authority's financial and contract rules 2006 & contract rules 2010;
    - income, including grant income, is properly accounted for;
    - there are appropriate promotional activities;

- service data and information is accurate, secure and of value to managers; 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 will 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 the integrated young people's support 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; service planning, monitoring of performance by the youth justice team, joint working initiatives, risk management relating to the IAG (Prospects) contract, effective team communication, and online development of www.mywalsall.org.uk.

3. A significant number of areas for improvement have, however, been identified, including; performance monitoring, business continuity planning, sickness management reporting, cash income collection and security; and purchasing procedures. Anti fraud and corruptions arrangements require significant management attention. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

4. There were 22 agreed actions still applicable from the last audit youth justice service report. The administrative team manager confirmed implementation of all 22 actions on 20 February 2007. During this audit 17 actions were found to have been implemented and 5 were not fully implemented, which have been reiterated in the report, marked (*) in the action plan.

5. There were 38 agreed actions still applicable from the last audit of youth services (now positive activities). Confirmation was received that all actions had been implemented from each individual youth centre & head office audits completed during 2005/06. During this audit 21 actions were found to have been implemented and 17 were not fully implemented, which have been reiterated in the report, marked (**) in the action plan.

6. There are 15 high priority actions in the action plan.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, service strategies and customer consultation	✓			
Service performance		✓		
Corporate performance management			✓	
Joint working partnerships		✓		
Procurement			✓	
Income			✓	
Activities programme & promotion	✓			
Anti-fraud & irregularity			✓	

D. Acknowledgements

1. Please thank the IYPSS strategic lead - positive activities, the strategic lead – youth justice & targeted youth support and all other staff who contributed to this audit for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

1. Planning, service strategies and customer consultation

AUDIT OPINION

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

Good practice includes:

- A universal services portfolio plan is in place and is included on PIMS. The portfolio plan includes positive activities, youth justice & [redacted] activities.
- Service aims take account of all service drivers, including customer, partner and other stakeholder consultation & feedback.
- A portfolio plan action plan is monitored on PIMS on a monthly basis.
- Service issues, slippage or non-achievement of the portfolio plan is discussed at integrated young people support services (IYPSS) management meetings.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

2. Service Performance

AUDIT OPINION

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

Good practice includes:

- Benchmarking working group meetings are attended by positive activities and youth justice managers. The meetings include other local authorities and identify best practice and key service issues.
- The portfolio plan is approved at the IYPSS performance board and links in with the portfolio holder's objectives.
- The youth justice service monitors performance on a monthly basis and submits data to the youth justice service performance and management board.
- Performance is reported and discussed at the youth justice board quarterly.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	***	Positive Activities New performance indicators have not yet been identified following the ending of national indicators for positive activities.	Inability to review and compare performance. Under performance may go un-noticed.	Appropriate performance indicators have now been established. Quarterly performance meetings have now been set to monitor performance against the indicators.	IYPSS strategic lead - positive activities Implemented
2.2	**	Positive Activities Performance data available for 2010/11 is compared against results from 2009/10 but trends over a longer period are not currently evaluated.	Under performance may go un-noticed. Timeline trends may not be identified.	Quarterly performance meetings are now in place and will be focusing on monitoring appropriate data. Data is now compared at area partnership meetings, this includes seasonal trends.	IYPSS strategic lead - positive activities Implemented
2.3	***	Positive Activities Six youth clubs are not up to date with inputting information onto the youth	Incomplete performance data produced. Results produced may be	Data input onto the youth zone system is now up to date. A clear timeframe is now in place for inputting data on MIS and has been	IYPSS strategic lead - positive

		zone database (Pelsall, Palfrey, Pool Hayes, Blackwood, Caldmore & Dartmouth youth clubs) as well as 2 youth projects (Palfrey boys to men & Aldridge youth theatre). Further, there is a procedure note in place for updating the MIS system and extracting data; however this requires updating following the service reconfiguration. A timetable detailing deadlines for MIS input by youth workers is not in place.	inaccurate and may not provide a true reflection of service performance. Under performance may go un-noticed. Lack of information and guidance available leading to inconsistent and incomplete data entries onto youth zone.	communicated through the planning process. Non-compliance with the deadline is now picked up monthly and accuracy and completeness of data input is signed off monthly. Data is now reported on a quarterly basis and exceptions are discussed at quarterly performance meetings. (**) A review of guidance will be completed and will be included as part of the IYPSS positive activities operating manual. (**) The procedure will include a requirement that MIS input will be verified by an independent senior officer. The procedure will also detail the reports that are expected to be extracted from youth zone and when this will be completed. (**) Refresher training on MIS has now been scheduled as part of IYPSS reconfiguration induction process.	activities Implemented IYPSS strategic lead - positive activities 31 July 2011
2.4	**	Positive Activities There is no detailed guidance to district youth workers to ensure consistency of approach in their monitoring of youth centre activities.	Inconsistent standards and achievements across youth centres.	Checklists will be used by senior area youth workers to ensure that monitoring of youth centre activity is done comprehensively and consistently. This will include checks on outcomes against aims, financial tasks and recording of information/data. New procedure framework and flowchart will be put in place.	IYPSS strategic lead - positive activities 30 September 2011

3. Corporate Performance Management

AUDIT OPINION

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

Good practice includes:

- Regular management & staff meetings take place.
- Archiving of paper documents has been recently completed by the youth justice team.
- Workforce planning is reflected in the IYPSS service plan.
- The youth justice service & positive activities have a designated equalities officer.
- A risk register has been established for the contract with [redacted] which is monitored quarterly by senior management.
- An equality impact assessment was undertaken with the reconfiguration of services when IYPSS was created.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	**	Youth Justice Service A review of 6 employee IPM/EPA's highlighted the following exceptions: • 2 IPM forms were used following the implementation of the new EPA process in September 2010 ([redacted]). • 1 IPM/EPA was completed but did not include an agreed target plan ([redacted]). • 2 IPM/EPA's were completed but did not include an agreed personal development plan and were not fully signed by employee and manager ([redacted]).	Inconsistent employee performance assessments. Incomplete records held. Employees may be unaware of agreed performance improvements and training needs.	Employee performance assessments are now conducted in accordance with new EPA requirements. Assessments are now fully completed and signed by both the employee and manager. All managers have now undertaken training to undertake the new EPA's. A service audit of EPA's will be undertaken in October 2011. Monthly support and supervision now occurs for all service members and this is monitored through the line management process.	[redacted] IYPSS strategic lead – youth justice & targeted youth support Implemented

3.2	**	Youth Justice Service Following a review of 6 employees who have had a period of sickness the following exceptions were identified: • 3 employees did not have a return to work completed within 3 days of their return to work ( ). • 1 employee's return to work form was not signed by the employee ( ). • 3 employees had 3 periods of sickness within a rolling year but a notification of concern was not issued as required under previous sickness absence guidelines ( ). Positive Activities Following a review of 6 employees who have had a period of sickness the following exceptions were identified: • 3 employees did not have a return to work completed within 3 days of their return to work ( ). A review of Trent & Intelligence records for a further 4 employees	Lack of compliance with the corporate sickness management policy. Poor sickness records may not be addressed. Lack of records available to accurately monitor employee sickness.	All managers are now trained in the new Bradford factor sickness absence management framework and the management team review the Bradford factor scores for all staff. The framework is now adhered to by staff and managers. A copy of the sickness policy has been circulated to reiterate to managers and employees of their responsibilities with regards to return to work interviews and sickness management reviews.	IYPSS strategic lead – youth justice & targeted youth support Implemented IYPSS strategic lead - positive activities Implemented

		indicated that no sickness was recorded for the duration of their employment with the council. Discussions with managers during the audit were unable to fully clarify the accuracy of this position. ( )			
3.3	**	Youth Justice Service Some health & safety procedures are in place; however require review. Officers have not recently attended health & safety training.	Risk of safety to staff and young people. Health & safety risks may not be identified promptly and managed.	A health & safety risk assessment will be undertaken and an action plan prepared and monitored, including identification of appropriate staff training needs. Health & safety procedures will be reviewed and updated as necessary	IYPSS strategic lead – youth justice & targeted youth support 31 July 2011
3.4	**	Positive Activities Health & safety procedures located within positive activities have not been reviewed within the last 12 months.	Risk of safety to staff and young people. Health & safety risks may not be identified promptly and managed.	Procedures will be reviewed and updated as necessary on an annual basis and the reviewing officer and date will be evidenced on the document.	IYPSS strategic lead - positive activities 31 August 2011
3.5	**	Positive Activities Following the review of 6 employee IPM/EPA's the following exceptions where identified: • 4 performance assessments were not available at the time of the audit. ( )	Incomplete records held. Employee & manager may be unaware of agreed performance improvements and training needs. Lack of information available in the event of a query.	The employee and manager will be clearly detailed on performance assessment forms. They will both sign the assessment as evidence of agreeing the content. All assessments will be retained and be readily available for reference during performance management monitoring.	IYPSS strategic lead - positive activities 31 July 2011

		• For the 2 available performance assessments, the manager conducting the review was not detailed and neither the employee nor the manager had signed the document ( ).			
3.6	**	IYPSS A business continuity plan is in place but this has not been updated since the establishment of the IYPSS.	Lack of preparation and guidance in the event of an emergency.	The business continuity plan will be updated and be subject to review at least annually.	Head of service – (IYPSS) IYPSS strategic lead – youth justice & targeted youth support 31 August 2011
3.7	**	IYPSS A service risk register is not in place.	Key business risks may not be identified and therefore managed.	A risk register will be completed and monitored on a quarterly basis to support the strategic plan. Risks which fall above a set risk appetite will be monitored via risk management action plans.	Head of service – (IYPSS) IYPSS strategic lead – youth justice & targeted youth support 31 August 2011

3.8	**	<u>Positive Activities</u> Risk assessments held at youth centres are not up to date and there is no evidence of their review. The assessments for Pelsall youth centre have not been reviewed or updated since 2006.	Inaccurate/out of date documents. Inappropriate protection of staff and young people.	All risk assessments have now been renewed. Spots checks will now be completed by the operational lead, team leader and Strategic lead. All risk assessments will be kept on a secure file.	IYPSS strategic lead - positive activities Implemented IYPSS strategic lead - positive activities 31 August 2011
3.9	*	<u>Positive Activities</u> Health & safety checks are not consistently completed at the start of each youth club session.	Risk of young people and staff health & safety.	Health & safety check lists will be designed as part of the operational guide review.	IYPSS strategic lead - positive activities 31 July 2011
3.10	**	<u>Positive Activities</u> Although there is a staffing structure in place for management and administration staff, there is not one for youth centre & youth project staff.	Unclear reporting lines and responsibilities.	The staffing structure has now been updated and has been shared with staff as part of the reconfiguration. Part time and administration staff will be added to the structure following the reconfiguration process. The structure will be reviewed and updated as necessary on an annual basis and be disseminated to all teams. (**)	IYPSS strategic lead - positive activities 30 September 2011

4. Joint Working Partnerships

AUDIT OPINION

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

Good practice includes:

- Service level agreements are in place and are updated annually for joint working partnerships relating to the youth justice team.
- The youth justice service holds regular meetings with joint working partners.
- Third party providers are subject to a business case review by the youth panel prior to partnerships being established.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	**	Positive Activities Senior officers are not fully aware of the council's partnership toolkit.	Partnership benefits are not optimised.	Briefing sessions for senior officers on the partnership toolkit will be undertaken.	IYPSS strategic lead - positive activities 31 July 2011
4.2	*	Positive Activities The deadline for the submission of 2010/11 funding applications was 14/05/10. Partner organisations have to fund their youth service provision from other resources as the approval and subsequent budget for youth provision is not received until well into the new financial year.	Non-compliance with stated application deadlines. Potential allegations of unfair treatment from organisations that adhered to the funding deadline of 14/05/2010. Lack of audit trail in the event of a query.	Funding applications are now requested and provisionally approved (depending on available funding) prior to the end of the financial year in preparation for the new year. (**) Letters of intention will be going out for year 3 in prior to the 31 March 2012 outlining timeline for budget confirmation.	IYPSS strategic lead - positive activities Implemented
4.3	***	Positive Activities Two out of 3 small grant invoices	Lack of segregation of duties and inappropriate authorisation.	Separate officers have now been established and will be used for authorising orders and certifying corresponding invoices	IYPSS strategic

		tested were approved by the officer who had authorised the purchase order. ( )	Incomplete information provided for payment request.	for payment.	lead - positive activities Implemented

5. Procurement

AUDIT OPINION

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

Good practice includes:

- All invoices tested evidenced appropriate segregation of duties between the officer raising orders and the officer authorising subsequent invoices.
- All invoices tested were allocated to an appropriate Oracle code.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	Youth Justice Service 6 out of 10 orders tested were authorised after the date of the invoice. (Invoice refs: SINV00108904, 0001, IN00011302, 1105255462, IN00000610 & 399494) Positive Activities 6 out of 10 purchase orders tested were authorised after the date of invoice. (Invoice refs: 946177977, 54837, INV 0910-26, 454962, CN17232260 & A122)	Unauthorised expenditure. Risk of budget overspends.	Finance procedures have now been reiterated to all staff to ensure regulations are complied with. New procedures have been put into place to ensure that there is robust monitoring of financial activities. The finance procedures and flowchart in place have been communicated to staff. Training has been delivered to senior officers and a training programme has been put into place for full time youth workers. Non-compliance with procedures is now addressed in staff supervision or employee performance management reviews.	IYPSS strategic lead – youth justice & targeted youth support Implemented IYPSS strategic lead - positive activities Implemented
5.2	**	Youth Justice Service 3 out of 10 invoices tested were not paid within 15 days of being received.	Poor achievement of creditor payment targets. Damage to supplier	The youth justice service & positive activities now ensure that invoices are processed promptly to ensure that payment within 15 days can be achieved.	IYPSS strategic lead – youth justice & targeted youth

		(Invoice ref: SINV00108904, 946959719, 0001) Positive Activities 5 out of 8 invoices that contained date paid information were not paid within 15 days of receipt. (Invoice refs: 946177977, 54837, 33200, A122 & 9301162701)	relationships.		support Implemented IYPSS strategic lead - positive activities Implemented
5.3	**	Youth Justice Service 1 invoice tested contained VAT but no VAT registration number was included on the invoice. (, invoice ref: 0001) Positive Activities 1 invoice tested contained VAT but no VAT registration number was included on the invoice. (454962)	Ineligible VAT reclaims.	Invoices are now sent directly to consolidated creditors as part of the implemented finance direct project. When invoices are sent directly to the service they are now checked to ensure that they are legitimate invoices and contain all appropriate information, including that required for VAT purposes.	IYPSS strategic lead – youth justice & targeted youth support IYPSS strategic lead - positive activities Implemented
5.4	*	Youth Justice Service 1 invoice did not have the date received detailed, therefore it was not possible to determine the actual number of days taken for the invoice to be paid. (invoice ref: 0001) Positive Activities	Delays in supplier payments may go unnoticed. Damage to supplier relationships.	Invoices are now sent directly to consolidated creditors as part of the implemented finance direct project. When invoices are sent directly to the service they are now detailed with all appropriate information including date received and date sent for payment. (*)	IYPSS strategic lead – youth justice & targeted youth support IYPSS strategic lead - positive

		1 out of 8 invoices available for testing did not have the date sent for payment detailed on the invoice. (Invoice ref: 4602)			activities Implemented
5.5	***	Positive Activities 1 out of 10 orders reviewed had the same requesting and approving officer. (Invoice ref: 4602)	Lack of segregation of duties.	Authorised signatories have now been set up; therefore separate officers will now be involved in requesting and authorising orders.	IYPSS strategic lead - positive activities Implemented
5.6	*	Positive Activities 1 out of the 10 invoices tested could not be located at the time of the audit. (Invoice ref: CN17232260)	Unaccounted expenditure. Lack of audit trail. Lack of information in the event of a query.	This invoice finding relates to a member of staff who has now left the authority. Care is now taken to ensure that invoices are retained and are readily available.	IYPSS strategic lead - positive activities Implemented
5.7	***	Positive Activities One invoice tested was not signed by an appropriate authorised signatory. (Invoice ref: 33200)	Unauthorised expenditure.	Authorised signatories have now been set up; therefore all orders and invoices are now authorised only by an authorised signatory.	IYPSS strategic lead - positive activities Implemented
5.8	**	Positive Activities 2 out of 10 requisitions tested had an automatic printed signature for the	Potential risk of unauthorised use of signature. Risk of fraud & irregularity.	The requisition template has been amended so that no automatic signatures can be used. Emails are now retained as audit trail for authorisation.	IYPSS strategic lead - positive

		officer requesting the goods/service. (Invoice refs: 209943 & 33200)			activities Implemented

6. Income

AUDIT OPINION

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

Good practice includes:

- Positive activities has established designated officers responsible for ensuring that the market is scanned for funding opportunities and that bids are submitted.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	***	Positive Activities Following a review of 2 youth centre which charge for club subscription (Rosehill and Aldridge) it was identified that some young people do not pay and there is not a clear procedure in place to ensure equality and fairness.	Unclear and inconsistent charging arrangements.	Guidelines will be reviewed as part of the operational manual. (**)	IYPSS strategic lead - positive activities 31 July 2011
6.2	**	Positive Activities There is little guidance available to youth workers to administer a tuck shop. There is a lack of consistent practices used across the youth centres. Tuck shop replenishment of stock at Pelsall youth centre is by cheque at a cash & carry; however Aldridge issue	Inconsistency of working practices including that arising from staff rotation / changes at centres. Anomalies in cash held and records kept may not be identified. Potential risk of theft.	Guidelines will be reviewed as part of the operational manual.	IYPSS strategic lead - positive activities 31 July 2011

		a cheque for cash or 'borrow' money from income taken during the month.	Misappropriation of stock.		
6.3	***	Positive Activities After completing a review of income controls at youth centres, the following was identified: All youth centres • A cash handover form is not completed when young people pay their subscriptions or tuck money. • Income & expenditure forms do not contain sufficient information to ensure effective recording & security of cash. Aldridge Manor • Cheques issued for cash are not reconciled to subsequent expenditure receipts to demonstrate that money has been fully accounted for.	Lack of evidence of cash movements. Cash income anomalies may not be identified. Potential risk of theft and fraud.	Where possible a record of all cash handover transactions will be completed for young people's payments of subscriptions and tuck money. Income and expenditure forms will be completed fully and contain sufficient information to ensure adequate recording and an appropriate audit trail. (see suggested format at Appendix 1) Cheques issued for cash will be reconciled to subsequent expenditure receipts to ensure that all monies can be appropriately accounted for. A record of reconciliations will be retained for audit purposes and review by district youth workers. This will be included in the operational manual.	IYPSS strategic lead - positive activities 31 July 2011

7. Activities Programme & Promotion

AUDIT OPINION

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

Good practice includes:

- www.mywalsall.org.uk has been developed to advertise positive activities.
- Positive outcomes for youth justice service work with the police and court is completed.
- An IYPSS newsletter promoting activities and events is completed on a quarterly basis.
- Good news stories are promoted regularly.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

8. Anti-Fraud & Irregularity

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
8.1	***	Youth Justice Service Inventory The same officer updates the inventory with new equipment and completes the stock take.	Lack of segregation of duties. Possible lack of accountability of assets.	Officers responsible for completing inventory checks are now responsible for updating the inventory.	IYPSS strategic lead – youth justice & targeted youth support Implemented
		A stock take was completed in March 2011; however there was no evidence of the check on the inventory.	Missing items may not be promptly identified for officers to take appropriate action.	An annual inventory check is now undertaken by 2 officers. Evidence of this check is now detailed within the inventory. (*)	
		The inventory includes computer equipment but does not include other assets held on the premise and staff.	Loss or theft of assets may go unnoticed.	Assets with a value of £50 and over are now entered onto the inventory.	
		Serial numbers are not included on the inventory.	In the event of loss or theft assets may not be recovered.	Serial numbers are now included for all appropriate assets. (*)	
		Equipment held by staff is not included on the inventory.	Lack of security of assets.	All portable equipment are now included on the service inventory.	
		Items of valuable portable equipment have not been security marked	Stolen items may be more difficult to recover.	All valuable portable equipment are now security marked. (*)	

8.2	***	Positive Activities Inventory Following a review of the inventory process the following has been identified: • Youth centres are required to update the head office with new equipment to be added to the inventory although this information will already be available as all orders and invoices are processed via the head office. • The inventory for the head office and youth centres has not been updated for 2010/11. • There is no evidence on the head office or youth centres' inventory to show that two people are involved in the inventory process and that the inventory is checked.	Possible lack of accountability of assets. Missing items may not be promptly identified for officers to take appropriate action.	Youth centre inventories will be updated centrally following receipt of invoices and confirmation of goods received. The inventory will also be updated immediately after any disposals An annual inventory check will be undertaken by two officers who have no responsibility for updating the inventory. Evidence of this check will be detailed within the inventory. (**) Inventories will include all equipment, including non-electrical.	IYPSS strategic lead - positive activities 30 Sept 2011
8.3	**	Youth Justice Service Inventory Youth justice staff can borrow a sat nav owned by the youth justice team. A record book for this is held, however staff are not required to sign when the devise is loaned out. Further, youth justice staff have their own allocated portable equipment such as mobile phones; however staff	Lack of asset accountability. Lack of evidence in the event of loss or theft.	The sat nav record book is now signed by the employee when the asset is borrowed and evidenced by a second officer. When the asset is returned the employee and the receiving officer now sign the record to evidence the return of the asset. A record of all assets held by employees is now in place. The employee signs to evidence that they hold the assets. This will be reviewed on an annual basis as part of the inventory asset check.	IYPSS strategic lead – youth justice & targeted youth support Implemented

		are not required to sign for the equipment.			
8.4	**	Youth Justice Service Physical security Keys are required to be passed between officers but there is no key register in place to clarify responsibility for their custody. Positive Activities Physical security A key register is not consistently used at the youth centres or head office.	Potential misappropriation of cash and equipment.	Key registers will be completed to identify key holders and any handover of responsibilities. (*) (**)	IYPSS strategic lead – youth justice & targeted youth support Implemented IYPSS strategic lead - positive activities 31 July 2011
8.5	*	Youth Justice Service Petty cash Following a review of 25 petty cash receipts, 5 were found to include shopping reward points.	Council staff are seen as favouring certain suppliers for personal gain.	Staff have now been reminded that shopping reward points cannot be claimed when purchasing goods on behalf of the service.	IYPSS strategic lead – youth justice & targeted youth support Implemented
8.6	***	Youth Justice Service Procedures Some local procedures were not in place, for example, the updating & reviewing of the inventory, order & invoice administration, timesheet processing, usage of portable equipment and for the issue of travel warrants.	Lack of guidance and information for staff on operational activities. Opportunity to review and improve procedures is lost.	Policies & procedures have now been written to include detailed instructions and guidelines for key day to day operational, financial and administrative activities completed. (**) The procedures will be issued to staff who will sign to acknowledge receipt and their	IYPSS strategic lead – youth justice & targeted youth support Implemented

		Positive Activities Procedures No local procedures are held for day to day key duties. Local procedures are not in place at the youth centres.		understanding and they will be reviewed on an annual basis. (**)	IYPSS strategic lead - positive activities 31 July 2011
8.7	**	Positive Activities Quality Assurance Following the review of 6 youth centre quality assurance inspections the following was identified: • The quality assurance process document has not been reviewed and updated since September 2007. • A timetable of scheduled inspections is not in place. • There is no evidence on the inspection forms sampled that outcomes from the visit have been agreed with the youth centre officer or that it has been certified by the visiting officer. • Action plans have not been developed following the inspection although notes for improvements are detailed on the inspection forms.	Inspections may not be undertaken consistently and poor quality of service may not be promptly identified. Inspection results may not be understood or agreed. Areas of poor quality may not improve.	The quality assurance process document will be reviewed and updated as necessary. A timetable of scheduled visits will be established and be sent to the youth centres. Inspection reports will be agreed by the youth centre officer and be approved by the inspecting officer. An action plan will be produced to support inspection findings and to address areas of poor quality. (**) Where poor performance is identified random spot check inspections will be completed to ensure that quality improvements have been implemented.	IYPSS strategic lead - positive activities 31 July 2011
8.8	**	Positive Activities	Officers may be able to access unauthorised folders.	Access levels to folders held on the shared drive will be reviewed to ensure that	

		Data security Following discussions with the strategic lead for positive activities, it was identified that access to folders held on the shared drive require review to ensure that appropriate access levels are established.	In the event of officer absence folders and documents may not be able to be accessed.	appropriate access levels are established.	IYPSS strategic lead - positive activities 31 July 2011
8.9	**	Positive Activities Data security Archiving has not been completed for a long period of time at the head office and within the youth centres. There is no evidence of compliance with document retention guidance.	Data and information may be kept for longer than necessary. Risk of data security.	An archiving exercise will be completed to ensure that data and documents are kept only for the period necessary and in line with corporate document retention guidance (see intranet under "Council Information").	IYPSS strategic lead - positive activities 30th Sept 2011
8.10	***	Positive Activities Petty cash Following a review of petty cash procedures, the following was identified: • All youth centres have a £100 imprest which was initially set up in February 2006; however 5 youth centres no longer hold an imprest and there was no evidence of when or where the imprest money had gone. It should be noted that this occurred under the management of the previous administration officer, who has since left the service. Additional controls were being identified by senior	Incomplete records maintained. Failure to reconcile the imprest. Accounting records may be inaccurate / up to date. Lack of security of cash. Risk of theft and fraud.	Youth centre and head office petty cash will be reviewed as a matter of urgency; if petty cash imprest money cannot be located, internal audit and financial services will be contacted to arrange for the amounts to be written off. A review of the petty cash held at the youth centres will be reviewed by senior management to ensure that imprests are held only where necessary. A petty cash procedure will be drafted to provide guidance on how to effectively manage petty cash, including a maximum spending limit and checking of reconciliations and reclaims by a second independent officer. This procedure will be distributed to all responsible officers at each of the youth centres.	IYPSS strategic lead - positive activities 31 July 2011

		management. • At the time of audit testing the head office had an imprest of £100; it was later identified that the head office will hold an imprest of £500 but there was no evidence of where or when the imprest money had gone. • A petty cash expenditure record book is not maintained by Pelsall youth centre. • Following a petty cash reconciliation at Pelsall youth centre the petty cash was found to have a deficit balance of £29.32. • There is a lack of knowledge across the youth centre regarding how to effectively monitor and reconcile petty cash and complete claims. • A petty cash procedure is not in place to provide guidance to youth workers on how to manage petty cash. • A maximum individual transaction expenditure limit has not been set.			
8.11	**	Positive Activities Cash handling A safe contents register is not in place at Aldridge Manor, Rosehill & Pelsall youth centres.	Theft not detected.	A safe contents register will be established at relevant youth centres and kept up to date. (**)	IYPSS strategic lead - positive activities 31 July 2011

8.12	***	Positive Activities Banking Following a review of the banking process at the youth centres visited, the following was identified: Rosehill youth centre: • The dates of bankings are not logged in the income & expenditure book. • Loose change that is found around the centre is added to the banking but is not recorded in the records book. Aldridge youth centre: • 7 out of 8 income & expenditure records examined could not be accurately reconciled to receipts and banking records. • Reconciliation of income to bank statements is not completed. Pelsall youth centre: • 1 out of 8 supporting income & expenditure records did not reconcile to the actual cash income banked. Daily reconciliations of income & expenditure does not involve at least 2 officers in the process (Aldridge Manor, Rosehill & Pelsall youth centres)	Inadequate protection of staff from allegations of irregularity. Incomplete / inaccurate records. Potential for the misappropriation of cash. Lack of audit trail. Errors / omissions may go unnoticed. Potential inadequate segregation of duties.	Cash income collected and banked will be reconciled to supporting records held. Additional income 'found' around youth centres will be investigated and recorded separately to avoid confusion and anomalies. Preparation of bankings will be completed by two officers to ensure sufficient segregation of duties. (**) Bank statements will be promptly reconciled to income and expenditure records. The monthly bank account reconciliation will be signed and dated by the completing officer and checked by a second independent officer (preferably a senior officer), who will sign and date the appropriate record to evidence their review. (**) This will be addressed within the operational manual review and training will be provided to appropriate officers. Spot checks for compliance will also be introduced.	IYPSS strategic lead - positive activities 31 August 2011

8.13	***	Positive Activities Segregation of duties Following a review of the segregation of duties at the head office and youth centres the following exceptions were identified: • 26 out of 75 income & expenditure records examined have not been countersigned by a second officer (Aldridge Manor) • The tuck shop float is not verified by two youth workers at the end of each session. (Aldridge Manor & Rosehill) • One officer prepares, reconciles and completes the bankings (Aldridge Manor, Rosehill & Pelsall youth centres) • Petty cash functions are completed by one officer at Pelsall youth centre. • Banking of cash income is sometimes completed by only one officer.	Inadequate protection of staff from allegations of irregularity. Incomplete / inaccurate records. Potential for the misappropriation of cash. Errors / omissions may go unnoticed. Potential risk of theft and fraud.	Income and expenditure records will always be checked and signed by two officers. Cash floats will be counted and verified by two separate officers. Evidence of this check will be recorded. (**) Daily reconciliations of income & expenditure will be completed and be checked by an appropriate senior officer Petty cash staff reimbursement claims, reconciliations and imprest reclaims will be checked by an independent second officer. (**) The cash in transit policy will be complied with at all times. This will also be distributed to the youth centres to ensure consistent working practices. (see Appendix 2) This will be addressed within the operational manual review and training will be provided to appropriate officers. Spot checks for compliance will also be introduced.	IYPSS strategic lead - positive activities 31 August 2011
8.14	***	Positive Activities Cash handling Following a review of cash requests the following was identified: • The current cash request	Inappropriate/unnecessary use of cash requests. Incomplete / inaccurate records.	The financial procedure flowchart now includes cash requests and returns of receipts. Appropriate use of cash has been reiterated through the ordering procedure.	IYPSS strategic lead - positive activities

		procedure does not contain guidance to staff on the requirements for compulsory returns of receipts to evidence expenditure. • Cash requests are used for TV licences, hotel bookings, activities, trips and shopping where safer methods of payments (i.e. cheque / invoice / payment card) could be used. • A spreadsheet detailing all cash requests has been established; however it is not used to record that proof of expenditure has been obtained or to detail the residual cash that has been banked.	Lack of evidence of expenditure. Potential for the misappropriation of cash. Errors / omissions may go unnoticed. Potential increased risk of theft and fraud.	Cash requests have now been significantly reduced and new boundaries have been established. A purchase card has also been obtained. Receipts are now requested within a set time and the spreadsheet now captures all relevant information.	Implemented
8.15	**	Positive Activities Youth centre staff attendance Aldridge youth centre: Staff are required to complete a signing in sheet. However In October 2010, 7 out of 12 signing in forms were not signed and/or fully completed. Pelsall youth centre: The staff signing in book for November 2010 was reviewed for completeness and it was identified that:	Incomplete / inaccurate records. In the event of a query insufficient information is available.	Staff attendance records will be completed fully and periodically checked by the district youth worker. This will be incorporated into the quality assurance framework.	IYPSS strategic lead - positive activities 31 July 2011

		• JH had not signed out on 14/11/10. • No staff or visitors signed out on 15/11/10 • No staff signed out following the early session on 16/11/10.			
8.16	**	Positive Activities Young people session attendance & evaluations Following a review of session evaluations and attendance records the following exceptions were noted: Rosehill youth centre: • 3 out of 10 session plans were not signed by a young person. Pelsall youth centre: • 7 out of 10 after session evaluations tested were not signed by a young person. • 3 out of 10 signing in forms (form G) tested were not signed by a senior youth worker. Aldridge youth centre: • For the sessions in October 2010, attendance and evaluation records have not been completed for the Monday evening week commencing 25/10/10.	Incomplete / inaccurate records. In the event of a query insufficient information is available. Data entered onto youth zone may not be sufficient.	Session attendance and evaluations will be completed fully and include sufficient detail relating to the activities and work completed with the young people. Where possible a young person will be requested to provide feedback on the session and sign the session evaluation. The district youth worker will periodically spot check the session attendance and evaluation forms to ensure completeness. (**)	IYPSS strategic lead - positive activities 31 July 2011

Appendix 3

Walsall Council
Internal Audit Service

Community Mental Health Integrated Team

Audit Report 2010 / 2011
September 2011

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EXECUTIVE SUMMARY

A. Introduction

1. An audit review of the community mental health integrated team (CMHIT) was undertaken as part of the annual audit plan. In October 2008 Dudley and Walsall Mental Health Partnership NHS Trust was formed by Dudley Primary Care Trust, Walsall Teaching Primary Care Trust and Walsall and Dudley Council social care mental health services. Staff were integrated into the north, east, south & west integrated mental health teams, while remaining Walsall council employees. The community mental health integrated team provides mental health services to clients within Walsall. The team undertake assessments, care plans and risk assessments of clients and subsequently make referrals for the appropriate care required.

2. An audit was undertaken at both the north and west integrated mental health teams during this review of the service. The north CMHIT is managed by an NHS employed manager and the west CMHIT by a Walsall council employed manager.

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:

   - adequate planning, service strategies and customer consultation are in place;
   - service performance is monitored and managed;
   - the service operates within the corporate performance management framework, including:
     - workforce planning
     - EPA
     - equalities
     - procurement
     - budgetary control
     - business continuity
     - risk management
     - communications
     - sickness management
     - health & safety
     - information governance
   - joint working with partners and other council services is effective;
   - procurement is adequately controlled and in accordance with the authority's financial and contract rules August 2006 and contract rules September 2010;
   - adequate documentation is available to support the provision of the service to clients and subsequently arranged care packages/care plans;
   - income, including grant income, is properly accounted for; 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 within the community mental health integrated team 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;
   - awareness and promotion of the mental health service;
   - establishment and monitoring of performance indicators;
   - business continuity planning;
   - administration of petty cash; and
   - maintaining separate council and NHS asset inventories.

3. Areas for improvement have, however, been identified, including, ensuring:
   - the establishment of a partnership agreement under section 75 of the National Health Service Act 2006 clearly setting out the roles and responsibilities of each partner; such an agreement should also clarify expectations of staff, together with the relevant policies and procedures that should be followed;
   - that a team plan is developed and a service risk register put in place;
   - performance management arrangements on Oasis are fully implemented;
   - compliance with the council's sickness absence procedure;
   - the strengthening of procurement and budgetary controls;
   - client files are fully complete and reviews undertaken where necessary; and

- the documentation of day to day administration procedures.

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

4. Community mental health integrated team has not been previously audited. There are therefore no previous audit report actions to be followed up.

5. There are 19 high priority actions in the action plan.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, Service Strategies and Customer Consultation			✓	
Service Performance		✓		
Corporate Performance Management			✓	
Joint Working			✓	
Procurement			✓	
Provision of Client Care			✓	
Income	✓			
Anti Fraud and Irregularity			✓	

D. Acknowledgements

1. Please thank 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. Planning, Services Strategies and Customer Consultation

AUDIT OPINION

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

Good practice includes:

- Social care employees are aware of the council's complaints procedure.
- The mental health services provided by the Trust are promoted via the council and NHS websites.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	***	A partnership agreement under section 75 of the National Health Service Act 2006 has not yet been established.	Roles and responsibilities are not clearly defined.	A partnership agreement under section 75 of the National Health Service Act 2006 will be established and agreed.	[redacted] Head of Community Care (Operations) 1 December 2011
1.2	**	While a social care and health portfolio plan has been established it is dated 2009-2010.	Strategic objectives may not be clear and therefore not achieved.	The portfolio plan will be updated and reflective of 2010/11 objectives.	[redacted] Head of Community Care (Operations) 1 December 2011
1.3	***	A team plan has not been developed following the development of the Trust.	Unclear aims and objectives. Unable to measure service performance. Under performing areas may not be promptly identified and addressed. Lack of evidence of regular monitoring.	A team plan will be developed and finalised. Quarterly monitoring of the team plan will then be undertaken to identify and address slippage / non-achievement of actions and be subject to senior officer review.	[redacted] Head of Community Care (Operations) 1 December 2011

2. Service Performance

AUDIT OPINION

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

Good practice includes:

- Performance indicators have been established which are regularly monitored by the social care & inclusion performance and outcomes team.
- Benchmarking has been undertaken.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	***	The performance and outcomes manager advised the auditor that a new system, Oasis, is being developed by the Trust to improve the quality of the performance information required by the local authority.	Performance indicators do not reflect accurate performance. Under performance may go unnoticed.	Oasis will be implemented. Following this, a thorough review of data produced will be undertaken to ensure that it remains accurate and in accordance with the council's requirements.	[redacted] Head of Community Care (Operations) 1 December 2011
2.2	**	Meetings to discuss social care performance have not been regularly held with the Trust during 2010/11. The performance and outcomes team is in consultation with Trust members to re-establish these meetings.	Under performance may go un-noticed and corrective action not promptly taken.	Regular performance meetings will be held with the trust to ensure that performance data and requirements are effectively communicated.	[redacted] Head of Community Care (Operations) 1 December 2011

3. Corporate Performance Framework

AUDIT OPINION

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

Good practice includes:

- A business continuity plan is in place.
- Employees are required to attend equalities training every 3 years.
- Risk assessments have been completed and updated within the last 12 months.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	*	Walsall council employees use NHS performance assessment forms. Following examination of 10 employee assessments it was found in 1 case that the assessment had been completed by an officer at the same level ([redacted]).	Performance targets may not be appropriately established and agreed. Lack of clarity to staff of the organisational policies and procedures which are applicable to them.	Walsall council employees will be assessed using the corporate employee performance assessment (EPA). Performance assessments will be completed by the employee's line manager.	[redacted] Head of Community Care (Operations) 1 December 2011
3.2	**	The manager of the west community mental health integrated team was unaware of the change to contract rules in September 2010.	Potential for non-compliance with contract rules.	The manager of the west community mental health team will ensure that awareness of key local authority documents is maintained, including contract rules September 2010.	[redacted] Head of Community Care (Operations) 1 December 2011
3.3	***	Following discussion with council employees it was identified that there is no set guidance provided to staff to identify which budget should be used to purchase goods such as equipment or stationery. The auditor was informed that staff raise orders via the council's I-proc system or through the NHS systems.	Lack of clear procurement guidelines. Potential for overspends on budgets.	Managers will ensure that procurement guidance is provided to all staff and the appropriate systems are used.	[redacted] Head of Community Care (Operations) 1 December 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.4	***	The west community mental health integrated team manager authorises orders for all community mental health integrated teams. However, at the time of the audit, he did not receive regular budget monitoring statements and did know who to contact within finance to obtain the information.	Potential for overspends on budgets.	Orders will not be approved by the team manager unless he is aware that sufficient funds are available within the budget. Regular budget monitoring statements will be provided to the west community mental health integrated team manager.	[redacted] Head of Community Care (Operations) 1 December 2011
3.5	**	The west community mental health team manager stated that a Walsall social care forum meeting was held monthly for all social care staff, however, the administration officer based at North community mental health team was not aware of this meeting and had not attended any Walsall social care meetings in the last year. Further, the administration officer does not get provided with core brief updates.	Lack of communication. Staff may not be aware of council issues / initiatives.	All relevant council staff will be requested to attend Walsall council social care forum meetings where monthly core briefs will be presented. Minutes of the meeting will then be circulated to all staff. The administration officer has now been made aware of the forum and has been informed that attendance is permitted.	[redacted] Head of Community Care (Operations) 1 December 2011 [redacted] Community Mental Health Team Manager – North Implemented
3.6	***	From examination of 11 sickness absences tested it was identified that: CMHIT West (5 absence) • in 1 case a doctor's fit note was not on the personal file or recorded on Trent. ([redacted]) • in 1 case, where the employees Bradford factor score was above 150, an absence warning was not	Non compliance with the council's sickness absence procedure.	Officers now ensure that fit notes are obtained for all relevant absences and forwarded to HRD to be recorded on Trent and placed on the personal file. Managers now ensure that sanctions are appropriately issued in accordance with the attendance procedure and details forwarded to HRD to be recorded on Trent and placed on the personal file.	[redacted] Head of Community Care (Operations) Implemented

		recorded on Trent or held on the personal file. ( ) • in 2 cases a return to work form had not been completed. ( ) CMHIT North (6 absences) • in 2 cases a return to work had not been completed. ( ) • in 1 case a return to work had not been completed within 3 days of the employees return to work and had not been signed by the employee and manager until 10 days after the interview. ( ) • in 2 cases, where the employees Bradford factor score was above 150, an absence warning was not recorded on Trent or held on the personal file.. ( )		It is now ensured that return to work interviews are undertaken in accordance with the attendance procedure.	
3.7	**	Following discussions with social care staff during the audit it was identified that not all staff are able to access the HRD portal.	Potential for inconsistent procedures.	It will be ensured that Walsall council employees have access to the HRD portal.	Head of Community Care (Operations) 1 December 2011
3.8	**	The West community mental health integrated team is based within Darlaston town hall, a Walsall council owned building. Health and safety assessments are completed by the NHS health and safety team. Health and safety procedures are produced by the NHS.	Health and safety risks may not be appropriately managed.	Health and safety assessments carried out on council owned buildings will be undertaken by the authorities SHAW team. Walsall council employees will be made aware of the authority's health and safety procedures.	Head of Community Care (Operations) 1 December 2011

		The building is also occupied by leisure and culture staff who are responsible for ensuring health and safety checks e.g. fire alarms are carried out. The CMHIT manager does not communicate with leisure and culture regarding health and safety matters.		Communication will be established between all occupants of Darlaston town hall to ensure that health and safety checks are kept up to date and any issues communicated effectively.	
3.9	***	A service risk register detailing Trust operational risks has not been established.	Service risks may not be identified, monitored or escalated when necessary.	A service risk register will be established for the service and be monitored on a regular basis.	Head of Community Care (Operations) 1 December 2011
3.10	***	An equality impact assessment has not been completed since the development of the Trust.	Equality impacts are not identified and addressed.	An equality impact assessment will be completed for the implementation of the Trust. A review of equality impact assessments required will be undertaken annually.	Head of Community Care (Operations) 1 December 2011

4. Joint Working

AUDIT OPINION

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

Good practice includes:

- The service works jointly with a number of partners.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	***	There is not a service level agreement in place for administration services provided at Broadway North by the Trust. Further it was unclear of the administrative officer's role and the terms and conditions of her employment.	Desired outcomes and resource commitments may be unclear and open to dispute / challenge.	A service level agreement will be put in place for the administration services provided at Broadway North by the Trust. Further the administrative officer's role and terms and conditions will be documented.	Head of Community Care (Operations) 1 December 2011
4.2	***	The team leader of the west community mental health integrated team expressed concerns that there were originally council officers who acted as professional leads for Walsall and Dudley councils employed within the Trust, however, both of these officers have now left. It is understood that a restructure is currently being undertaken within the Trust.	Work force and service provision may not reflect the interests of all Trust partners.	Steps will be taken to ensure professional leads from Walsall and Dudley council social care are included within the new structure of the Trust.	Head of Community Care (Operations) 1 December 2011

5. Procurement

AUDIT OPINION

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

Good practice includes:

- Goods received are appropriately stored away and recorded on the inventory (if required).

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	From a sample of 6 paid invoices selected it was found that: • in 1 case an order had not been raised. (Invoice ref: HQ00416/2076231) • in 5 cases the orders had been raised after the date of the invoice. (Invoice ref: 21081001, HQ00416/2137207, 100204, 475, 1587) • in 1 case the order amount included VAT. (Invoice ref: 475)	Unauthorised expenditure. None compliance with the authorities financial & contract rules. Overstatement of budget commitments.	Orders will be raised and authorised prior to receipt of the goods / invoice. It will be ensured that VAT is excluded from all purchase orders raised.	[redacted] Head of Community Care (Operations) 1 December 2011
5.2	***	From a sample of 6 paid invoices selected it was found that: • in 3 cases the authorising officer had also been involved in the invoice certification process. (Invoice ref: HQ00416/2076231, 475 & 1587) • in 3 cases the order and invoice had been authorised by the same officer. (Invoice ref: 21081001, HQ00416/2137207, 100204)	Inadequate segregation of duties.	Authorising officers will not be involved in invoice pre-certification checks. All internal requisitions, orders and invoices will be approved by separate officers to ensure appropriate segregation of duties.	[redacted] Head of Community Care (Operations) 1 December 2011

		• in 1 case the internal requisition and invoice had been authorised by the same officer. (Invoice ref: HQ00416/2076231)			
5.3	***	From a sample of 6 paid invoices selected it was found that: • in 2 cases the invoice had not been stamped with the date paid. (Invoice ref: HQ00416/2137207 & 475) • in 1 case the date stamped paid was ineligible. (Invoice ref: 1587)	Potential for duplicate payments. Unable to identify date paid in the event of a query.	All invoices will be stamped clearly with the date paid.	[redacted] Head of Community Care (Operations) 1 December 2011
5.4	**	From a sample of 6 paid invoices selected it was found that in 3 cases it took more than 15 days for an invoice to be paid. (Invoice ref: HQ00416/2076231, 100204 & 1587)	Failure to adhere to creditor payment target. Poor supplier relationships.	Invoices will be paid within 15 days of receipt, unless contract terms state otherwise.	[redacted] Head of Community Care (Operations) 1 December 2011
5.5	**	From a sample of 6 paid invoices selected it was found on 2 occasions that the incorrect Oracle code had been used for copier leasing and copies charged have been coded to different codes on two invoices. (Invoice ref: HQ00416/2076231, HQ00416/2137207)	Potential for over/under statement of budgets.	It will be ensured that the correct Oracle expenditure codes are used.	[redacted] Head of Community Care (Operations) 1 December 2011

6. Provision of Client Care

AUDIT OPINION

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

Good practice includes:

- Walsall council social workers operate within the care programme approach.
- All 10 clients were identified as having a signed risk assessment which had been updated within the last 12 months.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	**	From a sample of 10 client files selected it was found that: • in 1 case a client's personal assessment (CPA) summary was not included. ( ) • 2 cases the CPA had not been signed by the care co-ordinator. ( )	Incomplete records maintained. Inconsistency in working practices.	It will be ensured that client personal files are complete and consistent with all relevant documentation retained.	Head of Community Care (Operations) 1 December 2011
6.2	***	From a sample of 10 client files selected it was found that: • in 6 cases an assessment review had not been undertaken in the last 12 months. ( ) • in 3 cases the date the assessment was completed was not recorded. ( ).	Incomplete records maintained. Clients needs may not have been addressed	Client assessments will be completed on an annual basis. The assessment form will include the completed date and will be signed by all relevant parties. Problems on case files have been highlighted to individuals for immediate action (North Community Mental Health Team)	Head of Community Care (Operations) 1 December 2011 Community Mental Health Team Manager – North Implemented

		• In 5 cases the assessment was not signed by the client. ( ).			
6.3	*	From a sample of 10 client files selected it was found that in 1 case the crisis and contingency plan had not been fully completed. ( )	Incomplete records maintained.	Crisis and contingency plans will be fully completed by the care co-ordinator.	Head of Community Care (Operations) 1 December 2011
6.4	***	From a sample of 10 client files selected it was found that: • in 2 cases care plans had not been updated within the last 6 months. ( ) • in 2 cases the care plans had not being signed by the client. ( ) • in 1 case the care plan included reference to another client. This clients CPA summary was also retained in the client care file. ( ) •	Incomplete records maintained. Clients needs may not have been addressed. Potential breach of data security.	Care plans will be reviewed on at least a bi-annual basis. Once complete care plans will be signed by all relevant parties. It will be ensured that client information is not included on another client's record. Problems on case files have been highlighted to individuals for immediate action (North Community Mental Health Team)	Head of Community Care (Operations) 1 December 2011 Community Mental Health Team Manager – North Implemented
6.5	**	Team managers do not periodically spot check client files for completeness and to ensure that all relevant reviews have been undertaken.	Errors / omissions may go un-noticed. Potential for inconsistencies in working practices.	Periodic file spot checks of client files will be undertaken by a senior officer and evidence of the checks retained.	Head of Community Care (Operations) 1 December 2011

				Client file spot checks are now completed periodically as part of clinician's supervision.	Community Mental Health Team Manager – North Implemented
6.6	**	A procedure for informing clients of rejected referrals is not in place. Further, a record of rejected referrals is not maintained.	Inconsistency in working practices. In the event of a query relevant information may not be readily available.	A procedure for informing clients of rejected referrals will be documented in writing and issued to all relevant officers. Further, a list of rejected referrals will be maintained.	Head of Community Care (Operations) 1 December 2011
6.7	**	At the time of the audit it was not possible to check the client information held in the personal files to the client information database. This was due to the data being uploaded onto the new system, Oasis.	Lack of audit trail.	Following the transfer of client information to Oasis a review of the accuracy of data will be undertaken.	Head of Community Care (Operations) 1 December 2011

7. Income

AUDIT OPINION

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

Good practice includes:

- Contributions are received from the NHS and a schedule of charges has been established.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

8. Anti Fraud and Irregularity

AUDIT OPINION

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

Good practice includes:

- Petty cash it is administered in accordance with petty guidance and with appropriate segregation of duties.
- Separate inventories are maintained for NHS & Walsall equipment.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.1	***	Officers are aware of the council's whistle blowing policy and employee code of conduct, however, other procedures provided to officers have been produced by the NHS. They are therefore not aware of all council procedures for example the administration worker based at the North community mental health integrated team was unaware of the flexible working hours scheme.	Potential for non compliance with council procedures.	Walsall council employees will be made aware of and have access to all council procedures. It will be made clear to employees that they will comply with council procedures.	Head of Community Care (Operations) 1 December 2011
8.2	***	Administrative procedures are not comprehensively documented in writing.	In the absence of certain officers, other staff may not be aware of their roles and responsibilities.	Administrative procedures will be documented in writing, approved and issued to all relevant officers. Thereafter, procedures will be reviewed on an annual basis and signed and dated by the completing officer. A comprehensive folder outlining the daily roles and responsibilities of the administrative officer has been established and is regularly updated. (North Community	Head of Community Care (Operations) 1 December 2011 Community Mental Health Team Manager – North

				Mental Health Team)	Implemented
8.3	***	The administration officer located at the North community mental health integrated team completes manual flexi sheets, these are not checked by a second officer.	Lack of segregation of duties. Errors / omissions may go un-noticed.	The administration officer flexi sheets are now checked by a senior officer. Evidence of the check is now retained.	[redacted] Community Mental Health Team Manager – North Implemented
8.4	***	In examining the inventory at West community mental health integrated team there was no evidence that a stock check had been undertaken. Further, the team leader was unaware of the procedure for disposing of redundant equipment and therefore it was being stored on site.	Missing items may not be promptly identified for officers to take appropriate action. Potential weakness in accountability of council assets.	An annual inventory check will be undertaken. Evidence of this check will be detailed within the inventory. The team leader will be made aware of the procedure for disposing of assets.	[redacted] Head of Community Care (Operations) 1 December 2011
8.5	**	Following a physical check of 5 items of council equipment it was identified that 2 items had not been marked as the property of Walsall Council (shredder / BT answering machine).	Potential weakness in accountability of council assets	All items of valuable portable equipment will be security marked.	[redacted] Head of Community Care (Operations) 1 December 2011
8.6	**	The petty cash is not available when the community mental health integrated team administrative officer is absent.	Lack of appropriate staff cover in the event of absence.	A further Walsall council employee has now been assigned responsibility for the petty cash in the administrative officer's absence.	[redacted] Community Mental Health Team Manager – North Implemented

Appendix 4

Walsall Council
Internal Audit Service

Learning Disabilities – Satellite Units

Audit Report 2010 / 2011
August 2011

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EXECUTIVE SUMMARY

A. Introduction

1. An audit review of learning disabilities – satellite units was undertaken as part of the annual audit plan; this included an audit of the head office at Electrium Point; and Rushall, Pleck and Brownhills satellite units.

2. Satellite units provide day care services to adults with learning disabilities. The units are located in various areas within the borough of Walsall with the aim to provide a local service to each service user in line with the personalisation agenda.

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:

   - adequate planning, service strategies and customer consultation are in place;
   - service performance is monitored and managed;
   - the service operates within the corporate performance management framework, including:
     - workforce planning
     - IPM, now EPA
     - equalities
     - procurement
     - budgetary control
     - business continuity
     - risk management
     - communications
     - sickness management
     - health & safety
     - information governance
   - joint working with partners and other council services is effective;
   - procurement is adequately controlled and in accordance with the authority's financial and contract rules;
   - income, including grant income, is properly accounted for;
   - there is adequate segregation of duties and controls in place during the payroll process;
   - arrangements are in place for controlling accommodation utilisation;
   - communication and sharing of information between head office and satellite units is robust;
   - activity income is effectively managed, recorded and reconciled; 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. At the request of the college's management, a review was also undertaken of the crèche facility and findings on this are also contained within this report. Additionally a special audit was undertaken on part of the college's payroll procedures and relevant systems findings have also been included. 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 will 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 learning disabilities – satellite units, 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; regular communication, timesheets being checked and authorised and the security of cash and assets.

3. A number of areas for improvement have, however, been identified, including; updating the team plan, measuring and monitoring key service performance indicators, compliance with sickness absence management procedures, documenting partnership arrangements, procurement and processes for the administration of tea and activity monies. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

4. As this is the first audit of learning disabilities satellite units there are no previously agreed actions.

5. There are 16 high priority actions within the action plan.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, Service Strategies and Consultation			✓	
Service Performance			✓	
Corporate Performance Management			✓	
Joint Working			✓	
Procurement			✓	
Grant and Other Income			✓	
Payroll Process		✓		
Accommodation Utilisation		✓		
Communication between Head Office & Satellite Units	✓			
Activity Money			✓	
Anti-Fraud & Irregularity			✓	

D. Acknowledgements

1. Please thank the support service manager and the service co-ordinator, and all other staff who contributed to this audit for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

1. Planning, Service Strategies and Consultation

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
1.1	**	The most up to date social care & inclusion portfolio plan is not held on PIMS as it refers to 2009/10.	Out of date information held.	It will be ensured that the most up to date portfolio plan is held on PIMS.	Service Manager - Provider Services Head of Provider Services 30 September 2011
1.2	***	An action plan to support the portfolio plan aims and objectives has not been compiled.	Aims & objectives might not be achieved. Under performing areas may not be identified.	An action plan will be completed to support the implementation of the portfolio plan aims and objectives.	Service Manager - Provider Services Head of Provider Services 30 September 2011
1.3	***	The team plan has not been updated since 2007.	Unclear aims and objectives. Unable to measure service performance. Under performing areas may not be identified.	The team plan will be updated and agreed. The team plan will then be monitored on a quarterly basis and appropriate corrective action taken/measures taken for the non-achievement of actions.	Team Manager – Provider Services - Assistant Team Manager – 30 September 2011

2. Service Performance

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
2.1	***	There are currently no key service performance indicators in place.	Service improvements are not identified. Adverse performance is not promptly identified and corrected.	Service key local performance indicators will be put in place and monitored on a regular basis. Corrective measure will be put in place for areas where targets are not being achieved.	Head of Provider Services Service Manager - Provider Services 30 September 2011
2.2	***	Benchmarking with similar organisations is not currently undertaken.	Good practice at other like organisations may not be identified. Inability to compare performance.	Benchmarking will be reviewed following the restructure of day services. Benchmarking with other local authorities and similar organisations will be undertaken, performance compared and corrective action taken where weaknesses are identified.	Team Manager Assistant Team Manager Senior Support Worker 30 September 2011

3. Corporate Performance Management

AUDIT OPINION

Limited assurance can be given that controls are in place to meet objectives in this area
For the financial year 2010/11 the profiled budget to January 2011 totals £1,761,692. Actual net expenditure for the same period totals £1,893,267, an over spend of £131,575. Current budget forecast reports prepared by the accountant for the service indicates an over spend of £164,127 at year end, this is due to pension contributions and agency costs.

Good practice includes:

- An up to date business continuity plan is in place and includes the 7 satellite units and the head office.
- Health & safety training needs have been reviewed and training has been booked for employees where necessary.
- There is regular communication between management and the team, including core briefs.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	**	Equalities training needs have not been reviewed within the last 2 years.	Knowledge and skills may not be adequate or up to date.	Equalities competencies and training needs will be reviewed and training undertaken where necessary. Equalities training will be provided to senior officers.	[redacted] Assistant Team Manager 30 September 2011
3.2	***	SHAW building health & safety and wellbeing assessments have not been completed at the satellite units for some time.	Health & safety risks may not have been identified and managed.	SHAW assessments will be requested and completed for all satellite units as a matter of urgency.	[redacted] Assistant Team Manager 30 September 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.3	**	From a sample of 6 employees EPA's examined it was found that : • The employee signed and dated the EPA form on 29/06/10 ( ); however the EPA was completed on 30/06/10. • In 1 case the target setting and personal development plan was not signed by the employee. ( ) • In 2 cases training had been identified but not signed. ( )	Non compliance with council procedures. Training needs may not be identified and acted upon.	EPA forms now include the correct date. It is now ensured that the employee signs the target setting and personal development plan. Managers now ensure that training needs are discussed and agreed within the EPA form. The EPA process has now been reiterated to the Senior Support Worker.	Team Manager Implemented
3.4	***	There is no service risk register in place.	Service risks are not promptly identified and monitored.	A service risk register will be completed and monitored on a quarterly basis. Risks which fall above a set risk appetite will be monitored via risk management action plans. Service risks will be escalated to the strategic or directorate risk registers where necessary.	Team Manager Assistant Team Manager All Senior Support Workers 31 October 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.5	**	From a sample of 6 employees sickness absences examined it was found that : • In 3 cases a return to work had not been completed. ( ). • in 1 case the return to work had not been signed by the employee ( ) • In 2 cases the reason for not issuing a notice of concern was not documented. ( )	Non compliance with sickness absence management procedures.	Return to work interviews will be completed within 3 days of the employee's return to work. Interviews will be signed by both the manager and the employee. Explanations for notices of concern not being issued to employees will be recorded on the return to work form.	Team Manager Assistant Team Manager All Senior Support Workers 30 September 2011
3.6	**	A copy of the accountability memo was not provided at the time of the audit however the service accountant confirmed that it was signed by the head of provider services on 17 March 2010.	Lack of evidence of agreement to budget. Documents may be lost / mislaid.	Officers now ensure that signed accountability memos are retained and held on file.	Team Manager Implemented
3.7	***	Current budget forecast reports prepared by the accountant for learning disabilities satellite units, indicate an over spend of £164,127 at year end due to pension contributions and agency costs. The team manager confirmed that 2010/11 agency worker expenditure related to costs transporting service users attending day & respite care. The budget for these costs was due to be covered from central budget, however, this was not devolved	Overspend at the financial year end for which resources are not available.	Corrective measures to reduce future overspends have now been put into place to restrict further overspend including reduction in agency staff use and continuing with non-essential spend. This is now regularly monitored to ensure that budget overspends are identified promptly and corrective action taken where necessary.	Team Manager Implemented Team Manager 30 September 2011

		contributing to the over spend identified above.			

4. Joint Working

AUDIT OPINION

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

Good practice includes:

- The service is in the process of developing links with the community.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	***	Partnerships and agreements with external providers are not documented in writing or signed and dated as agreed; this is not in line with the partnership toolkit.	Desired outcomes and resource commitments may be unclear and open to dispute / challenge.	Partnership agreements with external organisations will be documented in writing in accordance with the partnership toolkit.	Assistant Team Manager 30 September 2011
4.2	**	Documented rent agreements for satellite units which are being rented from external organisations were not made available for the auditor at the time of the audit.	Terms and conditions not formally documented. Fees and charges may be increased.	Agreements for satellite units which are being rented from external organisations are now retained on file and made available to relevant staff as required.	Assistant Team Manager Implemented

5. Procurement

AUDIT OPINION

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

Good practice includes:

- There was appropriate segregation of duties for all invoices tested.
- All invoices tested were found to have a fully certified bird cage stamp.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	From a sample of 10 invoices selected, it was found: • In 10 cases the invoice had not been stamped received at the head office. (Invoice ref - CP2123/CC950, 23082, 2442660, 56470364, 234355, 0100/00816637A, 0100/ 00835179, 0100/00841114, HQ00416/2111921 & 0122796) • On 7 occasions the order was raised after the date of the invoice. (Invoice refs: CP2123/CC950, 23082, 2442660, 56470364, 234355, 0100/00816637A & 0122796) • in 1 case the value of the order was different to value of the invoice.(Invoice ref: HQ00416/2111921)	Delays in invoice payments may not be identified. Non compliance with finance and contract rules 2006. Potential for budget overspend.	Invoices will be stamped with the date that they are received at the head office. Authorised orders will be raised prior to the commissioning of goods/service/works. Care will be taken to ensure that accurate costs are detailed on the original order, if the invoice does not match the order this will be investigated & queried with the supplier if necessary.	Team Manager Assistant Team Manager All Administration staff 31 August 2011

6. Grant and Other Income

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
6.1	***	Following a review of tea money procedures at Pleck, Rushall and Brownhills satellite units it was found that: • There is not a documented procedure in place for the collection of tea money from service users. • There are inconsistent methods of recording tea money across the satellite units. • Tea money has been used to replenish stocks which staff are also using. (Pleck) • tea money has been used to purchase items for council use e.g. postage (Rushall) • Tea money records are not periodically reviewed by an independent senior officer.	In the absence of certain officers, other staff may not be aware of their roles and responsibilities. Inconsistent procedures. Inappropriate use of service user funds. Lack of segregation of duties.	It will be ensured that: • Procedures for the collection of tea monies from service users are comprehensively detailed in writing. Procedures will be reviewed and updated/amended on an annual basis and signed and dated by the completing officer. This will ensure a consistent approach. • Staff do not have refreshments that have been funded by service users. • Service users' tea money is not used to fund items for council use. • Income and expenditure records for refreshments are reviewed by an independent senior officer who will sign and date the appropriate records as evidence.	Team Manager Assistant Team Manager Assistant Team Manager All Senior Support Workers 30 September 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.2	**	Following discussions with the Assistant Team Manager ([illegible]) and the Team Manager it was identified that the service does not have a clearly defined responsible officer for identifying possible grant funding possibilities e.g. lottery bids.	Funding opportunities may not be identified.	The service will consider designating an officer responsibility for having a 'watching brief' in identifying possible grant funding opportunities.	[illegible] Assistant Team Leader [illegible] Senior Support Worker 30 September 2011

7. Payroll Process

AUDIT OPINION

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

Good practice includes:

- Timesheets are appropriately checked and authorised prior to processing.
- Attendance sheets are completed by each satellite unit and are checked by the head office administration team.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	***	From examination of 3 agency worker timesheets it was found that, on occasions, an order had not been completed until after the agency worker had started working for the council.	Unauthorised expenditure. Over spend of available budget.	Authorised purchase orders will be raised prior to requesting an agency worker to ensure that the commitment is raised and expenditure appropriately authorised.	Assistant Team Manager 31 August 2011
7.2	***	From examination of 3 agency worker timesheets it was found that they had been covering the same post for up to 5 years.	Excessive salary costs resulting in budget overspends.	The use of agency staff has now been reviewed and the service is due to terminate 6 agency worker posts. Alternative staff cover arrangements are now considered prior to the engagement of agency workers.	Team Manager Assistant Team Manager Implemented

8. Accommodation Utilisation

AUDIT OPINION

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

- Satellite units provide services which can be accessed within the service user's local area in line with personalisation.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.1	***	Satellite unit capacity is almost full but there is no contingency plan in place to address this.	Service users may not be able to access the service that they require.	A contingency plan will be produced to address the possibility of satellite units being full to capacity.	Service Manager - Provider Services Team Manager Assistant Team Manager 31 October 2011
8.2	**	Monitoring of service user usage and service demand is undertaken; however further development is required.	Under utilisation may go unnoticed.	Monitoring of accommodation utilisation by service user usage will be undertaken on a quarterly basis.	Service Manager - Provider Services Team Manager Assistant Team Manager 31 October 2011

9. Communication between Head Office & Satellite Units

AUDIT OPINION

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

Good practice includes:

- The satellite unit seniors attend regular management meetings. Feedback is provided to staff at the satellite units via handovers and team meetings.
- Core brief updates are given at senior management team meetings and a copy is sent to each satellite unit.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		None			

10. Activity Money

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
10.1	***	Following a review of activity money processes at Rushall, Pleck and Brownhills satellite units it was identified that: • Service users are encouraged to retain their own activity money; however, it is, on occasions, collected and held at the unit. Records are not maintained of money held at 1 of the units and there is no evidence of appropriate segregation of duties. (Rushall) • Receipts are not retained for activity expenditure at the 3 units. (Rushall, Pleck & Brownhills)	Potential for the misappropriation of service user money. Lack of segregation of duties. Money may not have been spent appropriately.	A review of the activity processes will be undertaken to ensure that: • Records are maintained of service user activity money held. • Two officers are involved in the collection and recording of activity income money who will both sign the record maintained. • Receipts are retained for activity expenditure.	Team Manager Assistant Team Manager Assistant Team Manager All Senior Support workers 30 September 2011

11. Anti-Fraud & Irregularity

HEAD OFFICE

AUDIT OPINION

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

Good practice includes:

- Premises, cash and assets at the head office are kept secure.
- Complaints are dealt with in line with the council complaints procedure.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
11.1	*	Following examination of petty cash receipts for the period September to October 2010 it was found that in 1 case a member of staff had used their Tesco reward card to gain points.	Inappropriate gain by member of staff.	Staff have now been instructed that they should not use their personal reward cards when purchasing items on behalf of the service.	[redacted] Assistant Team Leader Implemented
11.2	***	From examination of the head office and satellite unit inventories it was found that: • They did not include serial numbers for all electronic equipment. • They were old format inventory books. • There was no evidence within the inventory that a stock check had been undertaken. • In 1 case the inventory included equipment which was broken or had been returned to another unit. (Rushall)	Potential weakness in the management of authority assets. Authority assets may not be promptly recovered in the event of a theft. Missing items may not be promptly identified for officers to take appropriate action. Inaccurate records maintained / in the event of loss/theft accountability of assets may be unclear.	Serial numbers will be detailed within the inventory for all appropriate items of equipment. Inventories will be held electronically. An annual inventory check will be undertaken. Evidence of this check will be detailed within the inventory. The inventory will be updated to reflect the obsolete equipment and equipment that has been transferred to another unit.	[redacted] Team Manager [redacted] Assistant Team Manager All Senior Support Workers 31 October 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
11.3	**	While basic procedure notes have been written for certain administrative tasks undertaken they are not comprehensive in detail, for example petty cash procedure and inventories. Further day to day administrative procedures have not been recorded in writing for procurement, timesheets and data input.	In the absence of certain officers, other staff may not be aware of their roles and responsibilities.	All office procedures will be comprehensively detailed in writing. Thereafter procedures will be reviewed and updated/amended on an annual basis and signed and dated by the completing officer.	Assistant Team Manager. All administration staff. 30 September 2011

SATELLITE UNITS

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
11.4	**	Procedures held at 2 of the satellite units had not been updated for over 12 months. (Brownhills & Rushall)	Policies & procedures may be out of date, providing inaccurate guidance to staff.	Policies & procedures held at the satellite units will be reviewed and updated where necessary on at least an annual basis.	Assistant Team Manager All Senior Support Workers 31 October 2011
11.5	**	The risk assessments for activities at Brownhills satellite unit had not been updated for over 12 months.	Risks may not be reflective of current working arrangements. Unable to mitigate high level risks.	Risk assessments will be reviewed on at least an annual basis and updated where necessary.	Assistant Team Manager All Senior Support Workers 30 September 2011
11.6	**	Staff, including agency workers, are not requested to familiarise themselves with completed risk assessments. (Brownhills & Rushall satellite units)	Risks may not be reflective of current working arrangements.	All staff will be requested to familiarise themselves with completed risk assessments.	Assistant Team Manager All Senior Support Workers 30 September 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
11.7	***	It was identified at the time of the audit that in some instances service users had not been issued with a personal swipe card to record their use of transport services. Instead, a general transport swipe card was used and a note sent to the head office so that the relevant service user could be charged.	Service users may not be charged for the use of transport. Potential loss of income to the authority.	All service users will be issued with a personal transport swipe card.	Team Manager Assistant Team Manager 31 October 2011
11.8	**	Key registers are maintained however it was found at 2 of the satellite units that the transfer of keys, for example when officers are on leave, is not recorded.(Brownhills & Rushall)	The location of key sets may not be known, which lowers security arrangements.	The transfer of keys will be recorded in the key register and signed by both officers.	Assistant Team Manager All Senior Support Workers 31 October 2011

Appendix 5

Walsall Council
Internal Audit Service

Pinfold Day Care Centre

Audit Report 2010 / 2011
July 2011

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EXECUTIVE SUMMARY

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AUDIT OPINION & ACTION PLAN

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2. Service Performance

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4. Transfer of Services and Site Closedown

5. Joint Working

6. Procurement

7. Income

8. Anti Fraud and Irregularity

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of pinfold day dare centre was undertaken as part of the annual audit plan.

   Pinfold is a day centre for adults with learning disabilities providing a range of activities including; art classes, physiotherapy, kitchen, and leisure facilities. Following the retirement of the previous manager in January 2010 responsibility for the centre was transferred to the service co-ordinator. Currently, the services provided by the centre are also being transferred to Goscote Centre and the Stan Ball Centre in April 2011 and Pinfold Centre will then close.

2. 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:

   - adequate planning, service strategies and customer consultation are in place;
   - service performance is monitored and managed;
   - 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
   - adequate procedures are in place for the planned transfer of services and site closedown;
   - joint working with partners and other council services is effective;
   - procurement is adequately controlled and in accordance with the authority's financial and contract rules;
   - income is properly accounted for; and
   - key controls are in place to guard against fraud and irregularity.

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 Pinfold Day Care Centre, 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;
   - segregation of duties in the procurement process;
   - consultation meetings with staff and service users regarding the transfer of Pinfold Day Care Centre to the Goscote and Stan Ball Centre; and
   - the security of cash held.

3. Some areas for improvement have, however, been identified including;
   - developing a team plan;
   - undertaking benchmarking with other local authorities and similar organisations;
   - budget monitoring;
   - completing the closedown procedure checklist;
   - reviewing banking controls;
   - ensuring that service user files are up to date and include all relevant documentation; and
   - the documentation of day to day administration procedures.

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

5. The 9 agreed actions which remain applicable from the last audit were confirmed as implemented by the service co-ordinator on 12 June 2007. Of these, 5 had been fully implemented at the time of this audit, the 4 unimplemented, or partially implemented, actions have been reiterated in this report, marked (*) in the action plan.

6. There are 16 high priority actions in the action plan.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, Service Strategies and Consultation		✓		
Service Performance			✓	
Corporate Performance Management			✓	
Transfer of Services and Site Closedown			✓	
Joint Working		✓		
Procurement			✓	
Income		✓		
Anti Fraud and Irregularity			✓	

D. Acknowledgements

1. Please thank the support services manager, service co-ordinator and the team, for their help and co-operation during the audit, particularly for making records available and providing suitable accommodation for the auditor.

1. Planning, Service Strategies and Consultation

AUDIT OPINION

Borderline significant assurance can be given that controls are in place to meet objectives in this area

Good practice includes:

- The service consults with service users and their representatives / carers.
- Portfolio holder objectives have been included on PIMS and are appropriately monitored.
- Consultation sessions have been held with service users and staff regarding the closure of the centre.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	***	At the time of the audit a team plan was being developed. In addition, there had been no quarterly monitoring of previous plans.	Unclear aims and objectives. Unable to measure service performance. Under performing areas may not be promptly identified and addressed. Lack of evidence of regular monitoring.	A team plan will be developed and finalised which will incorporate the targets to be met to ensure that there is effective service delivery following the transfer of services to Goscote Centre and Stan Ball Centre. Quarterly monitoring of the team plan will be undertaken to identify and address slippage / non-achievement of actions and be subject to senior officer review.	Service Co-ordinator - [redacted] Team Manager - [redacted] September 2011
1.2	**	There is not a centralised, formal log of all complaints within the service area.	Complaints are not promptly dealt with.	A centralised formal log of complaints will be maintained at individual sites, together with actions taken to address these.	Service Co-ordinator - [redacted] Team Manager - [redacted] July 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.3	**	Although service users were consulted in preparation for the transfer of pinfold day care centre, procedures regarding the consultation process have not been formally documented.	In the absence of key officers, other staff may not be aware of duties / responsibilities in relation to service user consultation.	Procedures for consultation processes will be documented, approved and followed. Thereafter, procedures will be reviewed on an annual basis and signed and dated by the completing officer.	Service Manager - [redacted] July 2011
1.4	**	While a social care and health portfolio plan has been established it is dated 2009-2010.	Strategic objectives may not be clear and therefore not achieved.	The portfolio plan has now been updated and is reflective of 2010/11.	Head of Provider Services - [redacted] Service Manager - [redacted] Implemented

2. Service Performance

AUDIT OPINION

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

Good practice includes:

- Performance indicators are discussed at management team meetings.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	***	Internal performance targets for the service have not yet been developed. These will form part of the team plan that is currently being produced.	Under performance may go un-noticed and corrective action not promptly taken?	Internal performance targets will be produced. Thereafter quarterly monitoring will be undertaken to identify and address slippage / non-achievement. Evidence will be retained to support any necessary corrective action taken.	Head of Provider Services - Service Manager - August 2011
2.2	**	Although national indicators are in place and are monitored by the support service manager, a trend analysis of data, for example analysis of data over time, has not been undertaken.	Adverse performance trends are not promptly identified and corrective action taken.	National performance indicator data will be retained and compared over 3 years or more to ensure that performance is at optimum levels.	Head of Provider Services - Service Manager - August 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.3	***	Benchmarking with similar organisations is not currently undertaken.	Good practice at other like organisations may not be identified. Inability to compare performance.	Benchmarking with other local authorities and similar organisations will be undertaken, performance compared and corrective action taken where strengths and weaknesses are identified.	Service Co-ordinator - [redacted] Senior Day Care Manager - [redacted] Senior Support Worker - [redacted] September 2011

3. Corporate Performance Management

AUDIT OPINION

Limited assurance can be given that controls are in place to meet objectives in this area.
For the financial year 2010/11 the profiled budget to February 2011 totals £403,832. Actual net expenditure, including commitments and accruals for the same period totals £392,887 an under spend of £10,945. Budget forecast reports prepared in March 2011 by the accountant for social care and inclusion indicate an under spend of £13,967 at year end. The under spend is due to vacant posts partially offset by an overspend on premises costs and a shortfall in client contributions.

Good practice includes:

- A training and development plan is maintained which includes details of all training.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	**	From a sample of 4 IPM's (now EPA's) it was found that: • in all 4 cases an IPM had not been undertaken for over 12 months. ( ) • in 1 case the form had not been signed upon completion. ( ) • in 1 case the form had not been dated by the officer at the time of signing. ( ). • in 3 cases the forms had not been dated by the manager at the time of signing. ( ) • in 1 case the full date of the previous IPM had not been recorded. ( )	Non-compliance with corporate procedures. Lack of evidence of regular employee performance assessment. In the event of query / challenge, lack of evidence of manager / employee agreement of performance assessment undertaken.	EPA's will be carried out by managers in accordance with the EPA scheme. This will ensure that staff issues and training needs are addressed and acted upon accordingly. All sections of the EPA will be fully completed and signed and dated by both the employee and manager to confirm agreement of the actions set.	Service Co-ordinator Senior Day Care Manager - Senior Support Worker - Senior Support Worker - Senior Support Worker - August 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.2	***	An equality impact assessment has not been undertaken for the closure of Pinfold Centre and transfer to the Stan Ball Centre.	Non compliance with corporate procedures. Equality issues not addressed.	An equality impact assessment will be undertaken for the closure of Pinfold Centre and transfer to the Goscote Centre and Stan Ball Centre.	Service Manager - [redacted] July 2011
3.3	***	Budget positions are monitored via a document management system on the intranet. At the time of the audit, the most recent budgetary information accessed by the service coordinator was July 2010.	Inability to monitor budget which may result in overspends. Overspends / variances are not investigated on a timely basis.	Management will monitor and review expenditure under their control to ensure that it remains within budget on a monthly basis. Qlikview has now been installed and will assist with this. (*)	Service Co-ordinator - [redacted] July 2011
3.4	*	Risk assessments are completed for tasks undertaken by service users such as personal care, manual handling and outdoor activities. Officers are currently in the process of reviewing personal files to ensure that all risk assessments are up to date.	Risk assessments may be out of date / not reflect use of changes in service / activities provided.	The review of risk assessments for service users will be completed. Updates / new risk assessments will be completed where necessary.	Senior Day Care Manager - [redacted] Senior Support Worker - [redacted] Community Support Worker - [redacted] Care Assistant - [redacted] Care Assistant - [redacted] Care Assistant - [redacted]

					September 2011
3.5	***	From a sample of 4 sickness absences selected it was found that: • on 1 occasion a return to work had not been completed within 3 days of employee return. ( ) • on 1 occasion a return to work had not been completed. ( ) • on 1 occasion the reason for not issuing a notice of concern was not documented. ( )	Non compliance with the council's sickness absence procedure.	Return to work interviews are now completed within 3 days of the employee's return to work and appropriately documented. Explanations for notices of concern not being issued for employees are now recorded on the return to work form.	Service Co-ordinator - Senior Day Care Manager - Senior Support Worker - Implemented
3.6	**	An environmental health inspection took place for the rehabilitation kitchen area within the centre and the auditor was informed that there were no major concerns. However at the time of the audit a formal report had not been published and made available.	Health and safety risks may not be promptly addressed.	The environmental health inspection report has now been obtained and remedial action taken where necessary.	Service Co-ordinator - Implemented
3.7	**	Team meetings take place on a regular basis and are minuted, however, there is no record of news and views (now core brief) having been discussed.	Lack of communication. Staff may not be aware of council issues / initiatives.	Core brief is now a regular agenda item on all team meetings.	Service Co-ordinator - Implemented

4. Transfer of Services and Site Closedown

AUDIT OPINION

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

Good practice includes:

- Consultation sessions have been held with service users and staff regarding the closure of the centre.
- A register is in place which documents all current service users attending the centre.
- A closedown procedure schedule has been completed which provides an outline of the actions and controls in place and the actions that require management attention.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	***	No evidence was provided to the auditor during the audit, that a risk assessment for the transfer of provision of service from Pinfold to the Goscote Centre and Stan Ball Centre has been undertaken.	Key risks facing the transfer of services may go unaddressed.	A risk assessment will be undertaken identifying key service risks in the transfer of services from Pinfold to the Goscote Centre and Stan Ball Centre.	Service Manager - [redacted] July 2011
4.2	***	An inventory of all equipment is in place; however, the last stock check was undertaken in May 2009.	Missing items may not be promptly identified for officers to take appropriate action.	The inventory has now been checked and updated to record all equipment currently held at the centre. The inventory was updated upon site closedown to reflect all disposals and transfers; and authorised by an appropriately senior officer.	Service Co-ordinator - [redacted] Implemented

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.3	***	A closedown procedure checklist was provided to the service coordinator by the auditor; however, this has not yet been completed.	Service user, staff and financial records are not adequately controlled during the transfer resulting in the loss of records. Assets may not be adequately controlled resulting in their loss.	The closedown procedure checklist has now been completed and signed by two officers to evidence that all records and assets have been adequately controlled and accounted for.	Service Co-ordinator - [redacted] Implemented

5. Joint Working

AUDIT OPINION

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

Good practice includes:

- Joint working has been established with a number of services, organisations and groups.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	Joint working arrangements are not documented in writing.	Desired outcomes and resource commitments may be unclear and open to dispute / challenge.	Joint working arrangements with other external organisations will be documented in writing in accordance with the partnership toolkit.	Service Co-ordinator - [redacted] September 2011
5.2	**	A record is not maintained detailing joint working and partnership activity undertaken.	Staff may not be aware of potential joint working opportunities.	A record of joint working and partnership activity undertaken will be established and updated on an ongoing basis. This will then be used as a monitoring tool and as a basis for exploring new joint working opportunities.	Service Co-ordinator - [redacted] September 2011

6. Procurement

AUDIT OPINION

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

Good practice includes:

- There is segregation of duties in raising, authorising and certifying invoices for payment

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	***	From a sample of 5 paid invoices selected it was found that : • in 1 case it took more than 15 days for an invoice to be paid. (Ledger ref - 851550) • in 4 cases the order was raised following receipt of the invoice. (Ledger ref - 870998, 876039, 842740, 851550) • in 2 cases the order and invoice amount were different. (Ledger ref - 842740, 864970) • in 1 case, the invoice total had been manually amended. (Ledger Reference, 870998)	Failure to adhere to creditor payment target. Poor supplier relationships. Non compliance with finance and contract rules 2006. Inconsistent records maintained.	Invoices are now paid within 15 days of receipt, unless contract terms state otherwise. Orders are now raised and authorised prior to receipt of the goods / invoice. (*) Where an invoice differs in value to the associated order, the reason for the variance is now investigated and corrected. Invoices are no longer manually amended. If the details are incorrect it is returned to the supplier and a correct invoice requested.	Administration Officer - [redacted] Implemented

7. Income

AUDIT OPINION

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

Good practice includes:

- Cash is held in a safe.
- Lunch records are maintained which were found to be easily reconcilable to money held and meals provided.
- A daily float record is maintained which is signed by two officers.
- Till receipts are issued to all service users who pay for a meal.
- Income recorded on daily income sheets is reconciled to the paying in slip.
- Two officers are present when lunch money is collected from clients and a receipt issued.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	***	Although paying in slips are reconciled to income collected by 2 officers, an independent member of staff does not check banking made to Oracle.	Potential for misappropriation of cash. Lack of segregation of duties.	An officer now verifies income banked to the appropriate Oracle code. This is performed by an officer independent of the banking process. Evidence of this check is now retained.	Service Co-ordinator - [redacted] Implemented
7.2	***	From a sample of 5 income and bankings records it was identified that in 3 cases the income had not been banked promptly. (28.6.10, 23.8.10, 6.9.10,).	Potential for misappropriation of cash.	Officers will ensure that income is banked on a regular weekly basis.	Service Co-ordinator - [redacted] Senior Day Care Manager - [redacted] Senior Support Worker - [redacted] Administration Officer - [redacted] July 2011

8. Anti Fraud and Irregularity

AUDIT OPINION

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

Good practice includes:

- The petty cash tin is held securely and second checked by an officer.
- An adequate segregation of duties exists for the authorisation of timesheets.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.1	***	From a sample of 5 service user files selected it was found that: • in 5 cases a review of the files had not been undertaken. ( ) • on 4 occasions a care plan was not on file. ( ) • in 2 cases the assessment review forms was not signed by the carer or manager, ( ) and in 1 case it had only been signed by the manager. ( ) • on 3 occasions an overview assessment was not held on file. ( ) • on 4 occasions a disability care plan was not held on file. ( ) • in 4 cases an initial assessment form was not held on file. ( ) • on 4 occasions an occupational therapist assessment form was	Service user file may not be up to date. Delivery of care may not be managed appropriately / effectively. Incomplete records Delivery of care is not in line with the specific service user needs and requirements.	Officers will ensure that service user files include all relevant documentation which is up to date and fully completed. Regular reviews of the files will be undertaken, evidenced, and corrective action taken as appropriate.	Senior Day Care Manager - Senior Support Worker - Community Support Worker - Care Assistant - Care Assistant - Care Assistant - September 2011

		not held on file, ( ) • in 3 cases a physiotherapist assessment was not held on file. ( ) • on 4 occasions a service user profile photo was not on file and the reason for one not being available was not recorded. ( ) • in 5 cases a pinfold assessment form was not on file. ( ) • in 1 case a contact sheet was not held on file ( ) • in 2 occasions a recent risk assessment was not on file ( ) • on 4 occasions a service agreement was not on file, ( ) • on the 1 occasion where a service agreement was on file it had not been signed by the service user / carer and manager. ( )			

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.2	***	At the time of the audit, procedures were not available for the issue of contracts to clients in receipt of day care.	In the event of a dispute /query, terms and conditions of provision may be unclear.	Procedures for the issue of contracts to clients in receipt of day care will be finalised as soon as possible. (*)	Senior Day Care Manager - Senior Support Worker - Community Support Worker - Care Assistant - Care Assistant - Care Assistant - September 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.3	***	There are no procedure for administrative tasks undertaken, such as the collection and banking of lunch money, petty cash procedures and ordering procedures.	In the absence of certain officers, other staff may not be aware of their roles and responsibilities.	All administrative procedures, including financial responsibilities will be comprehensively detailed in writing. Once completed, procedures will be issued to relevant staff who will sign for their receipt. Thereafter procedures will be reviewed on a regular basis and signed and dated by the completing officer. (*)	Senior Day Care Manager - Senior Support Worker - Service Co-ordinator - Administration Officer - September 2011