Agenda Item No. 10

Audit Committee – 12 April 2011

No or Limited Assurance Internal Audit Reports

Summary of report:

This report presents audit reports which have been provided with a ‘no’ or ‘limited’ assurance opinion that have been finalised between 4 November 2010 and 8 March 2011.

Background papers:

Internal audit reports/files/working papers.

Recommendation:

1. To scrutinise the contents of the reports and obtain assurances from relevant managers that actions within the action plan of this report have been implemented; and that improvements have been delivered.

James Walsh – Assistant Director Finance
25 March 2011

No and Limited Assurance Opinion

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

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

Between 4 November 2010 and 8 March 2011, the following reports have been finalised with a 'limited' assurance rating:

- Transition and Leaving Care
- CCTV / Surveillance
- Social Care & Inclusion Transport Services
- Broadway North Centre
- Home Care Establishment
- Lower Farm JMI Admin Block Final Account

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

One of the reports above relates to contract final accounts. This account has been described by property services as one of the 'legacy accounts', that is, final accounts submitted for audit some while after their projects had been completed. For example, tenders for these accounts were received between 2 and 5 years ago.

An audit review of property services' current systems was recently finalised which gave an overall significant assurance opinion rating. Although there are a number of improvement actions identified in this report the audit showed that there has been good progress in implementing controls in the areas of common failure identified in the above final accounts, including:

- procurement under appropriate authority;
- completion of formal contracts;
- proper supervision and monitoring; and
- creation of completion reports to senior managers.

New contract rules do not require final accounts to be audited. Internal audit's future approach will be to carry out systems reviews of property services current procedures rather than examine historic final accounts.

No audit reports have been issued between 4 November 2010 and 8 March 2011 with a 'no' assurance rating.

SUMMARY OF LIMITED AND NO ASSURANCE AUDIT REPORTS

Transition and Leaving Care

An audit review of transition and leaving care was undertaken as part of the annual audit plan. Transition and leaving care provide support to children aged between 16-21; and up to the age of 24 if in a planned programme of education, who have been in care including:

- housing, advice and assistance;
- help to young people who want to return to education;
- support in finding employment and training;
- encouragement to participate in leisure activities and living a healthy lifestyle; and

- advice on accessing specialist groups, including mental health, drug and alcohol dependency support.

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
- 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.
- key controls are in place to guard against fraud and irregularity;
- the provision for the service is in accordance with qualification guidelines;
- pathway / personal education plans are appropriately managed;
- all claims and payments are made in accordance with the council's financial and contract rules and any statutory/official guidelines; and
- the care leavers' bank account is appropriately managed and regularly reconciled

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

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

Some good practices were noted during the audit, including;
- the corporate parenting strategy which is reviewed on a quarterly basis;
- joint working with a number of organisations, including; Walsall College, Walsall Adult & Community College, Links to Work and complimentary therapists; and
- quarterly national indicator data being collated and reported to the performance board.

A number of areas for improvement have, however, been identified, including:
- the tightening of controls surrounding cash handling and banking processes;
- ensuring receipts are available to support allowances paid;
- the completion of a business continuity plan;
- ensuring young person's files are kept up to date;
- ensuring an adequate segregation of duties is maintained; and
- pathway plan reviews are undertaken in line with agreed timescales.

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

A total of 41 actions for improvement were identified as part of the review with 24 being at high priority.

11 of the agreed actions were confirmed as implemented within the audit report action plan. An internal audit follow up memo is due to be sent out in May 2011 for the remainder.

CCTV / Surveillance

An audit review of the surveillance unit (CCTV and surveillance) was undertaken as part of the annual audit plan. The surveillance unit is part of the Safer Walsall Partnership.

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
- 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 grants and that from fees and charges, is appropriately accounted for and recovered;
- staffing, including time recording, is appropriately administered; and
- key controls are in place to guard against fraud and irregularity.

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

Internal audit is able to give a limited assurance opinion on the system of internal control operating within the surveillance unit.

Most areas reviewed required significant improvement. Controls regarding service performance and the service's adherence to corporate policies and procedures, joint working, procurement, income; and anti fraud and corruption measures all require attention. The prompt implementation of actions contained within the action plan, together with the commitment of the new management structure will assist in restoring the control environment.

A total of 43 actions for improvement were identified as part of the review with 32 being at high priority.

39 of the agreed actions were confirmed as implemented within the audit report action plan. An internal audit follow up memo is due to be sent out in April 2011 for the remainder.

Social Care & Inclusion Transport Services

An audit review of social care and inclusion transport services (including transport services reconfiguration) was undertaken during February and March 2010 as part of the annual audit plan.

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

- adequate planning, service strategies and customer consultation are in place;
- the process for reconfiguration of adult transport services has been effectively managed and progress against any actions arising are being robustly monitored;
- the selection of contractor/s is in accordance with financial and contract rules;
- payment mechanism controls to the contractor/s are robust;
- contract performance is monitored and managed;
- contract quality and monitoring procedures are in place;
- effective management information and budgetary control exists;
- there are policies and procedures in place for the charging of service users for transport provision and charges are made in accordance with these;
- joint working with partners and other council services is effective;
- key controls are in place to guard against fraud and irregularity; and
- previously agreed audit report actions have been fully implemented.

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

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

Some good practices were noted during the review, including:
- the introduction of the new electronic ‘swipe card’ facility which seeks to address weaknesses in the previously fallible charging mechanism;
- adult services within social care & inclusion are in the process of reviewing the way in which transportation services are delivered as part of their transport services reconfiguration exercise.
- social care & inclusion (the commissioner) has an embedded working relationship with fleet services (the provider); and
- social care & inclusion undertake a user survey every two years to elicit views and identify areas of potential improvement.

Some areas of improvement have, however, been identified including:
- the need to strategically map social care & inclusion directorate’s aims and objectives in respect of service user transportation;
- ensuring that the current split between the internal and external sourced transport services provided, are formally documented to increase the levels of transparency across transport services;

- undertaking urgent remedial action to recover progress on the adult services transportation reconfiguration exercise being undertaken and also ensuring that the project is properly risk assessed;
- ensuring that debts in relation to the council's previous charging policy which had to be suspended, are recovered or written off as appropriate and that a 'lessons learned' exercise be undertaken to ensure that similar issues do not occur in future; and
- implementing a consistent and robust management information framework to assist managers in both strategic and operational decision making.

A total of 17 actions for improvement were identified as part of the review with 7 being at high priority.

Responses to an internal audit follow up memo were received from the head of joint commissioning on 10 March 2011, who confirmed that 12 of the 17 agreed actions had been fully implemented. A further follow up memo is due to be sent out in October 2011.

Broadway North Centre

An audit review of Broadway North Centre was undertaken as part of the annual audit plan. The Broadway North Centre provides a secure environment to adults between the age of 18-65 with diagnosed mental health conditions and is made up of two services:

- a day centre providing a range of activities including, literacy and numeracy, art, catering, tai-chi, IT and complimentary therapy's; and
- a residential unit which provides respite and crisis accommodation on a 24 hour basis.

Walsall mental health services are jointly commissioned by Walsall Council and Walsall Teaching Primary Care Trust and jointly provided by Walsall Council and Dudley and Walsall Mental Health Partnership NHS Trust.

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
- 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.

- key controls are in place to guard against fraud and irregularity;
- the provision for the service is in accordance with qualification guidelines;
- client contributions / board & lodge payments are made in accordance with the authority's scale of charges and are appropriately recorded;
- residents' property, savings and personal allowances are appropriately administered and records maintained;
- residents' admissions / discharge records are up to date;
- any income from lunches / visitors is appropriately recorded and reconciled; and
- an inventory is maintained in accordance with financial and contract rules.

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

Internal audit is able to give a limited assurance opinion on the system of internal control operating within Broadway North Centre.

Some good practices were noted during the audit, including:
- joint working with a number of organisations;
- annual review and approval of the short stay residential care charge;
- monthly team meetings; and
- regular health and safety checks.

A number of areas for improvement have been identified, including:
- the tightening of controls surrounding petty cash and lunch monies collection; and banking processes;
- the documentation of all day to day administration procedures;
- review and update of the eligibility criteria;
- the completion of an annual inventory check and the review of inventory records on a regular basis; and
- ensuring an adequate segregation of duties is maintained.

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

A total of 43 actions for improvement were identified as part of the review with 26 being at high priority.

Responses to an internal audit follow up memo were received from the vocational services manager on 4 March 2011, who confirmed that 25 of the 43 agreed actions had been fully implemented. A further follow up memo is due to be sent out in May 2011.

<u>Home Care Establishment</u>

An audit review of homecare establishment was undertaken as part of the annual audit plan. The in-house homecare service provides personal care and domestic services to vulnerable adults in Walsall to help them to be as independent as possible. Care is provided 24 hours a day, 7 days a week. The homecare establishment service is split into three teams which are based at Tameway Tower, Bentley and Rushall.

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
- 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;
- all client referrals are dealt with effectively;
- delivery of care is appropriately recorded, monitored and managed;
- fees and charges are accurately applied and regular debtor monitoring is undertaken; and
- key controls are in place to guard against fraud and irregularity.

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

Internal audit is able to give a limited assurance opinion on the system of internal control operating within homecare establishment.

Some good practices were noted during the audit, including; 6 monthly training and development reviews; up to date health and safety standards; quarterly monitoring of joint working arrangements; procedures for client referrals; spot checking of care delivered; and weekly management reports detailing referrals received, homecare provided and available capacity.

Some areas for improvement have, however, been identified including ensuring that the team plan is finalised; that performance management and procedures for administering the delivery of care are strengthened; and that fees and charges processing is more robust, including debt monitoring. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

A total of 23 actions for improvement were identified as part of the review with 14 being at high priority.

14 of the agreed actions were confirmed as implemented within the audit report action plan. An internal audit follow up memo is due to be sent out in May 2011 for the remainder.

Lower Farm JMI Admin Black Final Account

An audit review of the contractor’s final account for the Lower Farm School admin block was undertaken during July 2010 as part of the annual audit plan. The examination was performed in accordance with the requirements of the council’s former financial and contract rule 15.3 (b) which requires:

- The contractor’s final account shall be made available to the Chief Internal Auditor wherever the contract’s value is £150,000 or more along with details relating to obtaining authority, planning, tendering, award, operation and payments relating to the project.

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:

- Contractors and consultants have been chosen and appointed in accordance with the council’s requirements for a contract of this value,
- All appropriate documentation has been obtained from the contractor and a suitable contract created,
- The works have been controlled in accordance with contract’s requirements and the council’s financial and contract rules, and
- All charges by and payments pertaining to the works are shown in the contractor’s accurate and timely final account.

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

Internal audit is able to give a limited assurance opinion on the system of internal control operating within the contractor’s final account for the Lower Farm School - admin block.

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

- A capital finance report included funding for this project.
- The tender list was obtained from the appropriate section of the council’s unified standing list of contractors.
- A tender return form (TRF) was used to control the tendering exercise.
- A portfolio holder opened the tenders.
- Tenders were evaluated.
- A letter of appointment was sent to the firm whose tender was accepted.
- Letters were sent to unsuccessful firms.
- The contractor provided evidence of insurance.
- The contractor agreed that the council could revoke the contract in case of fraud and corruption.
- Health and safety, and equalities documentation were provided.
- The form 10 was completed and sent to the Health and Safety Executive.
- Regular site meetings were chaired by the architect and monitored the project’s progress.
- Architect’s instructions were written and delivered to the contractor.
- The architect certified an extension of time following the contractor’s request.
- Practical completion and making good of defects were certified.
- The contractor produced a final account for the project.
- Certificates show appropriate payments to the contractor.

A number of areas for improvement were identified;

- A director's authority was not obtained prior to this project being procured.
- A service manager accepted the tender.
- There is no evidence that a surety was provided.
- There is no evidence that the contract has been recorded in a register.
- The architect only priced two of his eleven instructions to the contractor.
- The architect's final instruction to the contractor was written on 3 March 2010; almost six years after the works had achieved practical completion.
- The contractor's request for an extension of time was granted some five years after the project achieved practical completion.
- The architect certified the making good of defects some four months after the date set in the contract.
- A valuation made on 20 June 2004 was not paid until 5 January 2005.
- No documentation has been provided to evidence values shown in the contractor's final account.
- There is no evidence that the council agreed the proposed final contract sum.
- The final account was presented for audit examination some eighteen months after the contractor prepared it.

A total of 12 actions for improvement were identified as part of the review with 8 being at high priority.

All actions were confirmed as implemented within the final audit report action plan.

Resource and legal considerations:

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

Citizen impact:

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

Performance and risk management issues:

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

Equality Implications:

None arising from this report.

Consultation:

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

Author:

Rebecca Neill
Head of Internal Audit
☎ 01922 652831
✉ neillr@walsall.gov.uk

Appendix 1

Walsall Council
Internal Audit Service

Transition and Leaving Care

Audit Report 2010 / 2011
February 2011

CONTENTS

EXECUTIVE SUMMARY

A. Introduction

B. Overall audit opinion

C. Summary of findings

D. Acknowledgements

AUDIT OPINION & ACTION PLAN

1. Planning, Services Strategies and Customer Consultation
2. Service Performance
3. Corporate Performance Management
4. Joint Working
5. Procurement
6. Anti Fraud and Irregularity
7. Entitlement to Service Provision
8. Pathway Plans
9. Financial Assistance
10. Care Leavers' Bank Account
11. Setting up Home Grant

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of transition and leaving care was undertaken as part of the annual audit plan. Transition and leaving care provide support to children aged between 16-21; and up to the age of 24 if in a planned programme of education, who have been in care including:

- housing, advice and assistance;
- help to young people who want to return to education;
- support in finding employment and training;
- encouragement to participate in leisure activities and living a healthy lifestyle; and
- advice on accessing specialist groups, including mental health, drug and alcohol dependency support.

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
- 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.
- key controls are in place to guard against fraud and irregularity;
- the provision for the service is in accordance with qualification guidelines;
- pathway / personal education plans are appropriately managed;
- all claims and payments are made in accordance with the council's financial and contract rules and any statutory/official guidelines; and
- the care leavers' bank account is appropriately managed and regularly reconciled

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 transition and leaving care as described below:

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

2. Some good practices were noted during the audit, including;
   - the corporate parenting strategy which is reviewed on a quarterly basis;
   - joint working with a number of organisations, including; Walsall College, Walsall Adult & Community College, Links to Work and complimentary therapists; and
   - quarterly national indicator data being collated and reported to the performance board.

3. A number of areas for improvement have, however, been identified, including:
   - the tightening of controls surrounding cash handling and banking processes;
   - ensuring receipts are available to support allowances paid;
   - the completion of a business continuity plan;
   - ensuring young person's files are kept up to date;
   - ensuring an adequate segregation of duties is maintained; and
   - pathway plan reviews are undertaken in line with agreed timescales.

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

5. The 15 agreed actions which remain applicable from the 2005/06 planned audit were confirmed as implemented by the service manager on 20 November 2006. Of these, 6 had been fully implemented at the time of this audit. The 9 unimplemented, or partially implemented actions have been reiterated in this report, marked (*) in the action plan.

6. The 27 agreed actions which remain applicable from the 2008/09 special investigation audit were confirmed as implemented by the service manager on 19 August 2009. Of these, 14 had been fully implemented at the time of this audit. The 13 unimplemented, or partially implemented actions have been reiterated in this report, marked (*) in the action plan.

7. Most actions within the report were considered to be of a high priority.

C. <u>Summary of Findings</u>

	Full Assurance	**Significant Assurance**	**Limited Assurance**	**No Assurance**
Planning, Service Strategies and Consultation		✓		
Service Performance		✓		
Corporate Performance Management			✓	
Joint Working		✓		
Procurement			✓	
Anti-Fraud and Irregularity			✓	
Entitlement to Service Provision			✓	
Pathway Plans			✓	
Financial Assistance			✓	
Care Leavers' Bank Account			✓	
Setting up Home Grant			✓	

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, Service Strategies and Consultation

AUDIT OPINION

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

Good practice includes:

- The corporate parenting strategy is reviewed on a quarterly basis.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	**	The 2010/11 team plan is in the process of being finalised.	Non-achievement of targets. Restricted time available in which to achieve the plan.	The team plan has been finalised and is monitored on a quarterly basis, with appropriate corrective action taken for the non-achievement of actions. (*)	Operations Manager Implemented
1.2	**	Through review of the transition and leaving section of the corporate parenting strategy it was identified that not all sections had been fully completed.	Officers may not be aware of their roles and responsibilities.	All sections of the transition and leaving care section of the corporate parenting strategy have now been completed.	Operations Manager Implemented

2. Service Performance

AUDIT OPINION

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

Good practice includes:

- Quarterly national indicator data is collated and reported to the performance board.
- National indicator data is collated on a quarterly basis to summarise Walsall's performance against that of all other West Midlands local authorities.
- A key decisions document is produced by the information analyst following quarterly performance board meetings.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	*	A comparative costing exercise with similar service providers has not been undertaken.	Unable to demonstrate performance against similar organisations.	Management will, where possible, compare costs of the service with those of similar service providers/organisations to ensure the centre is operating at optimum cost efficiency. (*)	Operations Manager 30 April 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 October 2010 totals £685,404. Actual net expenditure for the same period totals £609,228, an under spend of £76,176. Current budget forecast reports prepared by the senior accountant for specialist services indicate an under spend of £16,695 at year end due to a combination of small savings mainly on payments to young people.

Good practice includes:

- Quarterly health and safety committee meetings take place to review current safety management standards in place.
- Team meetings take place on a monthly basis and are minuted.
- The service accountant provides the operational manager with monthly budget monitoring information.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	***	From a sample of 3 sickness absences selected, it was found: • In 2 cases a return to work form had not been completed. (██, ██) • In 3 cases the reason for not issuing a notice of concern was not documented. (██,██, ██).	Non-compliance with the council's sickness management procedures. .	Return to work interviews are now completed within 3 days of the employee's return to work where possible and the appropriate form completed and signed by the employee and manager. Explanations for notices of concern not being issued to employees are now recorded on the return to work form.	Operations Manager Implemented
3.2	***	A business continuity plan is not in place.	Inability to demonstrate that appropriate action in the event of an emergency/ interrupted function will be undertaken.	A business continuity plan will be documented, approved and followed. Thereafter, the plan will be reviewed on an annual basis and signed and dated by the completing officer.	Operations Manager 30 April 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.3	**	The transition and leaving care risk assessment is not in the current corporate format.	Non-compliance with corporate procedures. Out of date records.	The transition and leaving care risk assessment will be incorporated into the current corporate template.	Operations Manager 28 February 2011
3.4	**	The directorate health and safety committee terms of reference has not been updated to reflect manual changes made and is not dated. Further, the lone working arrangement document does not include the date of completion.	Unclear roles and responsibilities. Incomplete / unauthorised documents. Unable to identify review dates.	The directorate health and safety committee terms of reference has been updated and will be approved by the children's service health and safety board. Lone working arrangements will include the date of completion.	Operations Manager 30 April 2011 31 March 2011
3.5	***	From a sample of 4 IPM's selected, it was found: • In 1 case an IPM had not been signed and dated by the employee and manager. (█) • In 2 cases the dates of the current and previous IPM had not been fully completed on the front sheet. (█, █) • In 1 case an IPM form was not available to evidence an IPM completed in January 2010. (█) • In 1 case an officer had never received an IPM. (█)	Non-compliance with corporate procedures. Incomplete records. Service aims and objectives may not be achieved. Unable to identify IPM dates.	All sections of the IPM (now EPA) will be fully completed and signed and dated by both the officer and manager on a timely basis to confirm agreement of the actions set. IPM's (now EPA) will be carried out in accordance with the EPA scheme. This will ensure that staff issues and training needs are addressed and acted upon accordingly.	Operations Manager 31 March 2011

4. Joint Working

AUDIT OPINION

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

Good practice includes:

- The service undertakes joint working with a number of organisations, including; Walsall College, Walsall Adult & Community College, Links to Work and complimentary therapists.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	***	Joint working arrangements including those with the multi disciplinary group and NEAT (Not in Employment and Training) group are not documented in writing.	Desired outcomes and resource commitments are unclear and open to dispute.	It is a statutory obligation that the service undertakes joint working with external organisations and agencies. Consideration will be given to documenting partnership agreements with external organisations in writing in accordance with the partnership toolkit.	Operations Manager Head of Service Vulnerable Children 30 April 2011
4.2	**	A periodic review of joint working arrangements is not formally undertaken. Instead, joint working arrangements are discussed with the relevant representing officers during monthly supervision meetings.	Service delivery may not be effective because new opportunities for joint working are not considered or adequately managed.	It is a statutory obligation that the service undertakes joint working with external organisations and agencies. Consideration will be given to undertaking a formal periodic review of joint working arrangements.	Operations Manager Head of Service Vulnerable Children 30 April 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.3	**	The operational manager or team manager was not aware of the partnership toolkit.	Non-compliance with corporate procedures. Lack of awareness of partnership arrangements.	The operational manager and team manager will familiarise themselves with the partnership toolkit to enable partnership opportunities to be administered in accordance with the council's toolkit.	Operations Manager Head of Service Vulnerable Children 31 March 2011

5. Procurement

AUDIT OPINION

Limited 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
5.1	***	From a sample of 10 invoices selected, it was found: • In 8 cases the same officer authorised the order and invoice. (Ledger ref – 864008, 892394, 892874, 873174, 878752, 884481, 852655, 898543) • In 7 cases it took more than 15 days for an invoice to be paid. (Ledger ref – 892394, 892874, 873174, 878752, 852655, 896450, 898543) • In 1 case an order value was different to the invoiced amount. (Ledger ref – 896450) • In 6 cases a requisition was raised following receipt of the invoice. (Ledger ref – 892394, 892874, 873174, 878752, 884481, 898543) • In 1 case the payment date recorded on Oracle (27/05/10) differed to the date paid stamp on the invoice. (15/05/09). (Ledger ref – 864008)	Inadequate segregation of duties. Failure to adhere to creditor payment target. Poor supplier relationships. Inaccurate records maintained. Unauthorised expenditure commitments.	To maintain segregation of duties, officers authorising orders will be independent of the officer authorising invoices. Consideration will be given to increasing the authorisation limit for the transition and leaving care team leader. Invoices will be paid within 15 days of receipt, unless contract terms state otherwise. It will be ensured that order values agree to invoice amounts and corrective action is taken where the values differ. Requisitions will be raised prior to receipt of the goods/invoice. Spend vision will address the agreed actions above. Care will be taken to ensure that the correct paid date is stamped on invoices.	Operations Manager 31 March 2011 Administration Team Manager 31 March 2011 Payable Development Manager 31 January 2011

6. 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:

- Keys to the safe are held by the 2 administration officers at all times and removed from the premises over night.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	***	Through review of petty cash it was found that: • the physical amount of petty cash held in the petty cash tin did not agree with the balance recorded in the petty cash reclaim book. (£12.62 difference). • a surplus of £25.71 was identified when performing the petty cash imprest reconciliation.	Failure to reconcile the imprest. Accounting records may be inaccurate / up to date.	The reason for the petty cash discrepancies has now been resolved.	Administration Team Manager Implemented
6.2	**	From examination of 5 petty cash vouchers it was found that: • In 1 case a petty cash voucher had not been fully completed. (voucher date - 07/07/10) • a non current petty cash voucher was being used. • In 1 case a petty cash reimbursement was made for car parking. (voucher no 2265).	Incomplete records maintained. Corresponding tax / NI deductions may not be correctly made. All relevant information may not be provided.	All sections of the petty cash voucher are now completed. The most current petty cash voucher pro-forma has now been obtained and used by all officers. Claims for car parking claims are now made through the payroll not petty cash.	Administration Team Manager Implemented Operations Manager Implemented

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.3	**	The inventory is updated on an annual basis to record acquisitions and disposals. There was no evidence within the inventory that an annual check had been undertaken.	Possible lack of accountability of assets. Missing items may not be promptly identified for officers to take appropriate action.	The inventory is now updated immediately after any disposals An annual inventory check is now undertaken and evidence detailed within the inventory. (*)	Administration Team Manager Implemented
6.4	**	From examination of 8 financial administration and support procedure notes it was found that: • 6 had not been updated since January 2006. (Ref - care leavers bank account reimbursement, care leavers cheque payment run, care leavers new client set up, care leavers single/additional payments, care leavers standard payments, care leavers unused) • 2 had not been signed and dated by the completing and reviewing officers. (Ref - care leavers guidance note, care leavers database maintenance) From a sample of 5 administration procedures selected it was found that none had been signed and dated by the completing and reviewing officers. (Ref – duty working practice, petty cash, WSS80 money, expenses form, personal allowance).	Out of date procedures. In the event of query, the preparing officer may not be identifiable. Officers may be unable to conclude whether procedures are current/in date.	All written procedures will be reviewed on a regular basis. The reviewing officer will then sign and date the procedure notes to evidence that a review has been completed. (*)	Senior Financial Admin & Support Officer (SC) 31 May 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.5	***	The council's insurance limit for the safe is £1,000, however, it was noted that this is exceeded on a regular basis.	In the event of theft/fire, safe contents may not be adequately insured.	Discussions will be undertaken with the authority's insurance section with a view to increasing the safe limit. (*) In the interim, care will be taken to ensure the safe limit of £1,000 is not exceeded. (*)	Operations Manager Administration Team Manager 31 March 2011
6.6	**	The income log book used to record all allowances and setting up home grant is held on a shelf in the administration office.	Records may become lost / misplaced. Records may be manually amended / tampered with.	The income log book is now held in the safe. Consideration will be given to recording the income log book in an electronic format with access restricted to designated officers. (*)	Operations Manager Implemented 31 March 2011
6.7	***	Cash held in the safe is not checked when responsibility for safe contents is handed over. A safe contents register is not in place. A regular check of cash held in the safe to the supporting records is not undertaken.	Potential for misappropriation of cash.	All cash held in the safe is now checked when responsibility for safe contents is handed over. Additionally, when checked, all safe contents are now verified by two officers who both sign the corresponding record sheet in evidence of this. (*) A safe contents register is now maintained which includes all money held in the safe. (*) A check will be made by 2 officers, at least weekly, to verify that cash held in the safe agrees to the supporting records including a safe contents sheet. Both officers will sign to evidence the check. (*)	Operations Manager Administration Team Manager Implemented Administration Team Manager 28 February 2011

6.8	***	Security codes to safes, doors with key pad locks and alarms are not changed on a regular basis. Further, the administration office does not have a lock.	Loss / theft of data.	Security codes to safes, doors with key pad locks and alarms will be changed on a regular basis, ideally following the departure of members of staff. (*) Advice will be gained from the safety, health & wellbeing agency (SHAW) to seek a suitable solution to enable the administration office to be security protected and locked when not in use. (*)	Operations Manager 28 February 2011

7. Entitlement to Service Provision

AUDIT OPINION

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

Good practice includes:

- The eligibility criteria is set in line with leaving care act legislation.
- Advice is gained from legal services where there is any doubt that a young person may not meet the eligibility criteria.
- Where a young person's behaviour towards a team member becomes unacceptable a warning letter is issued by the operational manager.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	***	From a sample of 10 young people selected, it was found: • In 1 case there was no evidence available on file to support an assessment of the young person prior to placement. (Ref – ███)	Incomplete records maintained. Risks may not have been identified and managed.	It is now ensured that all young people are are assessed prior to placement.	Operations Manager Implemented

8. Pathway Plans

AUDIT OPINION

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

Good practice includes:

- Pathway plans are reviewed in conjunction with all relevant officers involved in the case and any decisions made agreed by the young person prior to being added to the plan.
- A pathway plan is completed jointly by the social worker and personal advisor when a young person is 16 years and 3 months.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
8.1	***	From a sample of 10 pathway plans selected, it was found: • In 5 cases it took more than 25 days for the pathway plan to be authorised. (Ref – ██, ██, ██, ██, ██) • In 1 case a pathway plan had not been fully completed. (Ref – BW) • In 6 cases a review date had not been recorded on PARIS. (Ref – ██, ██, ██, ██, ██, ██)	Pathway plan targets may not be achieved on a timely basis. Incomplete records maintained. Lack of audit trail. Plans may not remain reflective of service user needs	Pathway plans are now fully completed, authorised promptly and held on file. The pathway plan review date is now recorded on PARIS to ensure all information is fully recorded and available. (*)	Operations Manager Implemented

9. Financial Assistance

AUDIT OPINION

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

Good practice includes:

- All financial requests are discussed at weekly finance meetings and decisions whether to accept or reject the request are recorded.
- The operational manager undertakes a monthly check of files to ensure they are fully complete and regularly reviewed by social worker. Any exceptions are discussed with the relevant social workers during their monthly supervision.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
9.1	***	From a sample of 10 personal allowances selected it was found: • In 1 case a cheque for a personal allowance had been made payable to the wrong young person. (Ref – █) • In 2 cases allowances paid were not listed as eligible spend in the finance policy. (Ref – prison) • In 7 cases allowance payment details had not been recorded on PARIS. (Ref – █, █, █, █, █, █, █) • In 8 cases there were no receipts available on PARIS to support expenditure. (Ref – █, █, █, █, █, █, █, █) • In 1 case a personal allowance totalling £311.10 was repaid into the care leavers' bank account, however, there was no supporting documentation or	Payments made to incorrect recipient. Ineligible payments made. Incomplete records. Lack of audit trail. Lack of accountability.	Care is now taken to ensure cheques are raised for the correct young person. The transition and leaving care finance policy will be updated to include prison allowance. It is now ensured that all allowance payment details and receipts are recorded on the young person's PARIS file. All personal allowance repayments are now supported by appropriate documentation and authorised prior to re-banking.	Senior Financial Admin & Support Officer (SC) Implemented Operations Manager 28 February 2011 Administration Team Manager Implemented

		authorisation for the repayment. (Ref – [redacted]) • In 1 case a note was recorded on PARIS that an interpreter would be required but no further details were documented regarding dates and costs. (Ref – [redacted])			
9.2	***	From a sample of 24 emergency fund payments it was found: • In 9 cases a client transaction record did not appear to have been completed. (Ref – [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted]) • In 2 cases the client transaction record was not signed by the officer handing over the cash. (Ref – [redacted], [redacted]) • In 1 case the amount was not recorded on the client transaction record. (Ref – [redacted]) • In 5 cases the payment had not been recorded on the care leavers' database.(Ref – [redacted], [redacted], [redacted], [redacted], [redacted]) • In 3 cases the WSS80 or client transaction record could not be located to support payments that had been made. In 2 of these cases the amount paid out was signed as witnessed by 2 officers. (Ref – [redacted], [redacted], [redacted]) • In 4 cases the payment date required had not been recorded on the WSS80. (Ref – [redacted], [redacted], [redacted], [redacted])	Lack of accountability. Potential for the misappropriation of money. Unauthorised payments made. Inadequate protection of staff. Incomplete records. Errors/omissions or theft may go undetected	It will be ensured that WSS80'S and client transaction records are completed, signed and held securely for all emergency fund payments made. Regular checks are now undertaken to ensure that all client transaction forms are accounted for. (*) Client transaction records are now fully completed. All emergency payments are now recorded on the care leavers' database. WSS80's will be completed in full and appropriately authorised for all emergency payments. All financial transactions will be witnessed by two officers. Both officers will sign the corresponding entries in the income log book and verify that balance have been	Operations Manager 28 February 2011 Administration Team Manager Implemented Senior Financial Admin & Support Officer (SC) Implemented Operations Manager 31 January 2011 Administration Team Manager 31 January 2011

		• In 8 cases a WSS80 form had not been completed. (Ref – █, █, █, █, █, █, █, █) • In 1 case an amount paid out was not witnessed by another officer. (Ref – █) • in 19 cases the emergency fund allowance had not been deducted from the young person's personal allowance the following weeks. • Young people are not requested to provide receipts to support expenditure.		calculated correctly. (*) The decision to deduct an emergency payment from the young persons allowance for the following week is made at the discretion of the personal advisor/social worker. Therefore, the transition and leaving care finance policy will be updated to reflect this. Wherever possible clients will be requested to provide receipts to support expenditure incurred. (*) Consideration will be given to reviewing the current arrangements.	Operations Manager 28 February 2011 Operations Manager 28 February 2011
9.3	***	Through examination of the emergency fund book for the period 08/03/10 to 01/07/10 it was found: • In 1 case the name of the young person receiving the cash was not recorded and the transaction had not been witnessed by a second officer. (Ref – 07/05/10) • In 2 cases the emergency fund book was not signed by the administration officer or social worker to confirm the amount paid out. (Ref – █ 30/04/10, █ 09/06/10 • In 4 cases the emergency fund book had only been signed by the administration officer. (Ref – █ 08/06/10, █ 26/03/10, █ 01/04/10, █ 01/04/10)	Incomplete records. Inadequate protection of staff. Inaccurate records maintained. Errors/omissions or theft may go undetected	Care will be taken to ensure the emergency fund book is fully completed including the recording of amounts 'paid out' and 'paid back' in the correct columns. Two officers will be involved in witnessing payments made into and from the emergency fund and sign and date to evidence the transfer. (*) A review of the emergency fund system will be undertaken as a matter of urgency to ensure robust controls are introduced to eliminate any further errors.	Administration Team Manager 28 February 2011 Administration Team Manager 28 February 2011

		• In 2 cases the amounts returned had been recorded in the 'paid out' column. (Ref – both cases 22/04/10) • In 1 case the officer had witnessed their own transaction. ([redacted] 24/06/10) • Cash paid into the fund is not signed by 2 officers, the administration officer signs both the 'admin' and 'social worker' sections. However, in 3 cases cash paid in was not signed by the administration officer. (Ref – [redacted] 29/04/10, [redacted] 29/04/10, [redacted] 29/04/10)			

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
9.4	***	Through review of the activities fund for the period: 07/08/09-02/06/10, it was found that: • The fund had not been checked since 07/01/10. • The running total had not been recorded for the period 07/08/09 – 29/10/09. • In 5 cases the transaction had not been witnessed by a second officer. (Ref – 07/08/09 (x2), 14/08/09, 29/04/10, 02/06/10) • In 1 case the activity relating to an amount paid out was not recorded. (Ref – 02/06/10) • In 2 cases the client transaction number was not recorded. (Ref – 29/04/10, 02/06/10) • The activity fund monies held at the time of the audit did not agree with the balance recorded in the activities fund book. A surplus of £11.84 was identified.	Potential for misappropriation of cash. Errors/omissions or theft may go undetected. Incomplete records. Lack of audit trail. Inadequate protection of staff.	A review of the activities fund system will be undertaken as a matter of urgency to ensure robust controls are introduced to eliminate any further errors. The reason for the activities fund cash discrepancy will be investigated and rectified as a matter of urgency. (*)	Administration Team Manager Operations Manager 30 June 2011 Administration Team Manager 28 February 2011
9.5	***	From a sample 5 activity fund payments selected it was found: • In 3 cases receipts were not available as evidence of spend. (Ref – sport 07/08/09, activity money 07/06/10, go karting 27/08/09) • In 2 cases the amount of monies paid back into the activities fund had not been recorded on the	Potential for misappropriation of cash. Incomplete / inaccurate records maintained.	Till receipts will be obtained to support all expenditure from the activity fund and held securely. (*) A review of the activities fund system will be undertaken as a matter of urgency to	Administration Team Manager Operations Manager 31 January 2011 Administration Team Manager

		client transaction record. (Ref – sport 07/08/09, activity money 07/06/10) • In 1 case an amount to be paid out of the client transaction record had been amended from £70 to £63. The amendment had not been initialled. The amount recorded in the activities fund book was £70.(Ref – sport 07/08/09)		ensure robust controls are introduced to eliminate any further errors. Investigations will be undertaken for the case identified to ensure that the £70 has been fully accounted for.	Operations Manager 30 June 2011 28 February 2011
9.6	**	Spot checks are made at weekly finance meetings to compare authorised financial requests to receipts to ensure evidence of spend is available and items purchased are in accordance those detailed on the WSS80, however, this check is not documented.	Lack of audit trail. Unable to demonstrate regular monitoring.	Spot checks undertaken of authorised financial requests and receipts will be documented in writing.	Operations Manager 31 January 2011
9.7	**	The "personal allowance rates recommendations and rationale" briefing note does not include an approval section	Unauthorised payments may be paid. Rates may be set too high / low.	The "personal allowance rates recommendations and rationale" briefing note will be updated to include an approvals section to verify it has been authorised by a senior officer.	Operations Manager 28 February 2011
9.8	**	The procedure to be followed when deficits are noted in the income log book and actions to be taken is not documented.	In the absence of certain officers, other may be unaware of the processes to be followed.	The procedure for identifying, reporting and resolving income log book deficits will be located and issued to administration staff. (*)	Administration Team Manager 31 January 2011

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
9.9	**	Stock records of pre-numbered client transaction record sheets are not maintained.	Potential for the misappropriation of controlled stationery / cash	A stock record of client transaction record sheets will be maintained. This record will detail both incoming and outgoing stock together with a running balance. (*)	Administration Team Manager 31 March 2011
9.10	***	It was noted on the team meeting minutes of 1 July 2010 that officers were reminded that all monies must be accounted for and authorised as monies had been issued without approval and the emergency fund left without funds. This supports the findings detailed throughout this audit report.	Potential for the misappropriation of cash. Staff failing to follow policies and procedures.	Staff will be made aware of the findings and associated risks detailed within the audit report to highlight the importance of ensuring that policies and procedures are followed without fail. Officers will be informed that failure to comply with policies and procedures may result in disciplinary action.	Operations Manager 28 February 2011

10. Care Leavers' Bank Account

AUDIT OPINION

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

Good practice includes:
- The care leavers' database automatically generates reconciliations.
- The care leavers' bank account is independently operated by the assistant financial administration and support officer.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
10.1	**	The pro-forma invoice automatically generated by the care leavers' database is a non current version which includes the previous bank account number and finance codes. The details are then transferred onto the current pro-forma invoice.	Duplication of work. Errors may occur in transferring data.	The current pro-forma invoice will be uploaded onto the care leavers' database.	Senior Financial Admin & Support Officer (SC) 31 March 2011
10.2	***	Through review of the record of repayments to the care leavers' bank account dated 12/07/10, which included 11 transactions, it was found that: • In 2 cases the officer handing over the cash did not sign and date the client transaction record. (ref - 1780, 1776) • In 1 case a transaction had been crossed out on the client transaction record but still included within the total. (ref - 1776) • In 1 case the officer receiving the cash did not record the date of the handover. (ref - 0645)	Inadequate protection of staff. Incomplete / inaccurate records. Potential for the misappropriation of cash. In the event of theft/fire, safe contents may not be adequately insured. Lack of audit trail.	The client transaction record will be fully completed and signed and dated by the officers handing over and receiving cash. Amendments made to financial records will be initialled by the officer making the amendment. Care will be taken when recording and totalling amounts listed on client transaction records to ensure they agree. Returned monies will be re-banked on a regular basis. Further, a limit will be set to determine when the amount of returned monies received at transition and leaving care will be banked. Further, the transition	Administration Team Manager Operation Manager 28 February 2011

<table>
<tr>
<td></td>
<td></td>
<td>In 1 case the date the money was paid out was not recorded against the individual on the client transaction record. (ref - 1780, 0645)
The amount of returned monies handed over to the assistant financial admin and support officer for banking totalled £1,108.34, all of which was cash.
The previous re-banking was made on 07/04/10 totalling £1356.88, again all which was cash and related to repayments received since January 2010. In 1 case a client transaction record dated back to 10/12/08.(ref - 1356)
The record of repayments did not include the client transaction record number and was not totalled.
The record of payments template includes references to LAFIS and the wrong address.
Two officers count the cash together prior to banking, however, they do not sign and date the appropriate record as evidence this.
There is no evidence to support that income banked is verified by an independent officer.</td>
<td></td>
<td>and leaving care finance policy will be updated to reflect this

It is now ensured that the client transaction record number and total of all repayments listed on the record of repayments log is recorded.

The record of payments will be updated to include a section where officers sign and date to verify the amount of monies checked.

A second officer now verifies details of income banked to the appropriate oracle code. Evidence of this check is now retained.
However, due to the childrens service financial administration and support team consisting of two officers, an independent officer is currently not available. A review of the arrangements will be undertaken following a restructure.</td>
<td>Senior Financial Admin & Support Officer (SC)

Implemented

31 January 2011

Implemented

31 March 2011</td>
</tr>
</table>

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
10.3	***	There is no lower limit set for when the care leavers' bank account should be reimbursed; instead, this is monitored by the assistant financial admin and support officer.	Insufficient funds to meet requirements.	A lower limit of £2500 has now been set for when the care leavers' bank account will be reimbursed.	Senior Financial Admin & Support Officer (SC) Implemented
10.4	***	The weekly bank account reconciliation is not signed and dated by the completing officer and is not checked by a second officer.	Errors / omissions may go unnoticed. Potential inadequate segregation of duties.	The weekly bank account reconciliation is now signed and dated by the completing officer. The children service financial administration and support team consists of two officers, therefore, insufficient resources are currently unavailable for a second officer to check the weekly bank account reconciliation. A review of the weekly bank account reconciliation arrangements will be made following a restructure to ensure segregation of duties can be optimised.	Senior Financial Admin & Support Officer (SC) Implemented 28 February 2011
10.5	***	The assistant financial admin and support officer has been allocated a £300 float within the bank account. This is used when there is insufficient money in the emergency fund or where an authorised signatory is not available to sign a cheque. The 'float' is used by the assistant financial admin and support officer for small cheques to be raised. The float was last topped up in December 2009 and is rarely used.	Potential for misappropriation of cash. Inadequate segregation of duties.	The balance of the float remaining which has been allocated to the assistant financial admin and support officer in the bank account will be withdrawn and re-banked to the appropriate Oracle code.	Senior Financial Admin & Support Officer (SC) 31 January 2011

11. Setting Up Home Grant

AUDIT OPINION

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

Good practice includes:

- The setting up home grant is used to support young people in setting up home. Young people can be allocated up to £1500 based on a needs assessment which is completed by a personal advisor.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
11.1	***	The care leavers' database does not have the facility to monitor the amount of setting up home grant that has been allocated and to each young person to ensure it does not exceed the grant awarded.	Errors / omissions may go unnoticed. The maximum setting up grant value may be exceeded.	Arrangements have been made for the care leavers' database to be updated so that setting up home grants allocated and paid can be monitored to ensure they do not exceed the amount awarded. Consideration will be given to introducing a prompt where a young person's total setting up home grant exceeds the £1500 limit.	Senior Financial Admin & Support Officer (SC) Implemented 28 February 2011
11.2	**	The welfare rights officer contacts other local authorities on an ad-hoc basis to establish their maximum setting up home grant allocation however, this is not documented.	Setting up home grant limit may not have been appropriately approved. Rates may be too high / low and not in line with other local authorities. Lack of audit trail	Contact made with other local authorities is now documented to demonstrate the maximum setting up home grant allocation is in line with other local authorities.	Operation Manager Implemented

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
11.3	***	From a sample of 5 setting up home grants selected, it was found: • In 1 case a list of items purchased had been entered onto PARIS but supporting receipts were not available on PARIS. (Ref – ██) • In 1 case a note had been entered onto PARIS to show how the grant had been spent, however, there was no evidence to support the items purchased. (Ref - ██) • In 2 cases the grant had not been recorded on PARIS. (Ref – ██, ██) • In 1 case records held at transition and leaving care stated that a grant cheque had been cancelled, however, the assistant financial admin and support officer had not been notified and the cheque, which is now out of date, was still in issue on the care leavers' database. (Ref - ██)	Potential for misappropriation of cash. Lack of audit trail. Inaccurate / incorrect records maintained. Cheque may be cashed.	It will be ensured that all details in relation to setting up home grants are held on PARIS. Receipts will be obtained for all setting up home grant expenditure. (*) The care leavers database has been updated to reflect that the status of the cheque (ref – KH) It is now ensured that the assistant financial administration and support officer is promptly notified of all cheques to be cancelled.	Operation Manager 28 February 2011 Senior Financial Admin & Support Officer (SC) Implemented Operation Manager Senior Financial Admin & Support Officer (SC) Implemented
11.4	**	The price guidelines for essential items purchased with a setting up home grant has not been updated since 2009.	Prices not in accordance with current market values.	Catalogues and internet research are used to identify items purchased with a setting up home grant to ensure value for money. The price guidelines for essential items purchased with a setting up home grant will be reviewed to determine whether it is still required.	Operation Manager 28 February 2011

Appendix 2

Walsall Council
Internal Audit Service

CCTV / SURVEILLANCE

Audit Report 2010 / 2011
January 2011

CONTENTS

EXECUTIVE SUMMARY

A. Introduction

B. Overall audit opinion

C. Summary of findings

D. Acknowledgements

AUDIT OPINION & ACTION PLAN

1. Planning, Service Strategies and Customer Consultation
2. Service performance
3. Performance Management
4. Joint Working
5. Procurement
6. Income
7. Anti-Fraud and Irregularity

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of the surveillance unit (CCTV and surveillance) was undertaken as part of the annual audit plan. The surveillance unit is part of the Safer Walsall Partnership.

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
- 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 grants and that from fees and charges, is appropriately accounted for and recovered;
- staffing, including time recording, is appropriately administered; 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 the surveillance unit, 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. Most areas reviewed required significant improvement. Controls regarding service performance and the service's adherence to corporate policies and procedures, joint working, procurement, income; and anti fraud and corruption measures all require attention. The prompt implementation of actions contained within the action plan, together with the commitment of the new management structure will assist in restoring the control environment.

3. The 11 agreed actions which remain applicable from the last audit were confirmed as implemented by the resilience manager on 20 April 2010. Of these, 5 had been fully implemented at the time of this audit. The 6 unimplemented, or partially implemented, actions have been marked with an asterisk (*).

4. Most actions within the action plan are considered to be high priority.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, service strategies and customer consultation		✓		
Service performance			✓	
Performance Management			✓	
Joint Working			✓	
Procurement			✓	
Income			✓	
Anti-Fraud and Irregularity			✓	

D. Acknowledgements

1. Please thank the resilience manager and the senior resilience officer 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

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

Good practice includes:

- Service aims have been converted into management action plans via supplementary action plans which are monitored on a quarterly basis.
- The resilience manager is in the process of producing an options appraisal for the head of public safety to consider the options for providing the service in the future.
- Examination of a sample of 3 actions from the surveillance unit's action plans indicated that the service actions are SMART.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	*	CCTV and surveillance services are included as the surveillance unit within the public safety service plan 2009/11 (revised October 2009), which follows the corporate template. Service aims have been converted in to management action plans via the supplementary action plans, but they still show the ex-interim surveillance unit manager as the responsible officer.	Actions are not assigned to a current responsible officer. Actions may not be monitored or implemented.	The responsible officer details on the surveillance unit action plans have now been updated to include the current responsible post holder.	Resilience manager 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:

- CCTV operatives work closely with the police to assist in achieving performance indicator targets regarding anti-social behaviour.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	***	The customer experience action plan contains a target to 'respond to complaints about the CCTV service within 5 working days in writing'. However, the resilience manager confirmed that there are currently no procedures in place documenting how to respond and manage complaints.	In the event of key staff absence, other staff may not be aware of the procedure for managing complaints. This could adversely affect performance targets in this area.	Procedures for the management of complaints have now been documented and issued to key staff. The new procedure follows corporate guidance whereby complaints are submitted to the "Tell Us" database.	Resilience manager Implemented
2.2	***	There is no formal process for recording customer feedback. The ex-interim surveillance unit manager advised the auditor that he did get occasional ad-hoc adverse feedback on installations performed by surveillance officers but this was largely due to the quality of the equipment being installed.	Adverse performance is not promptly identified and corrective action taken. This could lead to poor value for money and ultimately service failure.	A system is now in place to maintain and monitor customer feedback. All activities relating to new private installations, however, have now ceased. The only works being performed are to repair previous installations which are still within their warranty period. The surveillance unit now only provides a commissioning service for installations to council departments for which they charge a 12.5% management fee.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.3	***	The resilience manager, who took over responsibility for the surveillance unit in April 2010, advised the auditor that he has received complaints from customers regarding the quality of workmanship on camera installations. One such an example was installations undertaken by the service at the Centro bus shelter.	Adverse performance is not promptly identified and corrective action taken. This could lead to poor value for money and ultimately service failure. Potential for action to be taken against the council for poor quality work.	Poor workmanship matters are now addressed as and when complaints come in. Such rectification measures are now required / honoured up until a reasonable 12 month warranty period expires as a gesture of goodwill. This is a consequence of there being no terms and conditions.	Resilience manager Implemented

3. Performance Management

AUDIT OPINION

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

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	***	A review of IPM records identified that IPMs were last performed for staff in 2009. Prior to this IPMs had not taken place for several years. It was also identified that where IPM's had taken place: • training issues identified had not been pursued due to a lack of budget; • IPMs examined did not follow the corporate template.	Lack of adherence to the corporate procedure. Staff resources including training and development are not planned to help meet key service objectives and demands. Staff output is ineffective in meeting key service aims because they are unclear on their contribution to service aims and their performance is not regularly reviewed.	Employee performance assessments (EPA) are now performed for all officers to ensure that training, development and performance issues are identified, discussed and acted upon. The standardised EPA forms are used. The resilience manager, senior resilience and surveillance officers attended EPA training on 6 October 2010.	Resilience manager Implemented
3.2	**	The ex-interim surveillance unit manager advised the auditor that surveillance unit officers had not attended any equalities training courses. He confirmed, however, that an 'IPM newsletter' enabled officers to raise any concerns that they have regarding equalities.	Staff are not adequately trained in equality matters. Inequitable service provision may inadvertently result.	An equalities training needs assessment has now been undertaken in consultation with the equality and diversity team. Training requirements identified are being delivered. Outputs from EPA's are now factored into training plans.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.3	*	The surveillance unit is not currently equalities compliant as there is no disabled access to the control room. However, the resilience manager expects this to be addressed in the future as he is looking in to the possibility of relocating the room.	Disadvantaged groups cannot fairly access Council services.	An access review of the current location of the control room will be undertaken and action taken as appropriate. A health and safety inspection carried out in November 2009 confirmed the limitations of the facility. The current premises cannot physically be improved to meet the equalities standard. Alternative premises are being considered subject to funding. The position is to be reviewed in conjunction with key partners. Should a decision to relocate the control room be taken, this will take into consideration access requirements to ensure the new premises are equalities compliant.	Head of public safety 31 December 2010
3.4	***	Procurement of goods is carried out as items are required, as opposed to keeping a stock of items. Procured goods are collected by surveillance operators from Telford (approximately 27 miles each way from Walsall) which is incurring mileage and manpower costs when a delivery service offered by this supplier is free.	Poor value for money.	All procurement activity is now performed in accordance with corporate procurement rules.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.5	***	The resilience manager advised that the original camera repair company used by the surveillance unit offer a free delivery and collection service but the surveillance officers travel to and from a separate company in Coventry with the equipment, which results in the council incurring avoidable travelling costs.	Poor value for money. Potential lack of adherence to the council's procurement rules.	Alternative suppliers have now been sourced who can collect and deliver from site.	Resilience manager Implemented
3.6	***	The digital upgrade of the control room and maintenance was a procurement project with a value exceeding £50,000. The ex-interim surveillance unit manager consulted with the procurement officer during the tendering process for the digital upgrade and maintenance tenders. The procurement officer provided an evaluation matrix for the tenders. IC2 were appointed for the digital upgrade contract, and ADT were appointed for the maintenance contract from 1 August 2009. Although the control room did not need to fully close, the upgrade had a major impact on the service as it was significantly reduced for approximately 6 weeks. The ex-interim surveillance unit manager informed the auditor that he knew that there would be some disruption during the upgrade but did not realise how long the upgrade would take. The upgrade has resulted in a loss of service for some areas that should be monitored by the surveillance unit and these problems have not yet been resolved. There is little evidence that adequate project management was performed during the digital upgrading process.	Poor project management. Unplanned disruption to service.	Officers now ensure that activities which fall under the project description are carried out using the council's project management methodology to ensure that robust project management is undertaken in future for projects of this nature.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.7	***	Any incidents or actions have to be logged on to the VTAS system by the CCTV operators each day. The VTAS system is backed up on a server at the Civic Centre, but back up is not done at specific intervals. The system is backed up when the CCTV Operators 'press the button' to action it. Where backups are performed, the backup information is not tested at regular intervals.	Loss of data.	A regular backup procedure has been implemented to prevent the loss of valuable data. (*) Backup information is tested at regular intervals to ensure that it is recoverable if necessary.	Senior resilience officer Implemented
3.8	***	A risk management plan is included within the service plan, however, only one of the risks refers to the surveillance unit – failure to meet income generation targets.	Critical service risks may not have been identified and therefore managed. The service fails to achieve its aims because managers fail to mitigate against foreseeable risks. Staff and customers are exposed to avoidable health & safety risks.	A comprehensive current risk assessment has now been performed for the surveillance unit to ensure that risks to the service and to officers are identified and managed including current and emerging business critical risks, as well as health and safety risks.	Resilience manager Implemented
3.9	***	The resilience manager advised the auditor that the sickness management policy was not being complied with prior to April 2010 by the surveillance unit as sickness had not been recorded. The senior resilience officer found evidence of this when examining the timesheets and sickness records for the surveillance unit. In addition, return to work interviews were not being performed and notice of concerns were not being	Lack of adherence to corporate sickness management policies.	Officers have now been made aware of the corporate absence management processes and management will ensure that it is complied with. Previous sickness absences have now been reported to HRD so that they can be retrospectively recorded.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		issued. The resilience manager discussed this with the staff in the surveillance unit and they advised that they were not aware of the sickness procedure.			
3.10	***	The budget accountability memo for 2009/10 onwards was obtained which identified that the head of safer Walsall partnership was responsible for the budget prior to 1 April 2010 as the previous manager was a temporary officer. Accountability memos have not yet been issued for 2010/11 but the accountant advised that these are planned to be issued.	Accountability may be unclear, leading to budget overspends.	The head of public safety has now signed the an accountability memo. (*)	Head of public safety Implemented
3.11	**	It was previously agreed that all expenditure should be accurately and completely recorded within separately maintained budgetary records. The resilience manager advised the auditor that two officers had been transferred from anti-social behaviour to CCTV but the budget for their salary costs was not transferred.	Budget information is not accurate. Decisions on which budget information is based may be compromised.	Budgets and corresponding expenditure have now been aligned. (*)	Resilience manager Implemented

4. Joint Working

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
4.1	***	The auditor was informed that the recent digital upgrade of equipment has meant that the new equipment is not compatible with the equipment of partners such as traffic management. The council has service level agreements in place to provide the service for certain organisations but the technical issues have meant that the council cannot currently deliver against the service level agreement. The auditor was informed that it would cost approximately £20,000 to resolve the technical problem with partner, Centro's equipment. It is understood that Centro gave the council £5,000 towards these costs. It is not clear how the balance of costs will be funded. The new digital system has considerably less capacity for camera inputs than the old analogue system. Therefore, there is insufficient capacity for all of the cameras that the unit previously monitored. It is understood that this can be overcome by additional hard drive(s), however, this represents a further unexpected cost.	Inability to deliver service to partners. Lack of thorough stakeholder consultation. Budget spending pressures. Potential for challenge from partners due to disruption in service.	A full gap analysis will be carried out along with the consequences to service delivery of the recent digital upgrade. The full cost of remedial works will be identified and funding decisions taken. For future potential upgrades, a robust project management approach will be undertaken, including full consultation with dependent stakeholders.	Resilience manager 31 March 2011 Senior surveillance officer 31 March 2011

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.2	***	There are service level agreements in place with certain partners where the surveillance unit monitors CCTV footage on their behalf. There is no evidence of performance being monitored against the agreements.	In the event of query/ challenge, the terms of service may be unclear. Poor performance may not be identified and action taken as appropriate.	A full review of all service level agreements (SLAs) has now taken place to ensure that up to date SLAs are in place with all relevant partners. Performance against SLAs will be monitored and corrective action taken if appropriate.	Resilience manager Implemented Senior surveillance officer 31 March 2011

5. Procurement

AUDIT OPINION

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

Good practice includes:

- Appropriately authorised requisitions are completed.
- Official orders are raised on the IPROC system to support expenditure.
- Invoices are stamped with a certification box which is fully completed.
- Invoices are stamped paid.
- Invoices are coded to an appropriate oracle code.
- There were no pre-signed orders/ requisitions as they were processed through the IPROC system.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	***	Of a sample of 10 invoices/items of expenditure tested, 1 occasion was noted of expenditure of £16,675 for 2 domehawk cameras with DVR and Imagelock video encryption where the requisite number of quotations had not been obtained in accordance with financial and contract rules.	Potential non compliance with financial and contract rules.	All expenditure is now in compliance with the council's contract rules without exception.	Resilience manager Implemented
5.2	**	Of the sample of 10 invoices examined 1 occasion was noted of expenditure of £455.63 for camera equipment where the payment had been made against a faxed copy of the invoice.	Potential for duplicate payments.	Payments are now only made against original invoices.	Resilience manager Implemented
5.3	**	Of the sample of 10 invoices examined, 5 occasions were noted where the invoices were not paid in accordance with the chief executive's instruction to pay within 15 days as follows: • 32 days to pay Apex Radio Systems Ltd £152.75; • 16 days to pay Carousel £183.30; • 23 days to pay Security Consultancy & Technical Ltd £455.63;	Invoices are not promptly paid. Performance targets are not achieved. Poor supplier	Wherever possible invoices are now promptly paid in accordance with the chief executive's instruction to pay within 15 days.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
		• 24 days to pay Rapid Vision System Ltd £16,675.00; and • 18 days to pay A D T Fire and Security £37,809.73.	relationships.		
5.4	**	Sample testing of 10 invoices identified that one of the orders and invoices was approved by the same officer. (Invoice number 55824).	Lack of segregation of duties.	Segregation of duties have now been introduced to ensure that orders and invoices are authorised by different officers. (*)	Resilience manager Implemented
5.5	**	It is possible that the date of receipt stamped on invoices is not correct. For example, they are often not date stamped until they are passed to consolidated creditors rather than the date of initial receipt.	Performance information is not accurate. Performance targets are not achieved.	Invoices are now date stamped when they are received.	Resilience manager Implemented
5.6	***	The ex-interim surveillance manager advised the auditor that the surveillance unit has used specific suppliers for several years but checks have not been performed to ensure that they are competitive.	Potential non compliance with the council's contract rules. Poor value for money.	A review of all suppliers has now been undertaken in consultation with officers from procurement services, to ensure that current contractual arrangements are adequate, suppliers have been sourced in accordance with the council's rules and that best value from suppliers is being obtained.	Resilience manager Implemented

6. 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	***	The surveillance unit does not have a procedure note setting out the process for providing quotations for works.	Inconsistent practices may evolve. Officers may be unaware of their duties/ responsibilities.	A procedure note has now been produced setting out the process for providing quotations for works.	Resilience manager Implemented
6.2	***	Quotations provided to customers do not include terms and conditions.	The council could be open to risk/ challenge if terms and conditions are not clearly set out at quotation stage.	Standard terms and conditions are now provided to service areas at the outset when approached for quotations.	Resilience manager Implemented
6.3	***	It was identified via discussions with the senior resilience officer that quotations produced are not based on full cost data. The senior resilience officer highlighted to the auditor that costs are being incurred by the surveillance unit due to installed equipment breaking down during the 12-month warranty period with no installation costs being recharged.	The full cost of providing work may not be recovered. This could lead to a loss for the council/the council subsidising external provider work.	The surveillance unit now provides a project management service for installations to council departments for which they charge 12.5% of the total installation project cost. The unit provides a quotation for the cost of works based on the costs of external installation contractors and the 12.5% commissioning charge. All activities relating to new private	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
			Inappropriate use of council funding.	installations have now ceased.	
6.4	***	CCTV and surveillance are two independent sections but the budget profile does not currently reflect this with budgets being held together.	Management information is impaired / budgetary control is mitigated.	Budgets for the surveillance officers and the budget for the CCTV operators are now split so that income recharges and expenditure are clearly identifiable for both areas. (*)	Resilience manager Implemented
6.5	***	The CCTV operatives are responsible for monitoring the 24-hour radio link system although income from the participating businesses is received via the regeneration directorate. The auditor was informed that during 2009/10, the regeneration directorate paid the surveillance unit £33,000 in respect of this service, but only £14,000 is expected during 2010/11, although the same level of service is required.	Potential negative impact on budget and service levels.	Officers from the surveillance unit have now liaised with officers from the regeneration directorate to determine a solution for service delivery within the existing resource constraints. Full responsibility for the running of the Retail Radio Link system was handed over to the Resilience Unit from 1 November 2010. This included all of the associated finances.	Resilience manager Implemented
6.6	***	Jobs performed by the surveillance officers are recorded on a spreadsheet. When a job is complete and due to be recharged the surveillance officers turn the job line a different colour on the spreadsheet to indicate that it needs to be recharged.	Income, including grant income, is not properly accounted for. Fraud, irregularity and error occur and are not detected.	Controls have now been implemented to ensure: • there is an adequate segregation of duties for commissioning and completing work; • a clear audit trail exists from commissioning to completion of works detailing adequate information; • management/quality reviews are	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
				performed and recorded; • data is protected against loss/manipulation; and • all works are promptly recharged.	
6.7	**	The surveillance unit does not monitor payment of its debtor invoices.	Income may not be promptly recovered. Fraud, irregularity and error occur and are not detected.	Regular monitoring of debtors has now been introduced to ensure that all income is recovered.	Resilience manager Implemented
6.8	***	Current rechargeable time statistics for the surveillance unit are poor. The resilience manager produced a document for the auditor detailing the hours worked by surveillance officers during April 2010. This identified that surveillance officers were working on jobs for 58 hrs 55 mins of the total 269 hrs 42 mins available during April 2010. Of the 58 hrs 55 mins, only 12 hrs 15 mins was recorded as chargeable works.	Poor value for money. Unproductive time. Inefficient practices. Poor management.	All activities relating to new private installations have now ceased. The senior surveillance officer now maintains records of time spent commissioning installations for other council departments and the 12.5% management fee is recharged to cover these costs.	Resilience manager Implemented
6.9	***	The surveillance unit monitors CCTV cameras on behalf of other organisations and charges for this service. The accountant provided a list of income received by the surveillance unit. It is noted that some of the organisations pay for this service on a quarterly basis whilst others pay annually.	Inconsistent practice. Income is not promptly recovered.	For consistency service charges are now billed quarterly and income recovered promptly. If this represents a change to a SLA then this change is notified to the organisation in writing. This is now being done as each SLA is reviewed so that there is a standard quarterly recharge for the service provided as SLAs are re-negotiated.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.10	***	A sample of 10 debtor invoices was selected. 1 of the invoices (£17625.00, Centro WMPTE) related to CCTV monitoring services provided to them for the period 1 April 2009 to 31 March 2010 but the invoice was not raised until 18 February 2010. Another invoice (£1556.75 Mercian Housing Association Ltd) relates to a service for the period March 2009 to August 2009, but the invoice was not raised until 22 October 2009.	Income is not promptly recovered.	Debtor invoices are now raised promptly. See also agreed action 6.9.	Resilience manager Implemented
6.11	***	The surveillance unit does not have a formal charging policy.	Inconsistent practices may evolve.	All activities relating to installations have now ceased.	N/A
6.12	*	Dates of installation/works are not always detailed on invoice requisition documents. (eg. Oscars News £2,108.85).	Incomplete information. Lack of audit trail.	All activities relating to installations have now ceased.	N/A

7. Anti-Fraud and 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
7.1	***	The auditor identified a general lack of staff awareness of corporate policies and procedures, e.g. sickness management, flexible working procedure, during the audit. A review has been undertaken of time recording within the surveillance unit by the senior resilience officer, identifying the following: • excessive amount of toil balances accrued; • officers were not able to justify their toil balances; • the balance of toil accrued was not always reduced when officers took a day off; • working hours were not in adherence to the council's core hours; • officers have carried balances over in excess of the flexi balance limits. These errors were not identified or corrected when the ex-interim surveillance manager checked and signed off the timesheets. Due to the problems identified by examination of the timesheets, the resilience manager has now implemented the use of the ATAR system for the two surveillance officers.	Lack of adherence to corporate polices and procedures. Fraud, irregularity and error occur and are not detected.	Officers have now been advised of all relevant corporate policies as part of the EPA process and any gaps in knowledge discussed and addressed. Monitoring of officers time recording on the ATAR system is now undertaken to ensure time recording is in accordance with the council's corporate procedure. An analysis of exceptions identified has now been undertaken to recover any time balances owing and determine whether further action, including disciplinary, was appropriate.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.2	***	The resilience manager has identified that surveillance officers have used their own vehicles for business journeys but they are not insured for business use. However, mileage claims have not been submitted to reclaim the costs.	Inadequate insurance arrangements.	An annual inspection of motor insurance for the surveillance unit is now performed.	Resilience manager Implemented
7.3	***	CCTV operators work a 12 hour shift, on a 4 days on then 4 days off basis. The number of toil hours incurred by the CCTV operatives is high due to the small number of officers in place. If an operative covers for another officer then they receive time and a half in toil due to unsociable hours. There is then a continuous knock on effect when the operative then has a day off to use their toil hours as another operative then has to cover their shift and therefore receives time and a half in toil hours.	Potential breach of working time directive. Budget pressures. Poor value for money.	The resilience manager has now reviewed this issue in consultation with officers from HR and put in place a robust workforce plan.	Resilience manager Implemented
7.4	**	The surveillance unit has a council vehicle which the surveillance officers use when transporting cameras/equipment to be deployed. A mileage form is not completed by officers to evidence individual journeys made in the van. The resilience manager also advised the auditor that the van often contains high value equipment.	Lack of audit trail. Potential misuse of council equipment. Inadequate insurance arrangements in the event of theft / damage.	A detailed mileage log has now been introduced and is completed by officers to evidence every journey made within the council vehicle. This log is subject to regular manager review. A review of insurance arrangements and security measures of the van has now been undertaken.	Resilience manager Implemented
7.5	**	Officers do not appear to have signed for council property when it was issued to them e.g. mobile telephones.	Items may not be recovered in the event of staff leaving.	The issue of any council property is now recorded and signed for in accordance with council policies and procedures. (*)	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.6	***	Although domehawk cameras are owned by other organisations, the council has agreed to store them. The resilience manager advised the auditor that some of the cameras are stored by the council and others are stored by a contractor (AMEY). The surveillance unit does not have a record of which cameras the contractor has or where they are stored.	Loss of assets. Potential financial consequence to the council as accountable body in the event of theft / loss.	Storage of equipment on behalf of other organisations has now been reviewed and third party contractors no longer hold equipment on behalf of the council. An inventory record has now been introduced to record all equipment and where it is stored. Contractors are now required to sign to evidence acceptance of equipment when it is passed over to them for installation. Any arrangements will be documented in writing setting out clear responsibilities, including insurance arrangements.	Resilience manager Implemented 31 January 2011.
7.7	***	There are no office procedures in place detailing the day to day administration of the service.	In the event of key staff absence, other officers may not be aware of procedures. Inconsistent practices may evolve.	Day to day procedures have now been documented in writing and issued to all relevant officers.	Resilience manager Implemented
7.8	***	The auditor was advised that surveillance officers download information from deployed cameras and leave evidential tapes and disks unsecured on the front seat of their vehicle.	Potential breach of the Data Protection Act.	Officers now ensure that all data is adequately secured as a priority and managed in strict accordance with the Data Protection Act.	Resilience manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.9	***	The contract for upgrading to a digital system and maintenance of the system were put out to tender. However, the resilience manager advised the auditor that he has discussed this with legal services and they informed him that a contract has not been put in place for maintenance of the system although the contractor has been maintaining the system since August 2009.	In the event of legal challenge/ dispute, contract terms may be unclear.	Legal services have now been consulted and a contract has been put in place.	Resilience manager Implemented
7.10	***	The auditor was informed that no performance clauses were included in the system/camera maintenance tender agreement with ADT. This is of concern to the urban traffic control unit as they have no way of improving poor performance under the existing tender agreement arrangements.	There is no contractual framework in which poor performance can be challenged.	Future contracts will contain performance and penalty clauses.	Resilience manager Implemented

Appendix 3

Walsall Council
Internal Audit Service

Social Care & Inclusion
Transport Services

Audit Report 2009/10
November 2010

CONTENTS

EXECUTIVE SUMMARY

A. Introduction

B. Overall audit opinion

C. Summary of findings

D. Acknowledgements

AUDIT OPINION & ACTION PLAN

1. Planning, Strategies and Consultation

2. Reconfiguration

3. Contractor Selection

4. Policies & Procedures for Charging

5. Contract Performance

6. Management Information & Budgetary Control

7. Partnership Working

8. Fraud & Irregularity

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of social care and inclusion transport services (including transport services reconfiguration) was undertaken during February and March 2010 as part of the annual audit plan.

2. The objectives of the audit were to assess the adequacy of controls governing financial and management arrangements, and to seek assurance that:

   - adequate planning, service strategies and customer consultation are in place;
   - the process for reconfiguration of adult transport services has been effectively managed and progress against any actions arising are being robustly monitored;
   - the selection of contractor/s is in accordance with financial and contract rules;
   - payment mechanism controls to the contractor/s are robust;
   - contract performance is monitored and managed;
   - contract quality and monitoring procedures are in place;
   - effective management information and budgetary control exists;
   - there are policies and procedures in place for the charging of service users for transport provision and charges are made in accordance with these;
   - joint working with partners and other council services is effective;
   - key controls are in place to guard against fraud and irregularity; and
   - previously agreed audit report actions have been fully implemented.

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

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

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

6. The committee has expressed concern with a failure, in a number of instances, to implement agreed actions. The committee will seek explanation

from executive and assistant directors failing to ensure that appropriate action is taken.

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

B. Overall Audit Opinion

1. Internal audit is able to give a limited assurance opinion on the system of internal control operating within social care and inclusion transport 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 review, including:
   - the introduction of the new electronic 'swipe card' facility which seeks to address weaknesses in the previously fallible charging mechanism;
   - adult services within social care & inclusion are in the process of reviewing the way in which transportation services are delivered as part of their transport services reconfiguration exercise.
   - social care & inclusion (the commissioner) has an embedded working relationship with fleet services (the provider); and
   - social care & inclusion undertake a user survey every two years to elicit views and identify areas of potential improvement.

3. Some areas of improvement have, however, been identified including:
   - the need to strategically map social care & inclusion directorate's aims and objectives in respect of service user transportation;
   - ensuring that the current split between the internal and external sourced transport services provided, are formally documented to increase the levels of transparency across transport services;

- undertaking urgent remedial action to recover progress on the adult services transportation reconfiguration exercise being undertaken and also ensuring that the project is properly risk assessed;
- ensuring that debts in relation to the council's previous charging policy which had to be suspended, are recovered or written off as appropriate and that a 'lessons learned' exercise be undertaken to ensure that similar issues do not occur in future; and
- implementing a consistent and robust management information framework to assist managers in both strategic and operational decision making.

4. Of the 12 agreed actions which remain applicable from the last audit, all were confirmed as implemented by the fleet services manager on 7 August 2007.At the time of this audit, 9 agreed actions were found to be fully implemented. The 3 unimplemented, or partially implemented, actions have been reiterated in this report, marked (*) in the action plan.

5. There are 7 high priority actions, as follows:-

Section	Action Plan Ref.	Agreed Action
Planning, Strategies and Consultation	1.1	A strategy will be created and agreed, articulating the social care & inclusion directorate's aims and objectives in respect of service user transportation. Once a strategy has been agreed and adopted, this will be detailed in a plan for the service, providing clear actions, responsibilities and timescales for achievement.
	1.3	The current split between the internal and external sourced transport services provided will be formally documented to increase the levels of transparency across transport services.
	1.4	A robust plan of actions, timescales and responsible officers will be developed in order to make the necessary changes to identify the efficiencies identified following recent reviews of the service.

Section	Action Plan Ref.	Agreed Action
Reconfiguration	2.1	The adult services transportation reconfiguration project plan will be updated to incorporate the latest objectives and timelines. Each action will be formally allocated to an officer for accountability and increased transparency, together with a timeline for implementation. Milestones will be closely monitored. Where these are not met, urgent remedial action will be undertaken to recover the plan.
Contractor Selection	3.1	The planned tender exercise has now been undertaken for social care & inclusions' taxi provision. The contract commenced with effect from 1 April 2010.
Policies & Procedures for Charging	4.1	Many of the debts involved are uneconomic to pursue and will be written off. As the implementation of the new process is now in its second phase, it is considered that undertaking a lesson learnt exercise would serve no purpose.
Management Information & Budgetary Control	6.1	A management information framework will be formally introduced, incorporating a scheduled production of key management information reports. These management reports will then be reviewed by senior officers on a regular periodic basis and any adverse issued reported, should be promptly identified and acted upon.

C. Summary of Findings

	Full Assurance	Significant Assurance	Limited Assurance	No Assurance
Planning, Strategies and Consultation			✓	
Reconfiguration			✓	
Contractor Selection		✓		
Policies & Procedures for Charging			✓	
Contract Performance		✓		
Management Information & Budgetary Control		✓		
Partnership Working			✓	
Fraud & Irregularity		✓		

D. Acknowledgements

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

1. Planning, Strategies and Consultation

AUDIT OPINION

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

Good practice includes:

- Discussions with the commissioning manager, social care & inclusion, and the resources manager, fleet services, indicated that their respective roles and responsibilities in respect of delivering transport services is, in the main, clear. The commissioning manager represents the "client" and effectively needs assesses the directorate's transport requirements. This need is then conveyed to the resource manager, fleet services, residing in the neighbourhood directorate, to source this need, initially via the in-house fleet service.
- Management have identified that the current charging mechanism is ineffective and has resulted in inaccuracies. A new charging policy is currently being introduced to address any previously fallible charging mechanisms.
- A new electronic solution of issuing service users with 'swipe cards' is currently being piloted.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	***	Discussions with the resources manager and commissioning manager indicated that there is currently no detailed strategy specifically covering the transportation requirements of social care & inclusion service users. The auditor was advised that there is a business plan for fleet services but this is a contractor orientated plan (social care & inclusion, as the commissioning body, is able to either use the Council's 'in house' fleet service or external contractors).	In the absence of a formalised strategy setting out how social care & inclusion identifies and then plans to deliver its service users' transportation requirements, onerous and inefficient practices could arise, which could impact on the quality of service provision.	A strategy will be created and agreed, articulating the social care & inclusion directorate's aims and objectives in respect of service user transportation. Once a strategy has been agreed and adopted, this will be detailed in a plan for the service, providing clear actions, responsibilities and timescales for achievement.	Lead officer on behalf of SC&I Executive Directorate Management Team. 31 December 2010

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.2	**	There is a lack of evidence of a formalised consultation framework helping to shape social care & inclusion transport service delivery.	Lack of evidence that service user and other stakeholder views and needs have been consulted and acted upon. Important stakeholder feedback which could ultimately lead to valuable improvements to the service may go unnoticed.	A formalised consultation framework helping to shape social care & inclusion transport service will be introduced.	Commissioning manager – vulnerable adults 31 October 2010
1.3	***	Currently, the transportation requirements of social care & inclusion are met by a combination of internal and external service providers. The split between internal and external provision is not, however, transparently documented in a way that makes clear, at a given point in time, the status of the providers (e.g., respective costs of providers; length of contracts).	Lack of transparency / rationale to determine when internal and external provision is required / used. Social care & inclusion are unable to efficiently and effectively “take stock” of how their transportation requirements are being serviced.	The current split between the internal and external sourced transport services provided will be formally documented to increase the levels of transparency across transport services.	Commissioning manager – vulnerable adults 30 September 2010

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.4	***	The auditor's discussions with management, indicated that looking ahead, there is likely to be a shift between external and internal transport sourcing arrangements as a means of seeking efficiencies. This follows the findings of a number of reviews, including a 4c's review, which have taken place over the past 3 years. Social care & inclusion intend to make the necessary changes to identify efficiencies, however, there has yet to be a formal plan of action developed to instigate such changes.	In the absence of clearly documented plans, actions required to implement recommendations may not be carried out. Desired efficiencies in ways of working may not be realised.	A robust plan of actions, timescales and responsible officers will be developed in order to make the necessary changes to identify the efficiencies identified following recent reviews of the service.	Lead officer on behalf of SC&I Executive Directorate Management Team. 31 March 2011
1.5	**	The auditor's review of the system for sourcing transportation arrangements indicated an absence of sufficient challenge and scrutiny underpinning the system. For example, although the resources manager, fleet services is charged by social care & inclusion, the 'client', to service their requirements and it is understood that the first port of call is the 'in house' provision, there is no scrutiny of costs or benchmarking of the in house provision undertaken by the client.	Ineffective, inefficient and uneconomic service provision may exist unidentified and therefore unchallenged.	Key performance indicators for social care and inclusion transport services will be identified. These will be established and benchmarked with similar providers to ensure that the service being provided is performing at optimum levels.	Commissioning manager – vulnerable adults 30 September 2010

2. Reconfiguration

AUDIT OPINION

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

Good practice includes:

- Adult services within social care & inclusion are in the process of reviewing the way transportation services within adult services are delivered. A project initiation document (“PID”) was developed in October 2008 for this purpose.
- Adult Transport Services Reconfiguration was discussed and approved by Cabinet. This very much followed on from a number of reviews in the past three years, including a 4c’s review that pointed to such a shift as a way to make efficiencies.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.1	***	Review of the project initiation document for adult services transportation reconfiguration (October 2008), identified that the actions relating to consultation, awarding of contracts and implementation have slipped by approximately a year. No remedial measures have been put into place to address the slippage.	In the absence of an updated adult transportation reconfiguration project plan, inconsistent objectives and timelines could result.	The adult services transportation reconfiguration project plan will be updated to incorporate the latest objectives and timelines. Each action will be formally allocated to an officer for accountability and increased transparency, together with a timeline for implementation. Milestones will be closely monitored. Where these are not met, urgent remedial action will be undertaken to recover the plan.	Lead officer on behalf of SC&I Executive Directorate Management Team. 31 December 2010
2.2	**	There is no evidence that the reconfiguration exercise has been subject to a risk assessment.	The project may be exposed to risks which have not been identified and therefore without adequate controls in place for mitigation.	An assessment of the risks involved in undertaking the adult services transportation reconfiguration exercise will be undertaken.	Lead officer on behalf of SC&I Executive Directorate Management Team. 31 December 2010

3. Contractor Selection

AUDIT OPINION

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

Good practice includes:

- Financial and contract rules set out the framework in which officers should procure.
- The services current use of minibus companies is formalised in signed agreements, which are held by legal services. While the agreements expired in September 2009, the council has temporarily extended the contract under a call off arrangement, until the outcome of the transport services reconfiguration exercise is known.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	***	To date, the use of taxi firms for the provision of social care and inclusion transportation provision has not been sourced using the council's formal tendering procedures as set out in financial and contract rules. The auditor was informed that this is currently being addressed in a tender exercise which will shortly take place with assistance from legal services and procurement.	Lack of adherence to the council's financial and contract rules. In the absence of a formal tender process, inability to demonstrate value for money; nor an open and transparent provider selection / procurement exercise for service provision.	The planned tender exercise has now been undertaken for social care & inclusions' taxi provision. The contract commenced with effect from 1 April 2010.	Procurement manager Implemented

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.2	**	It was agreed as part of the previous audit review that simplified, easy to follow and relevant guidance should be produced to help ensure that social workers do not inadvertently breach contract and financial procedure rules in their procurement of transport services. At the time of this audit, the auditor identified this had yet to be implemented.	Financial and contract rules may be breached inadvertently.	Simplified, easy to follow and relevant guidance will be produced to help ensure that social workers do not inadvertently breach financial and contract rules. (*)	Commissioning manager – vulnerable adults 30 September 2010
3.3	**	Whole life cost is not currently considered when evaluating tenders.	Expenditure over the life of the contract may be higher than necessary.	A recent procurement exercise has been completed which considered and factored in whole life cost as far as call off contracts allow. (*)	Procurement manager Implemented

4. Policies & Procedures for Charging

AUDIT OPINION

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

Good practice includes:
- The council is aware of weaknesses in the previous charging mechanism and is consequently in the process of developing and piloting a new charging mechanism, namely the roll out of swipe cards

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	***	A charging policy which introduced charges for transportation for social care and inclusion service users commenced in December 2008. Due to issues relating to the accuracy of data collection methods, a decision was made by cabinet on 24 June 2009 to suspend charging. The auditor was informed that a number of debts from invoices in respect of this policy, raised from the period December 2008 to March 2009, are still being chased. Some have been passed to a debt collection agency and some are due to be considered for write off as they are uneconomical to pursue.	Income due to the council may not be recovered. Lessons may not be learned.	The remaining debts will be reviewed and action taken as appropriate. Many of the debts involved are uneconomic to pursue and will be written off. The implementation of the new swipe card process is now in its second phase and charging controls are considered to be operating effectively.	Commissioning manager – vulnerable adults 30 November 2010

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.2	**	The procedures relating to the swipe card are currently in draft stage with no formal timeline for finalisation.	In the absence of a finalised set of procedure notes, staff may not be aware of procedures. Inconsistent / unapproved procedures may develop in the interim period.	The procedures relating to the swipe card have now been finalised and issued to all relevant staff who have signed for their receipt. Thereafter, procedures are now subject to a formal review and refresh timetable.	Commissioning manager – vulnerable adults Implemented

5. Contract Performance

AUDIT OPINION

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

Good practice includes:

- The commissioning manager, social care & inclusion undertakes a user survey every two years to elicit views and identify areas of potential improvement.
- There is a clear distinction between the roles discharged by fleet services and that of social care & inclusion. The former will monitor the quality and suitability of the vehicles being used, while the latter reviews the overall quality of the service from a client perspective.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	*	The commissioning manager, social care & inclusion undertakes a user survey every two years to elicit views and areas of potential improvement. It is understood that the commissioning manager intends to review the frequency of user surveys, however, no formal plans to implement this review has been put in place yet.	Plans to review the frequency of user surveys may not be implemented. In the absence of frequent user feedback analysis, issues with service quality may not be addressed in a timely manner.	The commissioning manager will review the frequency and adequacy of user surveys. As part of the review, the commissioning manager will consider obtaining service user feedback on a more frequent basis.	Commissioning manager – vulnerable adults 31 October 2010
5.2	**	Contract monitoring is not currently reported to a senior level i.e. assistant / executive director level.	Issues regarding performance may not be identified and therefore acted upon, at an appropriate level.	Results of monitoring exercises for contracts will be reported to the appropriate assistant director / executive director. (*)	Commissioning manager – vulnerable adults 30 September 2010

6. Management Information & Budgetary Control

AUDIT OPINION

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

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	***	The auditor was advised by management that there is currently no consistent flow of management information with respect to the performance of the transport service. For example, financial reporting and performance items such as benchmarking, reporting on customer feedback and status reporting of internal vehicles.	In the absence of periodic management information, management decision making may be compromised.	A management information framework will be formally introduced, incorporating a scheduled production of key management information reports. These management reports will then be reviewed by senior officers on a regular periodic basis and any adverse issued reported, will be promptly identified and acted upon.	Commissioning manager – vulnerable adults 31 March 2011

7. Partnership Working

AUDIT OPINION

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

Good practice includes:

- Social care & inclusion have an embedded working relationship with fleet services.
- The commissioning manager and the resources manager have ad hoc meetings with neighbouring authorities to share information and knowledge.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	**	The council's partnership toolkit has yet to be considered by officers responsible for social care and inclusion transportation in both social care and inclusion and fleet services.	Best practice in partnership working arrangements may not be implemented.	The partnership toolkit will be considered and applied where applicable to partnership arrangements involving social care and inclusion transport services.	Commissioning manager – vulnerable adults 30 September 2010
7.2	**	Themes and developments in transport are monitored by officers within social care and inclusion. In addition to this, they are also communicated via the consultative forum, operational managers transport group (OMTG). The OMTG has evolved out of the transport section's requirement to have ongoing communication with operational managers within social care & inclusion. However, it was noted during the review that there is currently no terms of reference in place for OMTG.	In the absence of a formal terms of reference, ineffective and undirected meetings could take place.	Formal terms of reference will be introduced and agreed for the OMTG.	Commissioning manager – vulnerable adults 30 September 2010

8. Fraud & Irregularity

AUDIT OPINION

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

Good practice includes:

- Staff involved within social care and inclusion transportation are aware of the prevailing anti fraud and corruption policy

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Suggested Action	Responsibility & Timescale
		None.			

Appendix 5

Walsall Council
Internal Audit Service

Homecare Establishment

Audit Report 2010 / 2011
March 2011

CONTENTS

EXECUTIVE SUMMARY

A. Introduction

B. Overall audit opinion

C. Summary of findings

D. Acknowledgements

AUDIT OPINION & ACTION PLAN

1. Planning, Service Strategies and Customer Consultation

2. Service Performance

3. Corporate Performance Management

4. Joint Working

5. Procurement

6. Client Referrals

7. Delivery of Care

8. Fees and Charges

9. Anti Fraud and Irregularity

EXECUTIVE SUMMARY

A. Introduction

1. An audit review of homecare establishment was undertaken as part of the annual audit plan. The in-house homecare service provides personal care and domestic services to vulnerable adults in Walsall to help them to be as independent as possible. Care is provided 24 hours a day, 7 days a week. The homecare establishment service is split into three teams which are based at Tameway Tower, Bentley and Rushall.

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
- 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;
- all client referrals are dealt with effectively;
- delivery of care is appropriately recorded, monitored and managed;
- fees and charges are accurately applied and regular debtor monitoring is undertaken; 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 homecare establishment, 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; 6 monthly training and development reviews; up to date health and safety standards; quarterly monitoring of joint working arrangements; procedures for client referrals; spot checking of care delivered; and weekly management reports detailing referrals received, homecare provided and available capacity.

3. Some areas for improvement have, however, been identified including ensuring that the team plan is finalised; that performance management and procedures for administering the delivery of care are strengthened; and that fees and charges processing is more robust, including debt monitoring. The prompt implementation of actions contained within this audit report will further assist in enhancing procedures undertaken.

4. As this has been the first audit review of homecare establishment there were no previously agreed actions to follow up.

5. Most actions within the report were considered to be of a high priority.

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		✓		
Client referrals		✓		
Delivery of Care			✓	
Fees and charges			✓	
Anti Fraud and Irregularity		✓		

D. Acknowledgements

1. Please thank all officers concerned, 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

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

Good practice includes:

- A record is maintained of all corporate complaints dealt with by the homecare establishment team.
- All complaints received are appropriately documented and followed up.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
1.1	***	A team plan for homecare establishment is in the process of being developed. The service manager confirmed that there has been no previous quarterly monitoring of plans.	Unclear aims and objectives. Unable to measure service performance. Under performing areas may not be identified.	The homecare establishment team plan will be completed 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.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 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	***	Performance indicators for the service are currently being developed by the performance action board.	Under performance may go un-noticed and therefore unaddressed.	Clear business critical performance indicators will be developed for the service. Once developed, regular monitoring of these indicators will be undertaken and evidence retained to support any necessary corrective action taken.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 2011.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
2.2	***	Benchmarking with other local authorities and 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 weaknesses are identified.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 2011.

3. Corporate Performance Management

AUDIT OPINION

Significant 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 October 2010 totals £2,361,595. Actual net expenditure for the same period totals £ 2,042,458, an under spend of £319,137. Budget forecast reports prepared in October 2010 by the senior accountant indicate an under spend of £482,269 at year end due to vacant posts.

Good practice includes:

- A training matrix is retained by the project manager. Six monthly training and development reviews are carried out and action plans formed to help monitor requirements.
- An equality impact assessment has been undertaken and action plan produced with is regularly reviewed.
- Team meetings take place on a regular basis and are minuted.
- Health and safety standards have been risk assessed and local arrangements updated as appropriate.
- Return to work interviews had been completed on a timely basis and signed by the employee and relevant manager for all 3 periods of sickness examined.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.1	**	An annual IPM (now EPA) had not been undertaken for homecare establishment managers.	Non-compliance with corporate procedures.	IPM's (now EPA) will be carried out in accordance with the EPA scheme. This ensures staff issues and training needs are addressed and acted upon accordingly.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader Assistant Team Leader Assistant Team Leader.

					April 2011.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.2	**	The business continuity plan is in draft format. Further it does not include the out of hours service.	Appropriate action in the event of an emergency/ interrupted function may not be undertaken.	The business continuity plan will be updated to include the out of hours service and finalised as soon as possible.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader Resilience Officer. April 2011.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.3	***	There is no evidence that the service has undertaken an assessment of potential risks affecting it. The service manager confirmed to the auditor that this will be addressed as part of the service / team plan update.	The service fails to achieve its aims because managers fail to mitigate against foreseeable risks.	As part of the service / team plan update, a risk assessment will be undertaken to ensure that all potential risks to service delivery have been identified and mitigated via management action plans where appropriate.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 2011.
3.4	**	In examining team minutes for 15 April and 10 June 2010 it was found that: • there is no reference to news & views (15/4/10). • it was noted there had been problems retrieving news & views (10/6/10).	Staff may not be aware of developments within the council.	Officers have now been made aware of the core brief (previously news & views) and this is now included within the minutes of each meeting.	Acting Team Leader Assistant Team Leader Assistant Team Leader. Implemented.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
3.5	***	From a sample of 3 sickness absences selected it was found that: • In 2 cases, the reason for not issuing a notice of concern was not documented. (ref: ██ and ██).	Non-compliance with the council's sickness management procedures.	Explanations for notices of concern not being issued to employees are now recorded on the return to work form and updated on the sickness portal.	Assistive Technology & Telehealthcare Manager Acting Team Leader Assistant Team Leader Assistant Team Leader. Implemented.

4. Joint Working

AUDIT OPINION

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

Good practice includes:

- Quarterly monitoring of activity is undertaken to identify whether joint working arrangements are beneficial.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.1	**	The service level agreement for joint working arrangements between social care and Walsall primary care trust at Rushall Mews rehabilitation centre is currently in draft format. At the time of the audit, it could not be established whether a business case had been conducted prior to entering into the joint working initiative with the primary care trust.	Desired outcomes and resource commitments may be unclear and open to dispute / challenge. Inappropriate joint working initiatives may be entered into.	The draft SLA which covers joint working arrangements between social care and inclusion and Walsall primary care trust will be finalised as soon as possible. A prior evaluation / business case will be undertaken prior to entering into future partnership/joint working initiatives.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 2011.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
4.2	**	The service manager was not aware of the partnership toolkit.	Non-compliance with corporate procedures. Lack of awareness of partnership arrangements.	Key staff will be made aware of the partnership toolkit to enable partnership opportunities to be administered in accordance with council toolkit.	Assistive Technology & Telehealthcare Manager Service Manager - Provider Services Acting Team Leader. April 2011.

5. Procurement

AUDIT OPINION

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

Good practice includes:

- All invoices sampled for testing had been allocated to an appropriate Oracle code.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
5.1	**	From a sample of 10 paid invoices selected it was found: • in 2 cases the order was raised on or after the invoice received date (ledger ref: 869526 and 854504). • In 1 case the same officer authorised the order and invoice (ledger ref: 863073). • in 1 case it took more than 15 days for an invoice to be paid. (ledger ref: 869526). • in 2 cases the invoices were not stamped as paid (ledger refs: 869526 and 869947). • in 1 case the order value was lower than the invoice value (ledger ref: 863156).	Non compliance with financial rule 8.3. Inadequate segregation of duties. Failure to adhere to creditor payment target. Poor supplier relationships. Invoices may be paid twice. Inconsistent records.	In accordance with the authority's financial rule 8.3 official orders are now raised for all work, materials, goods or services to be supplied to the council. This is now prior to goods/invoices being received, and not in retrospect. To maintain segregation of duties, officers authorising orders are now independent of the officer authorising invoices. Invoices are now paid within 15 days of receipt, unless contract terms state otherwise. Invoices are now stamped as paid when they have been passed for payment. Care is now taken to ensure that order values accurately reflect the current price of goods to allow for the matching of invoices.	Acting Team Leader Administrative Assistant Payables Development Manager. Implemented.

6. Client Referrals

AUDIT OPINION

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

Good practice includes:

- A database is maintained by the project manager detailing all referrals received.
- Care plans are signed by the client or an advocate of the client and the senior care officer prior to the commencement of care.
- Risk assessments are completed as part of the service user pack.
- The project manager undertakes independent checks of the service user profile forms and orders to ensure records are accurate.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
6.1	**	From a sample of 13 new referrals it was found in 1 case that a variation had been made to a clients care hours, however, a new order form had been completed rather than a variation order form resulting in the client being shown on the database as a new referral. (ref: [illegible])	Inaccurate information maintained.	Officers now ensure that the correct forms are completed at all times to allow records to be accurate and up to date.	Assistant Team Leader Assistant Team Leader. Implemented.

7. Delivery of Care

AUDIT OPINION

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

Good practice includes:

- All spot check forms examined had been signed by the homecare assistant and monitoring officer.
- All annual monitoring forms examined had been appropriately completed and signed by the interviewing officer.

ACTION PLAN

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.1	***	There is no requirement for contact sheets, which detail the date and time of each visit and tasks undertaken, to be signed by the client. It is understood that the introduction of electronic call monitoring is in progress.	Inadequate supporting evidence that care has been provided as required by the client.	The service now ensures that contact sheets are signed by the client or an advocate of the client to ensure care has been provided as required. The introduction of an eABLE pilot (performance monitoring tool) has now commenced.	Assistant Team leader Assistant Team Leader Project Manager. Implemented.
7.2	***	Monthly timesheets, which are completed by care assistants showing the total hours worked on each day, are reconciled to annual leave /sickness/ training/ records and also hard copies of the 'Staffplan' rotas which may have been amended to reflect any changes to care provided by the senior care officers. The timesheets are not reconciled to contact sheets.	Fraudulent / irregular time may be claimed.	The service has now reviewed the procedure for the verification of timesheets to ensure that timesheets are compared to contact sheets.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.3	***	From a sample of 13 new referrals it was found that: • on 3 occasions the number of visits scheduled as per the electronic rota did not match the number of visits on the contact sheet or 'Staffplan' order (ref: ██ w/c 26.04.10; ██ w/c 28.05.10; ██ w/c 19.04.10). • in 1 of these 3 cases a variation order had been completed but the 'Staffplan' system had not been updated to reflect this. (██) • in 1 of these 3 cases a variation order had not been completed when 2 scheduled visits had been cancelled. (ref: ██)	Inaccurate records maintained. Care may not be provided to the client / staff may undertake visits that are not required. Lack of audit trail. Charges to clients may not be appropriately made.	It is now ensured that: • all appropriate records are kept up to date including the 'Staffplan' system. • a variation order form is completed for all amendments to the care package.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.
7.4	***	From a sample of 13 new referrals it was found that on 3 occasions the homecare assistant included on the electronic rota was different to the homecare assistant on the contact sheet. The 'Staffplan' rota is not updated on the database for any changes in homecare assistants or visits only a hard copy is amended. (ref: ██ w/c 27.05.10; ██ w/c 14.05.10; ██ w/c 07.04.10).	Inconsistent records maintained.	Officers now ensure that the 'Staffplan' rota is updated at the end of each day to reflect changes in staff undertaking care visits / visits being undertaken.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.5	***	From a sample of 13 new referrals it was found that: • on 1 occasion the homecare assistant had not signed the contact sheet. (ref: [redacted] 02.06.10) • on the majority of occasions the times of the visits on the contact sheet differed to those on the rota and order.	Incomplete records maintained. Lack of evidence that visit undertaken by homecare assistant. Clients may not have received the care that they are entitled to.	Homecare assistants now ensure that they sign all contact sheets to evidence their visit. Care is now taken to ensure that visits are made to clients in accordance with the care package.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.
7.6	**	From a sample of 5 annual monitoring forms tested, it was found on 2 occasions that form had not been signed by the homecare establishment manager to evidence that a review of the form had been undertaken. (ref: [redacted] and [redacted]).	Incomplete records maintained. Lack of evidence that review undertaken.	The assistant team leaders now review and sign all annual monitoring forms.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.

Ref	Priority	Finding	Risk Exposure	Agreed Action	Responsibility & Timescale
7.7	***	The auditor was informed by homecare managers that travel time is included within the time allocated to homecare assistants on the rota. However, from a sample of 5 client visits examined, it was found that on 4 occasions the duration of the visit was the same on the rota and the care package (ref: ██ 28.05.10; ██ 24.05.10 ; ██ 02.06.10; ██ 04.06.10). In examining 1 staff rota in detail it was found on 1 occasion that there was not a gap between the end time and start time of 2 visits which were not in the same vicinity. (ref: ██ – 25.06.10).	Clients may not have received the care that they are entitled to. Clients may be over / under charged for care received.	Arrangements for the planning of visits have now been reviewed. Homecare assistants are now allowed sufficient travel time between client visits.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.
7.8	**	The auditor was informed by the homecare establishment managers that financial transactions are occasionally carried out on behalf of the clients.	Possible inadequate protection of staff.	Continuation of the practice of undertaking financial transactions on behalf of clients has now been reviewed to ensure that it has been properly risk assessed and affords adequate protection for staff against any accusations of error, fraud or corruption. Service users now sign in agreement and on-going monitoring of this now takes place.	Assistant Team Leader Assistant Team Leader Project Manager. Implemented.

8. Fees and Charges

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	***	No debt monitoring is currently being undertaken for home care charges.	Potential loss of income to the authority.	All charges will be processed through Oracle in the new benefits based charging system and debts will then be progressed through the corporate debt system thereafter.	Specialist Debtors' Manager June 2011.
8.2	***	From a sample of 13 new referrals it was found that: • on 2 occasions there had been a delay in notifying the client of their assessed charges. Charges cannot be backdated. (ref: ██, ██) • on 1 occasion the client had been notified of a charge for 7 half hour visits per week but the FISCOM order stated that they should be receiving 21 half hour visits per week. (██)	Unnecessary delays in client notification. Loss of income to the authority.	Clients are now notified promptly of their assessed charge. Officers now ensure that the correct number of visits is included on the FISCOM order and the financial notification.	Specialist Debtors' Manager. Implemented.
8.3	***	From a sample of 13 new referrals it was found on 5 occasions that a financial assessment did not appear to have been undertaken and therefore the client had not been charged for care received. An explanation was sought from the specialist debtor's manager at the time of the audit but a response was	Loss of income to the authority. Charges may not be appropriately made.	Officers have now investigated each of the cases identified and ensured that financial assessments have been undertaken and the client charged where appropriate.	Specialist Debtors' Manager Implemented.

		not received. (ref: [redacted], [redacted], [redacted], [redacted] and [redacted])			

9. Anti Fraud and Irregularity

AUDIT OPINION

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

Good practice includes:

- Weekly management reports are produced and reviewed detailing referrals received, homecare provided and available capacity.
- The petty cash tin is held securely.
- Procedure notes have been signed and dated by 2 officers.
- Officers sign to acknowledge the receipt of all policies and procedures.

ACTION PLAN

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