INTERNAL AUDIT AND ANTI-FRAUD PROGRESS REPORT

London Borough of Southwark

For presentation to the Audit, Governance and Standards Committee

17 November 2021

CONTENTS

1. SUMMARY OF INTERNAL AUDIT WORK

Purpose of report

This report informs the Audit, Governance and Standards Committee of progress against completion of the 2020-21 and 2021-22 internal audit plans. It summarises the work we have undertaken, together with our assessment of the systems reviewed and the recommendations we have raised. Our work complies with Public Sector Internal Audit Standards.

Internal audit methodology

We have agreed terms of reference for each piece of work with the risk owner, identifying the headline and sub-risks, which have been covered as part of the assignment. This approach is designed to enable us to give assurance on the risk management and internal control processes in place to mitigate the risks identified. Our reporting methodology is based on four assurance levels in respect of our overall conclusions as to the design and operational effectiveness of controls within the system reviewed - substantial, moderate, limited or no assurance. The four assurance levels are designed to ensure that the opinion given does not gravitate to a "satisfactory" or middle band grading. Under any system, we are required to make a judgement when making our overall assessment. The definitions for our assurance levels are set out in appendix 1 to this report.

Internal audit plan 2020-21

All work relating to the 2020-21 plan has been completed. Where reports have been finalised, the executive summaries are included in section 4 of this report.

Internal audit plan 2021-22

The current status of audits within the 2021-22 is outlined within section 3 of this report.

Internal audit programme for schools 2021-22

We have agreed a work programme with the Director of Education that will meet the assurance needs of the Council, whilst recognising that schools have faced significant pressure during the year and have remained closed for significant periods of time. We completed the first set of individual school audits during the period April to July 2021. The plan for the remainder of the year is to be agreed with the Director of Education.

Follow up

As part of finalising each audit report, we agree with management the actions that will be taken in response to each finding and recommendation. Within their response, management include the date by which the actions will be completed. Internal audit routinely follows up all high and medium recommendations made ahead of each Audit, Governance and Standards Committee. A full schedule of recommendations falling due in the period is issued to each Departmental Management Team.

The recommendation implementation rate has increased from 75% to 87% since our last progress report (reported in September 2021), a significant improvement. This is primarily due to timely updates and evidence being provided by the required deadlines, although there continues to be some audits for which the required updates and / or evidence has not been provided. Therefore, the actual implementation rate may be higher than 87%, however without management responses and supporting evidence we cannot confirm this.

Other internal audit work

We are undertaking a reasonable assurance engagement in connection with the EU project URBACT Thriving Streets by performing First Level Control (FLC) claims verification for the period 1 April 2021 to 7 August 2022. Our report will be an independent assurance conclusion as to whether the subject matter is in agreement with the grant offer letter in all material respects with eligibility criteria for the costs taken into consideration. A separate letter of engagement has been agreed with the Council for this work. Phases 1 and 2 covering expenditure from 1 April 2021 to 30 September 2021 will be audited in November 2021. Phase 3 expenditure for the period 1 April 2022 to 7 August 2022 will be audited in August 2022.

2. ANTI-FRAUD UPDATE

BDO has been engaged to provide management support and strategic advice to the anti-fraud team at the Council. The lead for this work is Nick Baker (FCCA, ACFS), an accredited counter fraud senior manager and forensic accountant within BDO forensic services.

Summary of investigations 2021-22 to date

2021-22	Corporate Anti-Fraud		Housing Waiting List		Right to Buy		COVID-19 Referrals	
	Open	Closed	Open	Closed	Open	Closed	Open	Closed
C/f	**18**		**0**		**9**		**18**	
April 2021	**17**	*21*	**2**	*2*	**6**	*5*	**1**	*0*
May	**12**	*9*	**9**	*2*	**3**	*6*	**3**	*0*
June	**15**	*13*	**1**	*2*	**1**	*1*	**1**	*0*
July	**6**	*12*	**7**	*8*	**3**	*2*	**0**	*0*
August	**8**	*7*	**4**	*4*	**4**	*4*	**8**	*8*
September	**14**	*23*	**4**	*7*	**6**	*1*	**8**	*0*
October	**7**	*16*	**3**	*3*	**5**	*5*	**11**	*0*
Total	**97**	*101*	**30**	*28*	**37**	*24*	**50**	*12*

** The figures represent investigations from 1 April 2021 to 31 August 2021.*

Active investigations

There are currently 11 active investigations.

- Children & Adult Services 5 cases
- Environment & Leisure 2 cases
- Housing & Modernisation 1 case
- Finance & Governance 4 cases
- COVID-19
    - Business Grants- 18 cases
    - Community Grants- 9 cases.

In total three cases relate to former Council employees and two cases relate to a current Council employee. No further information in respect of these investigations can be given at this time.

Following a direction from BEIS concerning recovery of grant payments we reviewed with Exchequer Services to determine which cases should be referred to BEIS releasing resources so the Anti-Fraud Team could focus on actual fraud cases. The Anti-Fraud Team is writing to those who received grants that have since been identified as not eligible or may have submitted fraudulent applications and inviting them to attend an interview.

Pro-active Anti-Fraud Work

Training

The Corporate Anti-Fraud Team is working with Southwark learning to develop a new suite of eLearning in our efforts to raise awareness across the council to combat fraud, bribery, corruption and tax evasion.

Document Scanners

The Council uses document scanners to verify identity documents including passports, ID cards and driving licences. The current equipment, located at various sites across the borough, due to age and changes in Southwark IT systems has come to the end their operational effectiveness. The Corporate Anti-Fraud Team is engaging with key services who currently use the scanners as well as other services who we believe will benefit from future access to review the use of scanner technology. The availability of this technology which has seen significant changes in recent years will create a journey through ID verification that is effective and efficient for both staff and residents and continue to act as a deterrent for fraudulent applications.

Fraud and Verification

The Corporate Anti-Fraud Team conducts reviews of housing waiting list and Homelessness applications which have an identified cause for concern. A test of the veracity of the application enables housing management to make an informed decision on the applicant's eligibility to remain on the housing register.

Between 1 April and 31 October 2021 we have received 37 referrals, 14 have been removed or rejected, seven have been recommended to be maintained the remaining are waiting for further information from the applicant.

Right to Buy

The Council introduced forms to check the veracity of the sources of funds used for the purchase of properties under the right to buy scheme. Referrals are raised when the cash element of the purchase exceeds HMRC guidelines. For the referrals we review the source of cash funding and make a recommendation to the RTB team. Between 1 April and 31 October 2021 there have been 26 referrals. Three have been denied, eight have been approved and 15 applications require supporting evidence from the applicants for the source of the funds before we can make a recommendation.

NFI

We continue to investigate matches identified by The Cabinet Office National Fraud Initiative risk assessment focussing on reports that have been identified as high risk reports. There has been no significant change to NFI figures since the last report.

Fraud Response Plan

The Council's Fraud Response Plan sets out in detail the Council's approach to identifying and dealing with potential fraud, the responsibilities of staff and the public in reporting suspicions of fraud, the approach the Council is committed to in investigating allegations of fraud, and the possible sanctions open to the Council when fraud is proven to have taken place. We hope to launch the new Fraud Response Plan during International Fraud Week commencing 15 November 2021.

3. SUMMARY OF WORK IN PROGRESS

INTERNAL AUDIT PLAN 2020-21

The table below includes those audits currently in draft or finalised since the last meeting of the Audit, Governance and Standards Committee. For those shaded in grey, the executive summaries are included in section 4.

Audit	Director / Audit Sponsor	Days	ToR issued	Fieldwork	QA / Reporting	Design	Operational Effectiveness
2020-21							
Accounts Payable	Director of Exchequer Services	15	✔	✔	✔ Final report	Moderate	Moderate
Accounts Receivable and Debt Management	Directors of Exchequer, Environment and Leisure	15	✔	✔	✔ Final report	N/A – due to Covid-19, this was a reduced scope audit	
South Dock Marina	Director of Leisure	12	✔	✔	✔ Updated Draft Report to be issued following initial management responses, further evidence has been provided and additional testing has been undertaken		

INTERNAL AUDIT PLAN 2021-22

The table below includes those audits where planning work or fieldwork has commenced:

Audit	Director / Audit Sponsor	Days	ToR issued	Fieldwork	QA / Reporting	Design	Operational Effectiveness
2021-22							
Supporting Families Grant	Director of Children and Families	24	Council guidance compared to new MHCLG reviewed and audits completed on a sample of 10% of claims on a quarterly basis.			For the period to 30 September 2021, no exceptions were identified for the sample of claims reviewed.	
Covid-19 Expenditure	Strategic Director of Finance and Governance	15	✔	✔	✔ Final	Substantial	Substantial
Fraud Protocols	Strategic Director of Finance and Governance	20	✔	✔	✔ Final	Moderate	Limited
Youth Offending Service	Director of Children and Families	15	✔	✔	✔ Final	Moderate	Moderate
Adoption Services	Director of Children and Families	15	✔	✔	✔ Draft issued 28/07/2021 Partial management response received 08/09/2021. We are awaiting a final response following provision of additional information on the results of audit testing.		
All Age Disabilities Service	Director of Adult Social Care	25	✔	✔	✔ Draft issued		

Audit	Director / Audit Sponsor	Days	ToR issued	Fieldwork	QA / Reporting	Design	Operational Effectiveness
					12/08/2021. Initial management response received 17/09/2021. We are awaiting management availability to discuss.		
Data Protection	Director of Law and Governance	15	✔	✔	✔ Draft issued 25/08/2021 Partial management response received 05/11/2021.		
Departmental response to schools in financial difficulties	Director of Education	15	✔	✔	✔ Draft issued 21/10/2021		
Health and Safety	Director of Asset Management	20	✔	✔	✔ Draft issued 25/10/2021		
IT – Hornbill Service Desk	Head of ICT	15	✔	✔	✔ Draft issued 18/10/2021		
NNDR	Director of Exchequer Services	15	✔	✔	✔ Draft issued 16/08/2021 Management response received 19/10/2021 and under review		

Audit	Director / Audit Sponsor	Days	ToR issued	Fieldwork	QA / Reporting	Design	Operational Effectiveness
Objection Review	Strategic Director of Finance and Governance	10	✔	✔	✔ Draft issued 06/10/2021. Management response being finalised, report to be tabled at the meeting		
TMOs - Cyclical Compliance Audits – JMB Leathermarket	Director of Communities	15	✔	✔	✔ Draft issued 26/08/2021		
TMOs - Cyclical Compliance Audits – Cooper Close	Director of Communities	10	✔	✔	✔ Draft issued 31/08/2021		
Contracts Register	Director of Law and Democracy	25	✔	✔	✔ Draft report in collation		
Fairer Future Procurement Framework	Director of Law & Governance	25	✔	✔	✔ Draft report in collation		
Financial planning and budget monitoring	Strategic Director of Finance and Governance	25	✔	✔	✔ Draft report in collation		
Suspense Account Management	Director of Exchequer Services	15	✔	✔	✔ Draft report in collation		
Council Tax	Director of Exchequer Services	15	✔	✔			

Audit	Director / Audit Sponsor	Days	ToR issued	Fieldwork	QA / Reporting	Design	Operational Effectiveness
Customer Access Strategy	Director of Customer Experience / Director of Exchequer Services	15	✔	✔			
Emergency Planning	Head of Chief Executive's Office	15	✔	✔			
Housing Benefits	Director of Exchequer Services	15	✔	✔			
Older People's Services	Director of Adult Social Care	15	✔	✔			
Licensing	Director of Environment	15	✔	✔			
Major Works	Director of Asset Management	15	✔	✔			
Member / Officer Protocol	Director of Law & Governance	15	✔				
Pensions Administration	Strategic Director of Finance and Governance / Pensions Manager	15	✔				
Electoral Register and Elections	Director of Law and Governance	15	✔ Draft				
IT Disaster Recovery	Director of Customer Experience	20	✔ Draft				

4. EXECUTIVE SUMMARIES OF REPORTS FINALISED SINCE THE LAST MEETING

KFC07 **Accounts Payable** September 2021		LEVEL OF ASSURANCE Design: Moderate Operational effectiveness: Moderate		SUMMARY OF RECOMMENDATIONS High: - Medium: 3 Low: -	
Purpose of audit:	To provide continuing assurance on the adequacy of the design and operational effectiveness of internal controls in managing accounts payable processed via SAP, to ensure that they are promptly and effectively brought into use. We also reviewed the timeliness of payments to suppliers and the extent to which the 30 day payment terms are being met and determined the reasons where delays in payment are evident.	**Added value:**	We identified the following through data analytics, which management has confirmed and investigated where necessary: 1. Duplicate Payments are identified and variations resolved on a daily basis however, the software retains this information although reporting is not presently available. 2. Six employee's bank details and addresses were the same as six individual vendors. In addition two generic bank account numbers/sort codes were being utilised to process payments to several vendor and employee payroll transactions. These were investigated and confirmed as being appropriate for each case. 3. 96 duplications in vendor standing data, with the same bank account details being shared across several vendors. This has been investigated and any actual duplicates have been marked for deletion by management. 4. The average number of days from the Invoice date to clearing date is 43 days to be paid. These issues were identified at a population level, the results of sample testing is covered in the following section.
Background: The Council's main financial system is SAP within which accounts payable transactions are recorded. SAP allows invoices to be scanned onto the system and electronic purchase ordering /invoice approval is linked to the Council's scheme of management. The Financial Control and Processing (FC&P) Team within					

the Exchequer Service division supports the processing of the majority of these transactions. The departments can raise purchase orders electronically through SAP, these are work-flowed to the relevant individuals via ESS or via email, which are the sources of evidence and sign off for the FC&P Team to raise orders electronically. The departments send an email to the FC&P Team confirming the receipt of goods. Once the purchase order, invoice and goods receipted are completed (three-way matching system within SAP), the invoice is processed for payment.

Non-purchase order payments (direct entry) are requested via email on Excel spreadsheets which detail the requisition and contain authorisation of the delegated purchase within it. Invoices raised by suppliers are issued to the departments who are responsible for carrying out the relevant checks before providing them to the FC&P Team – it is not the role of the FC&P Team to assess the accuracy, completeness and validity of the invoices received but the relevant budget holder.

The FC&P Team undertakes payment runs every day at 1pm and checks for duplicate payments before the run. The transactions that are flagged as duplicates or unusual are not processed for payment on that day.

The FC&P Team is split into four teams: control, processing, quality and payroll. The team is led by the Head of Financial Control and Processing who reports to the Head of Assessments and Payments.

Good Practice:

- A vendor amendment form was completed in full for all vendor changes selected in our sample, with appropriate authority approving the forms prior to being sent to the FC&P team for processing
- All vendor changes were approved by the relevant staff members within the FC&P team
- All winshuttle payments, these are direct payments processed via a spreadsheet rather than via purchase order, were processed by the correct staff member within the FC&P team.

Key Findings:

- From a sample of 20 vendor payment transactions from 1 April 2020, we found the following exceptions:
  - On six occasions, the purchase order was raised after the invoice was received.
  - On three occasions, the authoriser of the purchase orders was not listed on the scheme of management.
  - On six occasions, payments were not made within 30 days.
  - From the above six cases, on two occasions the FC&P five day processing target was not achieved.
- From a sample of 20 direct payments (which do not involve a purchase orders) from 1 April 2020 we found that:
  - On one occasion, it was not clear who requested the payment.

Conclusion:

Overall, we have concluded moderate assurance in respect of the design of the control framework and limited assurance on the operational effectiveness of the controls in place. Whilst no payment errors have been identified, our review identified continued non-compliance with the Council's required procedures, some of which have been raised in previous audits. In relation to control design, it is apparent that a number of staff who are authorising payments have not been included within the scheme of management. In addition, during a recent SAP scheme of delegation audit, issues were identified with the processes adopted for ensuring that leavers are removed from the system in a timely manner and for ensuring that changes to users' roles within the Council are appropriately communicated to the FC&P team. In relation to control effectiveness, issues were identified with purchase orders are raised

before receipt of the invoices and suppliers are not paid within 30 days. It should be noted that the issues concerning the scheme of management and the timely raising of purchase orders were identified in the last three audits. Therefore, we advise that the implementation of the recommended actions and ongoing compliance with the Council's procedures should be monitored by senior management	
Looking forward: supporting the Council's journey from moderate to substantial assurance	
Design	• The schemes of management should be updated to reflect staff who are able to authorise payments.
Effectiveness	• Required purchase orders have been completed and approved before commitment to the purchase is allowed. • The FC&P team should run reports to identify cases where the 30 day target is being exceed and ensure that departments are reminded of the need to submit invoices for payment in a timely manner and full explanations should be requested and recorded when there are delays. • Winshuttle payments should not be processed by the FC&P team unless there is evidence of who requested and authorised the payment with dates.

KFC04 **Accounts receivable and debt management** November 2021	LEVEL OF ASSURANCE		SUMMARY OF RECOMMENDATIONS	
	Design	Operational effectiveness	High	-
			Medium	2
	NA	NA	Low	-

Purpose of audit:	The original purpose of the audit was to provide assurance on the arrangements to manage income processed via SAP (both by FC&P and other departments) to ensure that they are promptly and accurately collecting and recording income as well as debt recovery. However due to Covid-19, we were only able to perform a limited scope of work. Therefore we did not provide assurance opinions.

Background:

The Council input, record and manage their Accounts Receivable through the SAP Finance System. The income collected by the Council is from various income streams such as Social Care, Waste, and Licensing. The team produce a monthly dunning report directly from SAP; as of 31 July 2019 there was approximately £22m of income due to be collected.

New customer accounts are set up at a departmental level and processed by the SAP Financial Control & Processing (FC & P) team once they have received the supporting documentation. Once invoices have been raised and authorised they are processed by the SAP FC & P team.

Write-offs of invoices are approved in accordance with the council's policy.

The environment and leisure directorate has been selected as part of a rolling programme due to concerns being raised around the adequacy of debt recovery in relation to key departments within the directorate. This work has specifically focused on recovery completed by the South Docks Marina and the Parking Team. As a result of Covid-19 the Council was not able to provide the information to allow us to complete our work and were unable to complete all work identified as part of the terms of reference. We were able to complete reviews into the environment and leisure teams identified above: the South Docks Marina and the Parking Team; and reviewed the processes involved with debt management and recovery.

Good Practice:

- We reviewed four returns (April and October 2020, March and June 2021) and found that they were prepared using appropriate and accurate source data in each case (NB we have not tested the accuracy of the underlying data)
- Expenses charged to Covid-19 cost codes are kept in a holding account and reviewed and posted to the correct code by Departmental Finance Managers.
- Each line of the MHCLG return is supported by evidence and a narrative.
- All data submitted is reviewed and queried by Departmental Finance Managers, the Technical Accountant and the Strategic Director of Finance.
- A benchmarking exercise is completed to compare costs with other London boroughs and any large variances are investigated.
- A Covid-19 expense report is presented at each Audit, Governance & Standards Committee and was found to agree to the last MHCLG return submitted at the time.

Good Practice:

We confirmed through review of the governance, control frameworks and finance frameworks that information is available to staff relating to debt management across the Council.

Key Findings:

- Write offs have not been completed for both the Parking and South Dock Marina services.
- Reconciliations are completed for Parking and South Dock Marina, however it was not possible to confirm that variances were investigated and that they were reviewed by a second officer.
- For South Dock Marina the reason behind delays in invoice payment related to the Council holding incorrect email addresses of customers.

Conclusion:

As a result of Covid-19 the Council has not been able to provide the information to allow us to complete our work. Therefore, this report does not contain an assurance opinion but our audit to date has not suggested that the control environment has deteriorated. Below is a summary of the areas where further testing was required in order for this audit to be completed.

- Risk 1 – inaccurate records and invoices, resulting in non-receipt of payments.
- Risk 3 – databases are not cleansed periodically to remove duplicate accounts.
- Risk 4 – fraudulent amendments to income are possible due to inappropriate customers given credit and refunds.

We will consider if a further full audit is required as part of the internal audit planning process for 2022-23.

COT03 **Covid-19 Expenditure** October 2021	LEVEL OF ASSURANCE		SUMMARY OF RECOMMENDATIONS	
	Design	Operational effectiveness	High	-
			Medium	-
	Substantial	Substantial	Low	1

Purpose of audit:	To provide assurance over the design and operational effectiveness on the controls relating to the governance and reporting of Covid-19 related expenditure. To provide assurance that the process was robust, consistent and had the necessary oversight and governance and in line with MHCLG guidance.

Background:

During 2020-21, the UK government allocated emergency funding of approximately £4.6 billion to the local authorities in England to support local authorities through the Covid-19 pandemic and associated spending pressures, across four tranches.

- First tranche (27 March 2020): £1.6 billion (emergency grant)
- Second tranche (28 April 2020): £1.59 billion (emergency grant)
- Third tranche (11 July 2020): £494 million (support measures including £500 million of non-ringfenced funding to respond to spending pressures)
- Fourth tranche (22 October 2020): £919 million (non-ringfenced funding to respond to spending pressures).

The Council was allocated a total of £33.5 million across these four tranches as follows:

- First tranche: £11.1 million
- Second tranche: £8.8 million
- Third tranche: £3.6 million
- Fourth tranche: £10 million

The Ministry of Housing, Communities and Local Government (MHCLG) carries out a data collection exercise every month to gather information on the impact Covid-19 is having on local authority finances. The data collection is designed to provide government with ongoing financial management information on financial pressures councils are experiencing due to the Covid-19 pandemic. The data collection is not a formal return but best estimates to inform work in government on supporting local authorities.

This information collection exercise will be run on a regular basis while the government's response to the pandemic is ongoing. We recognise that both central and local government did not anticipate the severity and length of the pandemic. There has been three separate lockdowns and a tiered system of lockdown restrictions, which significantly altered expected council losses over the period, which is reflected in the multiple tranches of funding delivered by government.

There has been regular reporting of Covid costs/losses to the Audit, Governance & Standards Committee (at all meetings during 2020-21 and continuing into 2021-22).

We note that the Council has made returns within the prescribed timeframes and actively engaged with MHCLG officials to clarify, support and develop the data and reporting requirements throughout 2020-21, and will continue to do so in 2021-22.

Good Practice:

- We reviewed four returns (April and October 2020, March and June 2021) and found that they were prepared using appropriate and accurate source data in each case (NB we have not tested the accuracy of the underlying data)
- Expenses charged to Covid-19 cost codes are kept in a holding account and reviewed and posted to the correct code by Departmental Finance Managers.
- Each line of the MHCLG return is supported by evidence and a narrative.
- All data submitted is reviewed and queried by Departmental Finance Managers, the Technical Accountant and the Strategic Director of Finance.
- A benchmarking exercise is completed to compare costs with other London boroughs and any large variances are investigated.
- A Covid-19 expense report is presented at each Audit, Governance & Standards Committee and was found to agree to the last MHCLG return submitted at the time.

Key Findings:

- The internal guidance document on the preparation of MHCLG returns is informal and is not version controlled. It lacks sufficient detail on the roles and responsibilities of those involved in the preparation of the return.

Conclusion:

Within the context that the requirements of the MHCLG returns were regularly changed, we found that the Council has prepared the returns with accuracy, sufficient oversight and approval prior to submission. Therefore a substantial assurance rating was given for control effectiveness.

Due to the ongoing nature of the pandemic, it is our view that it would be appropriate to have a more formal procedure around the preparation of the MHCLG returns and Covid-19 expenditure. However, this has not affected our rating for the design of the framework, which is substantial assurance.

TR17 **Fraud Protocols** October 2021	LEVEL OF ASSURANCE		SUMMARY OF RECOMMENDATIONS	
	Design	Operational effectiveness	High	-
			Medium	5
	Moderate	Limited	Low	-

Purpose of audit:	To review whether Council staff are aware of the fraud protocols, the extent to which Council departments are using the new fraud protocols and the timeliness of the decision-making process for how concerns should be pursued and whether reporting on the KPIs is in place.

Background:

Due to a high turnover of staff within the corporate anti-fraud team and a concern surrounding the clarity of how departments refer frauds to the team, a documented procedure for reporting suspected fraud cases in relation to the Council's employees, corporate finances and services was created. The Fraud Protocol was developed based on existing controls and formally issued in July 2020. The process to follow is documented in a flowchart which is accessible to all staff members through the Council's intranet The Source. An Anti-Fraud Response Plan is in draft stages as of September 2021. Monthly fraud briefings take place; these briefings may be used as a fraud focus group and to market test the fraud protocol.

The protocol covers the process from when the initial information is received to final decision and any legal action or referral to be taken. This information is registered onto the case management system and the triage process begins. If insufficient information is received from the service, then the case is referred back to them. To triage the case more information is collected, and associated officers are identified. The case is assessed, and background information is collected. The Council's Section 151 and Monitoring Officer are informed of the incident and they decide whether there are sufficient grounds to proceed with a formal investigation based on the information provided. If they decide not to proceed with a formal investigation then the case is referred to the respective department and they resolve and close the case themselves.

Between April and August 2021, there were 116 new referrals.

- 20 cases are currently under investigation
- Two cases have been rejected
- 65 cases have been closed
- 28 cases have been transferred out to other organisations

Good Practice:

- The Source intranet page had been fully updated with details of the fraud protocol and was available to staff. Feedback was sought on the draft fraud protocol, anything received was actioned and approved by the Strategic Director to publish as final. The fraud response plan, currently in draft and due to be finalised before the end of 2021, fully incorporated the details contained within the fraud protocol.

- For a sample of 20 cases, we confirmed that sufficient information was provided to allow for initial assessment and triage of the case. This initial assessment took place within five working days of case opening as required under the protocol.
- For all 16 closed cases in the above sample, a formal decision had been recorded on the case confirming the closure.
- On a quarterly basis, reporting was completed and submitted to the Council's Audit, Governance and Standards Committee.

Key Findings:

- The Corporate Anti-Fraud Strategy was dated March 2012 to last until the 2015-16 financial year and had not been subsequently reviewed.
- Responses received to a survey sent out to staff identified that none had received communications in relation to the fraud protocol, no training had been received in relation to the fraud protocol and one response advised they were unsure of the correct route to follow when reporting a fraud.
- Two cases from the sample of 20 were not opened within the required three working days timescale.
- For 18 cases from the sample of 20, the s.151 and Monitoring Officer were not notified about the case by the fraud team case officer following initial assessment, in accordance with the fraud protocols. For seven cases there were delays of 31 days between action being taken and case notes being updated of any subsequent progress.
- Details of bespoke training delivered to the housing, social care, and parking teams between October 2020 and March 2021, was provided however this did not include references to the fraud protocol.
- A completion rate of the corporate mandatory fraud training was identified as 47% within the 12 months in the period March 2020 to April 2021. Reports were previously issued of those who had not completed the training but this has not been recently undertaken.
- Case reviews were undertaken on a monthly basis, however these were not always fully documented based on discussions held, and these did not cover the timescales recorded in the officer work plans.

Conclusion:

The fraud protocol had been fully approved and placed onto the Source for staff to review, sufficient information was provided to allow for an initial assessment and triage, with a formal closure notice recorded where necessary. There is quarterly reporting to the audit committee on fraud cases. However, the corporate anti-fraud strategy has not been updated since the 2015/16 financial year, so we have concluded a moderate assurance opinion on the control design.

Staff reported that no communications or training had been received in relation to the fraud protocol, two cases were not opened within three working days, and there were delays in recording updates to cases on the case management system. Whilst bespoke training had been delivered, this did not include information relating to the fraud protocol, and the mandatory fraud training had a completion rate of 47%, therefore, we have concluded a limited assurance for operational effectiveness.

Looking forward: supporting the Council's journey from moderate / limited to substantial assurance

Design	• Update the corporate anti-fraud strategy and keep under annual review
Effectiveness	• Send out communications to staff in relation to the fraud protocols, and update mandatory/bespoke training • Complete spot checks on a quarterly basis to confirm case opening timeframes • Update the fraud protocols to clarify the involvement of the s.151 and Monitoring Officer • Introduce a requirement that mandatory fraud training should be completed within six months of employment with the Council and introduce six monthly reporting to confirm who has yet to complete this, with escalation as appropriate.

CAS28 **Youth Offending Service and Youth Violence** October 2021	LEVEL OF ASSURANCE		SUMMARY OF RECOMMENDATIONS	
	Design	Operational effectiveness	High	-
			Medium	3
	Moderate	Moderate	Low	1

Purpose of audit:	To provide assurance over the design and operational effectiveness of the YOS's organisational delivery of service. In particular ensuring that their current framework aligns with Domain one of Her Majesty's Inspectorate of Probation's rules and guidance, in preparation for their forthcoming inspection.

Background:

Southwark's Youth Offending Service (YOS) works with young people that get into trouble with the law. The YOS is a service that responds to the criminal justice system when children commit crimes. They investigate the background of a young person and try to help them stay away from crime as well as undertaking preventative programs in schools when funding permits them to do so.

The YOS is subject to periodic inspections by Her Majesty's Inspectorate of Probations (HMIP), the next of which is due during the 2021-22 financial year. They will be rated across three broad domains: the arrangements for organisational delivery of the service; the quality of work done with children and young people sentenced by the courts; and the quality of out-of-court disposal work.

The Council's Youth Crime Management Board (YCMB) brings together the statutory partner agencies as identified in the Crime and Disorder Act 1998 and non-statutory partners who make a significant contribution to the delivery of youth justice services in the London Borough of Southwark. The YCMB is required to manage the performance of the youth justice services in LB Southwark and ensure the delivery of the statutory principal aims through the youth justice services and related provision. This includes reducing the number of young people who enter the Youth Justice System, the likelihood of reoffending by young people and the risk of harm that they can cause to other people and themselves, and the number of young people receiving custodial disposals.

Good Practice:

- Robust quality assurance mechanisms are in place within the YOS. This incorporates scheduled thematic and HMIP preparation audits throughout the financial year. YOS cases are consistently reviewed at key milestones at an operational level and discussed at monthly Out of Court Disposal and Risk Management Panel meetings.
- Partnership agreements are in place, which operate in an appropriate manner, allowing staff to conduct their roles and receive information in an efficient and timely fashion.
- The YOS has strong performance monitoring and trend analysis procedures. Actions to address key risk areas such as disproportionality and resettlements are being prioritised and escalated to appropriate stakeholders.

- The Performance Pack, Youth Justice Plan, Organogram and Handbooks provide sufficient information for staff to conduct their roles appropriately with regards to case management.

Key Findings:

- The YOS policies and procedures reviewed as part of this audit have not been reviewed and updated since 2015. The Youth Offending Rules and Guidance produced by HMIP was updated in May 2021, however, this has not been reflected in any YOS policies. In addition, the YOS has no defined communication channel by which it promotes new policy updates or procedures to its staff. Staff we spoke to did not definitively know where they could access all YOS policies or if certain ones existed.
- Not all Youth Crime Management Board (YCMB) members are appropriately engaged at meetings or knowledgeable about YOS operations. The December 2020 and March 2021 YCMB minutes indicated that 10 members were absent at consecutive meetings.
- The YOS team risk register does not align to the Council's methodology for assessing risks and the process that should be followed to ensure that risks are appropriately mitigated. Risks are not described in detail and are not provided with root causes, action owners or expected resolution dates.
- The YOS has no documented career pathway for staff, detailing routes they can take for promotion or sideways routes.

Conclusion:

The YOS has policies and guidance in place however these are currently out of date. Communication channels relating to rules or procedural updates are undefined. We note good practice within the department's own audit and quality assurance mechanisms.

The YCMB members are not adequately engaged, which contravenes HMIP rules and guidance. The risk register is monitored by the YCMB; however, it does not sufficiently meet the Council's requirements.

Based upon our work, we have therefore provided the YOS with an opinion of moderate assurance in respect of both the design and the operational effectiveness of the controls in place in respect to the organisational delivery of service.

5. SUMMARY OF RECOMMENDATIONS STATUS

Of the 357 high and medium recommendations relating to 2017-18 to 2020-21, that have fallen due as at the end of October 2021, we have confirmed with reference to evidence that 309 have been fully implemented or superseded, representing 87%. The chart shows the relative percentages for each of the four years.

The implementation rate for previous recommendations has increased from 75% to 87% since the last report to the Committee, a significant improvement. Whilst there are some longstanding recommendations from previous years that remain to be implemented, these have now reduced in number.

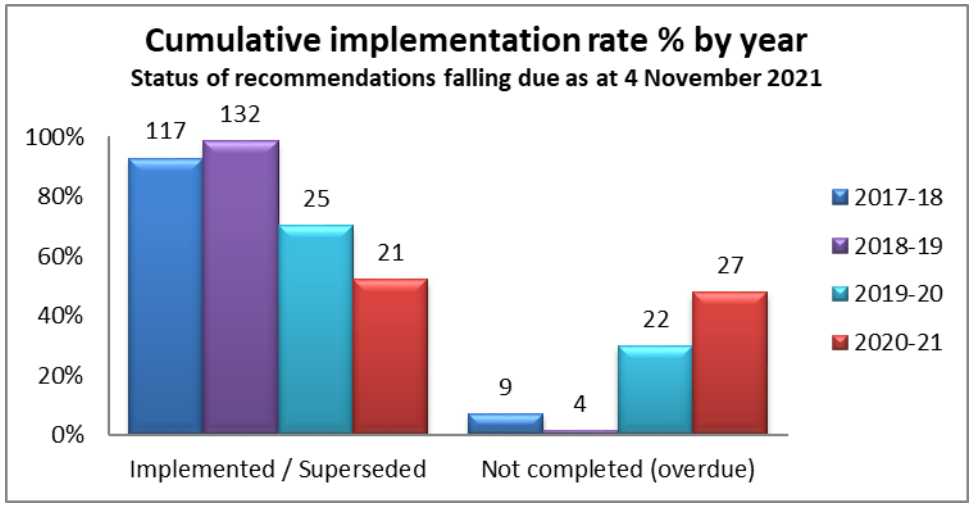
Some audits remain for which the required update was not provided by the date of reporting, which are indicated in our summary below. The implementation rate may be higher than 87%, however without management responses and supporting evidence, we cannot confirm this.

There are also a number of audits where the originally agreed implementation date has not been met and a new date has been provided.

The implementation status of each internal audit is summarised in the table overleaf.

Please note that the table does not include audits where:

- *All recommendations have been implemented*
- *Recommendations that will be followed up as part of another audit during the year (for example key financial systems)*
- *Recommendations are not yet due for implementation.*



RECOMMENDATION IMPLEMENTATION RATES BY AUDIT

Audit Area	Total High & Medium recommendations due for implementation	Implemented		In progress at the follow up date		Awaiting update, revised date or evidence		% verified complete	Management Implementation dates
		H	M	H	M	H	M		
Chief Executive's Department									
2017-18 Land Charges	5	-	2	1	2	-	-	40%	~~April 2019~~ ~~December 2019~~ Awaiting update
2019-20 S106 Agreements	3	-	-	-	3	-	-	0%	~~January 2021~~ December 2021
2020-21 Building Control	3	-	-	-	1	-	2	Not due	June 2022
2020-21 Community Infrastructure Levy	1	-	-	-	1	-	-	0%	~~December 2020~~ Awaiting evidence
2020-21 Movement Policy and Plan	6	-	-	-	-	-	6	Not due	January 2022
Children's and Adults Department									
2019-20 Mental Health Services	3	-	-	2	1	-	-	0%	~~September 2020~~ Awaiting evidence
2019-20 Appointeeships	3	-	-	-	3	-	-	0%	~~September 2020~~ Awaiting evidence
2020-21 Foster Carer Payments	4	-	-	-	-	-	4	0%	~~December 2020~~ Awaiting update
2020-21 Payments to Children and Families	3	-	-	-	-	1	2	0%	~~January 2021~~ Awaiting update
2020-21 Substance Misuse	5	-	-	1	4	-	-	0%	~~October 2021~~ Awaiting evidence

Audit Area	Total High & Medium recommendations due for implementation	Implemented		In progress at the follow up date		Awaiting update, revised date or evidence		% verified complete	Management Implementation dates
		H	M	H	M	H	M		
2020-21 Travel Assistance	1	-	-	-	1	-	-	0%	~~September 2021~~ March 2022
2020-21 Supported Living	3	-	-	1	2	-	-	0%	~~September 2021~~ Awaiting evidence
2020-21 Direct Payments	3	-	-	-	3	-	-	0%	~~August 2021~~ December 2021
Environment and Leisure Department									
2020-21 Climate Change	4	-	-	-	-	-	4	0%	November 2021
2020-21 Tree Management	2	-	1	-	-	1	-	50%	~~September 2021~~ December 2021
Finance and Governance Department									
2019-20 Home Ownership - Garages	3	1	-	-	2	-	-	33%	~~April 2020~~ ~~January 2021~~ November 2021
2020-21 Records Management	1	-	-	1	-	-	-	0%	~~March 2021~~ November 2021
2020-21 Bankline	3	-	1	-	-	-	2	33%	~~April 2021~~ November 2021
2021-22 Anti-Facilitation of Tax Evasion	3	-	-	-	3	-	-	Not due	December 2021
Housing and Modernisation Department									
2017-18 IT – Network Security	8	1	3	1	3	-	-	50%	~~December 2017~~ ~~October 2018~~ ~~June 2019~~ ~~September 2020~~

Audit Area	Total High & Medium recommendations due for implementation	Implemented		In progress at the follow up date		Awaiting update, revised date or evidence		% verified complete	Management Implementation dates
		H	M	H	M	H	M		
									~~April 2021~~ ~~October 2021~~ March 2022
2019-20 Materials	3	-	1	-	2	-	-	33%	~~June 2020~~ ~~April 2021~~ ~~June 2021~~ ~~October 2021~~ January 2022
2020-21 Supported Accommodation	3	2	1	-	-	-	-	100%	~~March 2021~~ ~~October 2021~~
2020-21 Software Asset Management	4	-	-	-	-	-	4	Not due	March 2022
2020-21 Housing Application and Allocations	2	-	1	-	1	-	-	50%	~~September 2021~~ February 2022

RECOMMENDATIONS NOT YET IMPLEMENTED

The tables below show the latest updates with regards to the recommendations not yet implemented, where this has been provided. It excludes recommendations that have not fallen due.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
Chief Executives Department		
2020-21 Building Control		
1a. A detailed set of procedure notes should be available for staff to refer to. This should be regularly reviewed and updated and held centrally so that officers can access the most up to date version as and when required. 1b. Looking ahead to the Council's aim to be ISO9001 compliant, we recommend that the procedures are evaluated against ISO9001 requirements and an assessment made against the tasks and / or resource required to meet those standards. **Medium**	Head of Building Control/Head of Technical Support Idox data cleaning: December 2021 Finalised Procedure notes and ISO QM introduction June 2022	We were advised that the team are carrying out a service review for the building control business support and processes. They are ensuring that the systems and resourcing are fit for purpose.
Environment and Leisure		
2020-21 Tree Management		
(i) Present the options appraisal report to the Cabinet at the earliest possible opportunity to determine the best approach for future tree services as the current arrangement is not operating effectively. **High**	Arboriculture and Tree Services Manager ~~September 2021~~ December 2021	We were advised that the report to Cabinet has now been deferred to December 2021.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
Finance and Governance Department		
2019-20 - Home Ownership - Garages		
b) Waiting lists should be moved onto iWorld to centralise the waiting list procedure. This would minimise the risk of the waiting list being manipulated and would increase the transparency in the awarding of garages. Changes made would be reflected in an audit trail and will be identified if unauthorised. This will also ensure that priority of application as recorded in the Garage Lettings and Voids procedure **Medium**	Operations Manager ~~November 2019~~ ~~August 2020~~ November 2021	We were advised that the Council is still waiting on availability of the i-world team to make the system amendments required. This is being chased and they still hope to have something in place in November, but it was not in time to be included in this report update.
Housing and Modernisation Department		
2017-18 Network Security		
All devices that are running unsupported operating systems should be upgraded to operating systems that are supported by the developer. Where it is not possible to upgrade the operating system of a device, it must be isolated from the Council's IT network and appropriate security controls should be implemented. **High**	Enterprise Architect - IT Shared Services ~~July 2017~~ ~~June 2019~~ ~~September 2020~~ ~~April 2021~~ ~~October 2021~~ March 2022	We were advised that the move to the Azure system cloud is ongoing where support for 2008 R2 has been extended to 2024. The cloud team are working with Southwark Applications team to move any services that are on 2000 \ 2003 servers to newer operating systems. A project is being spun up to look at the outstanding windows 7 and XP devices. There is still: Windows 2000 5 (-2) Windows 2003 69 (-43) Windows 2008 247 (-29) Windows 7 337 (-102) Windows xp 4 (-1) Completion of the DC migration is currently scheduled for March 2022.
Management should establish a complete record of the Council's firewall rules, which includes but is not limited to: • The service that the firewall rule supports, including the owner of the service	Enterprise Architect - IT Shared Services ~~July 2017~~ ~~June 2019~~ ~~September 2020~~	We were advised that rule reviews are now taking place, and all new rules need a business case. As items are moved from DC to Azure the rules are reviewed. The completion of the move from the on premises DCs to the Azure cloud will result in clearer rule sets for the differing LBS zones.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
• Whether the rule allows for inbound, outbound or both connections • The expected levels of traffic for the rule. Furthermore, a full review of the Council's internal and external firewall rules should be performed and, where necessary, insecure or redundant rules should be removed. **Medium**	~~April 2021~~ ~~October 2021~~ March 2022	Completion of the DC migration is currently scheduled for March 2022.
Network activity should be baselined and proactively monitored in order to identify unusual or suspicious activity. This monitoring should include, but not be limited to: • A record of the balance of network activity and external traffic • A record of all open and closed ports and where these have been changed • A record of standard network activity for any given time, which includes known peaks. Furthermore, management should establish a programme to review the efficacy of the network security controls that have been deployed. **Medium**	Enterprise Architect – IT Shared Services. ~~October 2017~~ ~~May 2019~~ ~~September 2020~~ ~~September 2021~~ March 2022	We were advised that no Network intrusion detection system is currently in place. The move to Azure will assist with monitoring. Tools from Solarwinds such as kiwi log and NPM have been bought to assist with logging and monitoring. Solarwinds is used to monitor network bandwidth to ensure that all links are sufficiently sized for the traffic across them. There are roadmap items to improve monitoring across the estate. Some work is ongoing with LOTI to look at a centralised SOC for London which could benefit all councils.
2019-20 Materials		
Where actions are raised in relation to social value, these should be included within the agreed actions and monitored by the Strategic Core Group. The council should seek to confirm the number of apprenticeship and work experience slots and compare these against an expected standard. Evidence should also be received detailing that staff are paid the	SBS Business Service Manager ~~April 2021~~ ~~October 2021~~ January 2022	We were advised that a framework core group meeting was held on 26/10/21 and that the material supplier Travis Perkins and Framework Provider, Pretium have agreed to provide work placements for their branch in Peckham. A meeting is being held on the 5/11/21 to gather the supplier's proposals and agree a recruitment plan for the end of 2021.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
London Living on a quarterly basis to ensure the contractor is meeting its requirements under the Fairer Future Procurement strategy. **Medium**		
2020-21 Housing Application and Allocations		
The Council should ensure that the identity document scanners are functional and are used to confirm the legitimacy of the identity documents submitted by the applicants. If it is agreed by the Council that the document scanners will not be useful due to the restrictions under GDPR, alternative arrangements should be identified and put in place to detect forged identity documents. **Medium**	Acting Head of Housing Solutions ~~September 2021~~ February 2022	We were advised that the housing solutions services and Accommodation & support are liaising with the Fraud and Verification team in order to secure new scanners. The Fraud and verification team are actually leading on replacing the equipment.
Children and Adult's Services Department		
2019-20 - Appointeeships		
1) The Client Finance Mosaic module should be finalised and training provided to staff as soon as possible. 2) The Council's senior management should liaise with NatWest Bank UK in advancing the introduction of real time client bank accounts and the new system should be implemented by Client Finance as soon as possible. **Medium**	Service Development Manager ~~July 2020~~ December 2021	We were advised that this is work in progress that has more recently involved assuring the Council's Corporate Banking officers that protocols safeguarding the moneys of clients and reputation of the client have been thought through. Corporate Banking has requested a flowchart on the Client Affair's Team's processes. This was drawn and sent, and a response is awaited. Focus is now on deputyship accounts as they already can work with the requested functionalities. The many appointeeships will follow once the "test and adjust" with the much fewer deputyship accounts.
Client CMS pooled account reconciliations should be carried out on a monthly basis and in a timely manner for example within three weeks of the month end. **Medium**	Service Development Manager ~~September 2020~~ December 2021	We were advised that individual client account reconciliations are now easier and quicker as cases are now allocated to client finance case worker – i.e. there is individual responsibility as well as better knowledge of cases. There is an Excel template undergoing some modifications/adjustments that will allow for standard presentation of reconciliations. Current reconciliations are also in Excel. The monthly

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
		CMS to SAP reconciliations and charges are getting completed in by about middle of the ensuing months. Inter-Account-Transfers are being prepared with a lag but this is an improving picture. Below shows communications on latest IAT prepared. **Awaiting evidence**
1) Client Finance review the 72 hour appointeeship referral processing target and consider its achievability to ensure it acts as a motivator to staff. 2) The Social Work Team should ensure that the induction programme for new staff reiterate the procedure for submitting referrals to Client Finance and reminders should be issued to all staff periodically by the Social Work Team and Client Finance. 3) Client payments should be approved in a timely manner for example within two days of preparation of the payment journal. 4) A standard template for personal budgets is developed and used in requesting client expenditure payments to Client Finance. **Medium**	1) Service Development Manager July 2020 2) Service Development Manager July 2020 3) Service Development Manager ~~September 2020~~ November 2021 4) Service Development Manager July 2020	These recommendations are partially implemented. We were advised that: 1) The 72 hours turnaround target has been included within the Service Development Personal Budget and Client Finance service plan for 2021/22. The Mosaic business analysts are in the process of building a performance report to monitor compliance with the 72 hour target. Requests for reports to IT Portal (Hornbill) and emails detailing requirements to Mosaic report builders are done and follow up activity continues. 2) The Social Work Client Affairs Working Group monthly meetings (since July 2020) are enabling better understanding of requirements and expectations. Additionally, manager of the Client Affairs Team attends social work team meetings to present on the teams work and take Q & As from social work teams. Below captures essence of Social Work Client Affairs Working Group 3) The latest iteration of policy and procedure updates is ongoing and should be completed before end November 2021. 4) Budgets are not set for appointeeship cases. Social workers get emails confirming incomes/payments from DWP and personal allowances are set to what is considered affordable for service users living in the community. Care home residents get a set amount.
2020-21 Substance Misuse		
(i)The funding for care packages should be authorised in accordance with the hierarchy stated in the Scheme of Management. These limits require that funding requests in excess of £250 and below £800 should be	Team Manager ~~June 2021~~	We were advised that all SMRT packages are now signed off at Service Manager Level. In practical terms Service managers authorise SMRT Panel sheets on Mosaic.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
authorised by the Head of Service or Service manager. An appropriate control should be put in place to ensure that payments are checked to ensure they are correctly authorised before funds are released. (ii)If required, the Team mangers and Deputy limits for authorising payments should be reviewed and appropriate authority provided in the Scheme of Management. **High**	September 2021	**Awaiting evidence**
An appropriate policy and procedure document should be drawn up to provide clear procedural guidance and details of the specific responsibilities within each role. This document should be readily accessible to all staff and should be subject to an annual review or updated when processes are changed. **Medium**	Team Manager ~~June 2021~~ November 2021	We were advised that this is in draft form and is being reviewed.
(i) Social workers should be reminded of their responsibility to ensure that the relevant Care Act Assessments are signed off on Mosaic when completed and the officer responsible for preparing the papers for the panel should ensure this is the case before the panel meets. (ii) In addition, management should undertake a bi-annual review of a sample of agreed care packages to confirm compliance with the above control. **Medium**	Team Manager ~~September 2021~~ ~~December 2021~~	We were advised that the review is not yet completed. This will be scheduled for the week 6-10 December 2021 when there will be a larger sample group to choose from since the relevant changes were actioned.
(i) The check-list form should be amended to ensure that the requirement to record details of the Care Act Assessment which have been input into the system is clearly stated and confirmed.	Team Manager ~~September 2021~~ October 2021	We were advised that: (i) Completed. The information is included in each panel sheet before sign off.

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
(ii) The relevant supporting evidence for each care package should be input onto Mosaic by the social worker. Instructions to appoint a provider should not be issued until this is checked. (iii) Management should undertake a bi-annual review of a sample of agreed care packages to confirm compliance with the above controls. **Medium**		(ii) Completed. The information is included in each Care Act assessment/substance misuse review and has a completion date in advance of any placement or placement extension. (iii) Completed **Awaiting evidence**
2020-21 Travel Assistance		
Supporting documentation such as the expense receipts for direct payments under £40 should be obtained and verified at least annually. These checks should be recorded as for the other payments over £40. **Medium**	Travel Assistance Manager, Education Access ~~September 2021~~ March 2022	We were advised that whilst it is agreed to check receipts for DPs under £40, at least once a year, this will not be undertaken until later in the academic year, during the next two terms.
2020-21 Supported Living		
(i)Staff undertaking the contract monitoring reviews should be reminded of their responsibility for checking that the provider has robust procedures for obtaining DBS checks when required. They should check a sample of the Provider's staff to provide assurance that these procedures are effective and record this as completed on the forms. (ii)Where issues are identified there needs to be a clear follow up strategy with dates for completion. This should be recorded on a centralised spreadsheet and readily accessible to staff to monitor. (iii)The checks being undertaken by CMOs in relation to DBS records should be reviewed to ensure that each provider has been adequately sampled.	Assistant Director for Quality, Performance and Transformation ~~September 2021~~ Ongoing	We were advised that this is part of the contract monitoring toolbox / template. Staff are required to DIP sample provider records in relation to DBS checks and also to check policies on where DBS checks are used, how providers manage positive disclosure and the requirements on staff to report any new convictions or cautions. **Awaiting evidence.**

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
(iv)One standard form should be used for the purpose of undertaking these required reviews. **High**		
(i) The contract monitoring forms should be amended to include a check that residents are receiving the services outlined in their support plans. (ii) Staff should be reminded to interview staff when visiting the providers. **Medium**	Assistant Director for Quality, Performance and Transformation ~~30 June 2021~~ Ongoing	We were advised that: (i) Staff are required to DIP sample care plans when completing monitoring visits (where applicable) however it is not unusual for resident to be receiving slightly amended services where this has been requested and agreed between the service user and provider but within the overall cost of the package – for example changes to tasks or timings. (ii) Staff are required to include service user feedback in their monitoring report though this is not always through interviews with residents and can be through the providers own service user feedback surveys. **Awaiting evidence.**
(i) A review of all the providers should be undertaken to ensure that an appropriate monitoring visit has been undertaken in accordance with the visiting schedule requirements. Management should review the providers visiting schedule monthly to ensure visits are going ahead as planned. (ii) Where issues are raised these should be separately recorded by management to facilitate a subsequent check that outstanding issues have been addressed in a timely manner. In addition, the monitoring forms should be amended to include a specific section to ensure that previously raised items remain satisfactory. **Medium**	Assistant Director for Quality, Performance and Transformation ~~September 2021~~ Ongoing	We were advised that: The provider visits schedule for 2021-22 has been under review as in person visits were only restarted in June 2020 and vacancies and absences within the team have impacted on the planned visit schedule. In Q1 20% of all providers were monitored and in Q2 an additional 21% were monitored. The schedule for the remainder of the year is being reviewed to ensure every contracted provider has had at least one in person monitoring visits during the course of the year and where providers have multiple operational locations and proportion of these locations have been visited as a DIP sample. The full risk based approach to contract monitoring, overseen by the quality and contracts board will be in place in time to set the annual contract management plan for 2022-23. **Awaiting evidence.**

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
2020/21 – CAS11 Direct Payments		
(i) Staff should be reminded of the necessity to ensure that appropriate contract documentation is complete and signed off. (ii) The direct payments team should not issue a direct payment until they have checked that a signed agreement is in place. **Medium**	Service Development Manager ~~August 2021~~ November 2021	We were advised that: (i) An email has been sent to staff in Direct payments team on 01.11.2021 stating that a direct payment cannot be setup until the personal budget agreement has been signed and uploaded to the Carestore document system. (ii) Presentation at OPPD SMT meeting on 03.11.2021 and supporting papers outline that a DP cannot be set up without a signed personal budget agreement form. The Direct Payment Working Group will be reviewing the ASC Direct Payment Policy by the end of Q4 2021/22, which will set out the requirement to obtain a signed personal budget agreement form before setting up a direct payment.
The monitoring forms currently in place should be extended to include a check that relevant annual reviews are completed, recorded and communicated to the operational adult social care teams. **Medium**	Service Development Manager ~~August 2021~~ February 2022	We were advised that staff in the Direct Payment teams complete monthly auditing checks for each self-managed direct payment service and any anomalies are discussed with the individual managing the direct payment service. A full review of each self-managed direct payment service will be completed by the direct payment team on a yearly basis. The monitoring form is due to be added to Mosaic and this will contain a tab to show when the next annual review has been completed. The form will be incorporated within mosaic by February 2022.
(i) Staff should be reminded of the correct process for completing monitoring forms, specifically with regard to third party payments where there is a requirement to check funds are being appropriately utilised. (ii) Monitoring should be completed regularly in line with relevant policies and where problems are identified, such as build-up of surpluses, remedial action should be implemented in a timely manner and monitored monthly. (iii) For self/individual managed direct payments, the return of the client information packs should be	Service Development Manager ~~August 2021~~ December 2021	We were advised that: i) The direct payment team meet every week to discuss cases where concerns have been raised about lack of monitoring information or potential misuse of funds. ii) The direct payment team complete monthly monitoring for all adults in receipt of a self-managed DP service. A member of staff monitors the Allpay prepaid card system used by some individuals in receipt of a DP. This staff member will raise any discrepancies or anomalies with the relevant monitoring officers in the Direct Payment team. The PBCF Service is working with the Commissioning Division and People Plus, a direct payment third party support provider, to review the arrangements

Recommendation and Priority Level	Manager Responsible & Due Date	Latest Implementation Status
monitored to ensure that information is received and the reviews can then be completed. Where the return of the information is delayed, matters should be escalated in line with the relevant procedures and suspension considered if appropriate. (iv) The direct payment team should determine whether it is possible to run a schedule report on a regular basis on Mosaic to capture relevant review dates. Should this not be possible, manual records should be kept on a spreadsheet indicating when the next review should take place and spot checks should be completed by management to ensure reviews are being completed. **Medium**		for monitoring accounts managed by a third party. In terms of self-managed accounts, the Monitoring officers in the direct payment team will review the client information submitted each month and will follow up with individuals who have not provided this documentation. Phone calls are made to individuals who have not provided monitoring information [client information] and a letter is subsequently sent. If two months have passed without monitoring information being provided an escalation letter will be sent with a further escalation letter sent after three months. The relevant social work team will be alerted if the monitoring forms [client information] have not been submitted within the last 3 months. Iii) At the time of writing the monitoring forms are completed outside of Mosaic but this is due to be amended in the coming months. Once the monitoring form is created within Mosaic we will be able to report the date of the last review date and add the due date for the next review. We will then be able to evidence the percentage of monitoring forms completed each month. At present a spreadsheet is kept and maintained to show when the last reviews were completed.

APPENDIX 1

OPINION SIGNIFICANCE DEFINITION

Level of Assurance	Design Opinion	Findings from review	Effectiveness Opinion	Findings from review
Substantial 	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
Moderate 	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non compliance with some controls, that may put some of the system objectives at risk.
Limited 	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
No 	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non compliance and/or compliance with inadequate controls.

FOR MORE INFORMATION:

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